

APPENDIX 1**REPORTS OF REFERENCE COMMITTEES**

November 2020 Special Meeting of the American Medical Association House of Delegates

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates at a given meeting and have precedence. Discrepancies between the reference committee reports and the Proceedings may exist, as the Proceedings are prepared using multiple sources, including a transcript of debate. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: Reference committee reports have historically been printed on blue paper; hence the blue background here. The original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a light-colored background as in the example below:

The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 18 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 18 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 18 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That the American Academy of Otolaryngic Allergy, American Association of Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Breast Surgeons, American Society of Interventional Pain Physicians, American Society of Retina Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart Rhythm Society, Infectious Disease Society of America, International Society for the Advancement of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the International Academy of Independent Medical Evaluators and the American Society of Abdominal Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Society for Aesthetic Plastic Surgery not retain representation in the House of Delegates. (Directive to Take Action)

The report was introduced by a member of the Board of Trustees and no further testimony was heard. Your Reference Committee recommends that Board of Trustees Report 18 be adopted.

- (2) COUNCIL ON CONSTITUTION & BYLAWS REPORT 1 – BYLAW ACCURACY: NAME CHANGE FOR ACCREDITATION BODY FOR OSTEOPATHIC MEDICAL SCHOOLS

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the Report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

1.1 Categories.

Categories of membership in the American Medical Association (AMA) are: Active Constituent, Active Direct, Affiliate, Honorary, and International.

1.1.1 Active Membership.

1.1.1.1 Active Constituent. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation ~~American Osteopathic Association~~ leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.2 Active Direct. Active direct members are those who apply for membership in the AMA directly. Applicants residing in states where the constituent association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the Federal Services that have been granted representation in the House of Delegates. Active direct members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation ~~American Osteopathic Association~~ leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

The report was introduced by the Council, and the limited testimony heard was supportive of the report. Your Reference Committee therefore recommends that Council on Constitution and Bylaws Report 1 be adopted.

(3) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 – AMENDMENT TO OPINION 1.2.2, “DISRUPTIVE BEHAVIOR AND DISCRIMINATION BY PATIENTS”

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 1 adopted and the remainder of the report filed.

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, “Discrimination against Physicians by Patients,” be rescinded; that the title of Opinion 1.2.2, be amended to read

“Disruptive Behavior and Discrimination by Patients”; that the body of Opinion 1.2.2 be amended by addition and deletion as follows; and the remainder of this report be filed:

The relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.

Disrespectful, or derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either ~~physicians-patients or physicians~~ can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.

(b) Always treat patients with compassion and respect.

(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient’s behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) Prioritize the goals of care when deciding whether to decline or accommodate a patient’s ~~prejudiced request for an alternative physician~~. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.

(e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests.

(f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.

(g) Terminate the patient-physician relationship ~~who uses derogatory language or acts in a prejudiced manner~~ only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient’s control, in keeping with ethics guidance.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

(i) Educate staff, patients, and the community about the institution’s expectations for behavior.

(j) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.

(1) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.

Mixed testimony was heard on this report. Speakers noted that the type of discriminatory, abusive, and disruptive behavior referenced in this report seems to be increasing and is thus critically important to address at this time. Other speakers approvingly noted that the report effectively offered protections to physicians. Opposing testimony, recommending referral, questioned certain clauses in the report's recommendations and expressed concern that as written would only allow physicians to refuse a patient under specific circumstances, and in addition, don't account for emergency situations. However, your Reference Committee believes that Principle VI of the *Code of Medical Ethics*, which states that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" addresses this sufficiently. Concerns were also raised regarding the feasibility of collecting data on these policies, but your Reference Committee believes that these clauses simply refer to medical practices examining the efficacy of their own policies. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 –
AMENDMENT TO OPINION 8.7, "ROUTINE UNIVERSAL
IMMUNIZATION OF PHYSICIANS"

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 2 adopted and the remainder of the report filed.

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.7, "Routine Universal Immunization of Physicians," be amended by insertion and deletion as follows and that the remainder of this report be filed:

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians ~~should~~

~~Accept~~ have a responsibility to accept immunization absent a recognized medical, ~~religious, or philosophic reason to not be immunized~~ contraindication or when a specific vaccine would pose a significant risk to the physician's patients.

~~(b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status.~~

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with

decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.

Testimony largely supported this report. Speakers noted that vaccine resistance and hesitancy is increasing among patients and non-physician healthcare practitioners alike, and that it is essential that the medical profession serve as an example on this matter. Other testimony noted that the report is appropriately consistent with advice given by physicians to their patients. Speakers noted that this is an urgent issue given the COVID-19 pandemic, and that as the organization representing medicine and science, the AMA should act on those principles. Testimony also noted that H-440.970, "Nonmedical Exemptions from Immunizations" holds 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."

Some speakers stated that banning philosophical and religious exceptions is unconstitutional, but others countered that philosophical and religious exemptions are often used in ways that are invalid. Further, regardless of the reason for declining vaccination, physicians who do decline vaccination should modify their roles to avoid direct patient-facing care as stated in the recommendations. Your Reference Committee recommends that CEJA Report 2 be adopted and the remainder of the report be filed.

(5) RESOLUTION 8 – DELEGATE APPORTIONMENT DURING COVID-19 PANDEMIC CRISIS

RECOMMENDATION:

Resolution 8 be adopted.

HOD ACTION: Resolution 8 adopted.

RESOLVED, That our American Medical Association extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022. (Directive to Take Action)

Limited testimony was heard in support of Resolution 8. Your Reference Committee recommends that Resolution 8 be adopted.

(6) RESOLUTION 11 – ELIMINATION OF RACE AS A PROXY FOR ANCESTRY, GENETICS, AND BIOLOGY IN MEDICAL EDUCATION, RESEARCH, AND CLINICAL PRACTICE

RECOMMENDATION:

Resolution 11 be adopted.

HOD ACTION: Resolution 11 adopted.

RESOLVED, That our American Medical Association recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology (New HOD Policy); and be it further

RESOLVED, That our AMA support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice (New HOD Policy); and be it further

RESOLVED, That our AMA encourage undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (1) demonstrates how the category “race” can influence health outcomes; (2) that supports race as a social construct and not a biological determinant and (3) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities (New HOD Policy); and be it further

RESOLVED, That our AMA recommend that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Directive to Take Action)

Testimony was unanimously in support of Resolution 11, reiterating that – as evidence clearly supports – race is a social rather than biological construct. Speakers emphasized that this is a critical issue facing our country, and because racism is a broadly embedded issue in medical research and scholarship, the AMA must work to combat racism throughout the profession. As such, using the more precise and accurate data markers of ancestry, genetics, and biology, as well as other indicators such as zip code and education, where appropriate, instead of race, will contribute to better outcomes and, hopefully, increase health equity. Further testimony noted that it is not sufficient for medicine to be non-racist, but that medicine must be anti-racist. Your Reference Committee recommends that Resolution 11 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) COUNCIL ON CONSTITUTION & BYLAWS REPORT 2 – DISCORDANCE BETWEEN POLICY AND BYLAWS--CEJA MEMBERSHIP ON AMA COMMITTEE ON CONDUCT AT AMA MEETINGS AND EVENTS

RECOMMENDATION A:

Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” be amended by addition to read as follows:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

...

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

RECOMMENDATION B:

Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” be adopted as amended.

RECOMMENDATION C:

Recommendations in Council on Constitution and Bylaws Report 2 adopted and the remainder of the Report filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 2 adopted. the remainder of the Report be filed. and Policy H-140.837 adopted as amended.

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Constitution and Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

6.5 Council on Ethical and Judicial Affairs.

6.5.5 Membership.

6.5.5.1 Nine active members of the AMA, one of whom shall be a resident/fellow physician and one of whom shall be a medical student. Members elected to the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy.

Limited and mixed testimony was heard on this report. The Reference Committee recognizes that the original purpose of this report was to reconcile the discordance created by policy adopted at A-19 requiring a member of CEJA be on CCAM, and the bylaws pertaining to CEJA. Your Reference Committee believes this to have been accomplished with the original recommendation of CCB 2.

However, a separate issue was raised during testimony regarding a potential conflict of interest for the CEJA member when cases brought before CCAM concern possible referral by the CCAM of a matter to CEJA for further review and action.

Your Reference Committee acknowledges that a conflict of interest might exist in those situations, and that it is not appropriate for an individual to participate both as a member of CCAM and member of CEJA for the same case. Your Reference Committee consulted with the Office of General Counsel on the most appropriate way to address this issue. As a result, your Reference Committee recommends that H-140.837, "Policy on Conduct at AMA Meetings and Events," be amended to address the perceived conflict.

Therefore, your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted, and HOD-140.837 be adopted as amended.

(8) RESOLUTION 5 – RACISM AS A PUBLIC HEALTH THREAT

RECOMMENDATION A:

The first Resolve of Resolution 5 be amended by addition and deletion.

RESOLVED, That our American Medical Association acknowledge 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 ~~historic and present racist medical practices~~ have caused and continue to cause harm to marginalized communities and society as a whole (New HOD Policy);

RECOMMENDATION B:

The third Resolve of Resolution 5 be amended by addition.

RESOLVED, That our AMA 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 (Directive to Take Action);

RECOMMENDATION C:

Resolution 5 be adopted as amended.

HOD ACTION: Resolution 5 adopted as amended.

RESOLVED, That our American Medical Association acknowledge that historic and present racist medical practices have caused and continue to cause harm to marginalized communities (New HOD Policy); and be it further

RESOLVED, That our AMA recognize 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 (New HOD Policy); and be it further

RESOLVED, That our AMA 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, and populations (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:

1. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and
2. How to prevent and ameliorate the health effects of racism (New HOD Policy); and be it further

RESOLVED, That our AMA: (a) support the development of policy to combat racism and its effects; (b) encourage 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 (New HOD Policy); and be it further

RESOLVED, That our AMA work to prevent and combat the influences of racism and bias in innovative health technologies. (Directive to Take Action)

Testimony strongly supported this resolution with amendments proffered in the Online Forum by the original author in collaboration with other groups. Speakers noted that it is essential for the house of medicine to acknowledge historical racism and that racism in all its forms is a public health threat. Testimony widely supported the first

resolve as amended. The second resolve was lauded as consistent with AMA policy and would strengthen future AMA advocacy efforts. While testimony was also offered suggesting that the third through sixth resolves be referred, a number of speakers suggested that the topic has been thoroughly studied and that referral is unnecessary. Your Reference Committee agrees that referral is not needed.

Importantly, testimony called attention to the fact that IMG's as a group have been significantly impacted by the effects of racism, which has been highlighted by the pandemic. There was overwhelming support of the amendment to include this overlooked group in the third resolve.

Your Reference Committee would like to acknowledge that there was significant discussion regarding the phrase "racist medical practices," which was used in the original language of the first resolve. It was suggested that such phrasing was imprecise and inflammatory, but others responded, and your Reference Committee agrees, that the phrase reflects fact and history. However, this discussion did not affect the enthusiasm for the previously noted amendment to the first resolve because the amendment doesn't include this phrase.

Your Reference Committee recommends that Resolution 5 be adopted as amended.

(9) RESOLUTION 10 – RACIAL ESSENTIALISM IN MEDICINE

RECOMMENDATION A:

The Third Resolve in Resolution 10 be amended by addition and deletion.

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders ~~organizations~~, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may ~~perpetuate~~ be perpetuating ~~teachings, assessments, and practices that reinforce institutional and structural racism~~ the mistaken belief that race is an inherent biologic risk factor for diseases (Directive to Take Action)

RECOMMENDATION B:

Resolution 10 be adopted as amended.

HOD ACTION: Resolution 10 adopted as amended.

RESOLVED, That our American Medical Association recognize that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME, other appropriate stakeholder organizations, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors (Directive to Take Action); and be it further

RESOLVED, That our AMA support research that promotes antiracist strategies to mitigate algorithmic bias in medicine. (Directive to Take Action)

Virtually all testimony strongly supported Resolution 10. In the online forum, the authors of the resolution provided the amendments shown above. They did so in response to concerns about unintended consequences and the potential vague nature of the original language. Testimony in the Online Forum and in the reference committee hearing agreed with the changes, as the amended resolve is much more precise: changing “organizations” to “stakeholders” allows for broader inclusion of appropriate parties to join future efforts, and the other changes now identify specific practices that perpetuate institutional and structural racism.

The few speaking against adoption as originally written suggested that the first three resolve clauses were based on opinion or limited evidence, but a number of speakers countered that assertion, reiterating that race is undeniably a social construct and should be treated as such. Others agreed, citing studies that demonstrate the false conflation of race with biological and genetic traits and the resulting detrimental outcomes for patients. Testimony also noted that the resolution is consistent with previous AMA statements.

An amendment was discussed regarding changing “support” to “encourage” in the fifth resolve clause, but testimony, including that from the authors, led to the original language being retained as it gives the AMA a much more active role in addressing these issues directly.

Your Reference Committee agrees with the rationale and language of the proffered amendments and thus recommends that Resolution 10 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(10) RESOLUTION 7 – ACCESS TO CONFIDENTIAL HEALTH CARE SERVICES FOR PHYSICIANS AND TRAINEES

RECOMMENDATION A:

That the following Resolution be adopted in lieu of Resolution 7:

RESOLVED, That our American Medical Association advocate that: (1) physicians, medical students and all members of the health care team (a) maintain self-care, and (b) are supported by their institutions in their self-care efforts, and (c) in order to maintain the confidentiality of care ~~when they have concerns about psychiatric or substance-related symptoms that are not responding to self-care, have access to affordable health care, including mental and physical health care, have the opportunity to seek appropriate care~~ outside of their place of work or education; (2) employers support access to mental and physical health care ~~do all they can,~~ including but not limited to providing ~~promoting~~ access to providers out-of-network in person and/or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment entry, for those who need professional behavioral health care services (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for ~~study~~ best practices to ensure physicians, medical students and all members of the health care teams have access to appropriate behavioral, mental, primary, and specialty health care and addiction services, as affected by deductibles, copays, coinsurance, out-of-pocket maximums and access to out-of-network providers. (Directive to Take Action)

RECOMMENDATION B:

Alternate Resolution 7 be adopted in lieu of Resolution 7.

HOD ACTION: Alternate Resolution 7 adopted in lieu of Resolution 7.

RESOLVED, That our American Medical Association advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors, should encourage them to maintain self-care and to seek professional help from a mental health professional or addiction professional when they have concerns about psychiatric or substance-related symptoms that are not responding to self-care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors should do all they can to reduce stigma, reduce or eliminate discrimination, and remove barriers to treatment entry for those who need professional behavioral health care services (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that employers in the health care sector including academic medical centers where residents and fellows are trained, as well as medical schools, who offer health benefits to their employees, fellows, residents and medical students, and where there is a defined set of in-network providers, should assure that physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors are able to go out-of-network to see a mental health or addiction professional who does not work in the same health system as the employee (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that fellows, residents and medical students be provided access to out-of-network providers when they are seeking to establish care with a primary care provider, so that they are able to use their health insurance benefits while not finding themselves under the care of a past, current or future faculty member, if the original provider network does not contain adequate options for primary care offered by clinicians not on the faculty of the medical school or academic medical center; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate that contracts should be established by medical schools, academic medical centers, and employers of practicing physicians such that the deductibles, copays, coinsurance, and out-of-pocket maximums for such practicing physicians, fellows, residents and medical students seeing out-of-network providers of mental health, addiction, and primary medical care should be the same as the deductibles, copays, coinsurance, and out-of-pocket maximums for seeing in-network providers. (Directive to Take Action)

Testimony was heard in support of the goals of Resolution 7. Speakers noted that physicians and medical trainees experience high levels of burnout, often do not receive mental health care, and are hesitant to reach out for mental health care due to stigma and concerns about job loss due to issues with confidentiality. Testimony also noted that this crisis has been exacerbated by the COVID-19 pandemic.

Some speakers suggested modifying the language to narrow the focus on physicians and physicians in training. Others suggested additional language to include advocacy for state and federal legislation. Other concerns included the need to specifically include addiction, existing systems for medical students to receive mental health care outside of their system, and the feasibility of finding a physician-led team when practicing in rural areas. All speakers noted the urgency of this issue in general and the need for AMA action.

All in all, your Reference Committee agrees that this is an urgent issue that our AMA should address now, yet also deserves further study to address the specific concerns regarding implementation. As such, your Reference Committee has offered resolves in lieu of the original resolves, and recommends that Alternate Resolution 7 be adopted in lieu of Resolution 7.

REPORT OF REFERENCE COMMITTEE A

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 3 – MEDICARE PRESCRIPTION DRUG AND VACCINE COVERAGE AND PAYMENT

RECOMMENDATION:

Recommendations in Council on Medical Service Report 3 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 203-A-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to solicit input from national medical specialty societies and state medical associations for their recommendations to ensure adequate Medicare Part B drug reimbursement. (Directive to Take Action)
2. That our AMA work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs. (Directive to Take Action)
3. That our AMA continue working with interested stakeholders to improve the utilization rates of adult vaccines by individuals enrolled in Medicare. (Directive to Take Action)
4. That our AMA reaffirm Policy H-440.860, which supports easing federally imposed immunization burdens by, for example, covering all vaccines in Medicare under Part B and simplifying the reimbursement process to eliminate payment-related barriers to immunization; and urges the Centers for Medicare & Medicaid Services (CMS) to raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy D-440.981, which supports adequate reimbursement for vaccines and their administration from all public and private payers; encourages health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and advocates that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-440.875, which states that our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices, the US Preventive Services Task Force, or based on prevailing preventive clinical health guidelines. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy D-330.954, which supports the use of Medicare drug price negotiation. (Reaffirm HOD Policy)
8. That our AMA reaffirm Policy H-110.980, which outlines safeguards to ensure that international drug price averages are used as a part of drug price negotiations in a way that upholds market-based principles and preserve patient access to necessary medications. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 3 was limited yet supportive. In introducing the report, a member of the Council on Medical Service emphasized that the prices and coverage of, and payment for, prescription drugs and vaccines under Medicare Parts B and D not only impact patients' ability to access the drugs and vaccines they

need, but also impact physicians' ability to cover their costs associated with acquiring, storing and administering Part B drugs, and Part B and Part D vaccines. The Council member further stressed that the time is now for organized medicine to move forward with building consensus on which alternative methods would be preferred to reimburse physicians for the cost of Part B drugs. A proposed amendment to Recommendation 2 of the report called for the deletion of the term "hospitals" from the recommendation. However, the majority of testimony supported the report as written, as prescription drugs administered in physicians' offices and hospital outpatient clinics fall under Medicare Part B coverage of physician services.

Your Reference Committee believes that Council on Medical Service Report 3 strongly responds to concerns raised at past House of Delegates meetings concerning the payment for and coverage of prescription drugs and vaccines under Medicare Parts B and D. As such, your Reference Committee believes that the recommendations of Council on Medical Service Report 3 should be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 5 – MEDICAID REFORM

RECOMMENDATION:

Recommendations in Council on Medical Service Report 5 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 809-I-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (New HOD Policy)
2. That our AMA reaffirm Policy H-290.986, which supports the Medicaid program's role as a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL) including the income disregard)] as authorized by the ACA. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and maintaining federal funding for Medicaid expansion populations at 90 percent beyond 2020. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-290.966, which supports state Medicaid waivers, provided they promote improving access to quality medical care; are properly funded; have sufficient provider payment levels; and do not coerce physicians into participating. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-290.963, which opposes caps on federal Medicaid funding. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. (Reaffirm HOD Policy)

Testimony was supportive of Council on Medical Service Report 5. A member of the Council on Medical Service introduced the report and stated that the Council agreed with the intent of the principles proposed in the referred resolution and found them to be largely addressed by existing AMA policies. Additional testimony focused on the need to help safeguard Medicaid funding as millions of newly unemployed Americans turn to the program for health

coverage. A representative of the AMA Women Physicians Section testified that Medicaid is a crucial safety net for low-income women and families, and that buttressing the program in times of economic difficulties via increased federal funding, as addressed by Recommendation 1, is critical to facilitating access to care.

A proposed amendment to Recommendation 1 of the report specified support for legislation that triggers automatic increases in states' Federal Medical Assistance Percentages (FMAPs) based on national and state unemployment data. However, the testimony supported the report as written. Your Reference Committee believes that the proposed amendment could be construed as too prescriptive and could hinder AMA support of proposals to increase states' FMAPs outside of an automatic trigger. Therefore, your Reference Committee believes that the recommendations of Council on Medical Service 5 should be adopted as written.

(3) COUNCIL ON MEDICAL SERVICE REPORT 6 – VALUE-BASED MANAGEMENT OF DRUG FORMULARIES

RECOMMENDATION:

Recommendations in Council on Medical Service Report 6 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 6 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 814-I-19, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-120.988, upholding the ability of patients to access treatments prescribed by their physicians. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-285.965, which states that pharmacy and therapeutics (P&T) committee members should include independent physician representatives, and that mechanisms should be established for ongoing peer review of formulary policy as well as for appealing formulary exclusions. (Reaffirm HOD Policy)
3. That our AMA advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class. (New HOD Policy)
4. That our AMA reaffirm Policy D-110.987, which supports improved transparency of PBM operations, including disclosing rebate and discount information as well as 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; and formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-110.986, which outlines principles guiding AMA's support for value-based pricing programs, initiatives and mechanisms for pharmaceuticals. (Reaffirm HOD Policy)
6. That our AMA advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients. (New HOD Policy)
7. That our AMA oppose indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (New HOD Policy)

There was supportive testimony on Council on Medical Service Report 6. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of Council on Medical Service Report 6

highlight a key AMA position: When the prescription of a drug represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy. In addition, the Council member noted that the report recommends policies that are timely and in the best interest of patients.

An amendment was offered to one of these policies, Recommendation 6 of the report, to change the wording so that refunds and rebates under an outcomes-based contract would be shared with patients directly if not being applied to reduce premiums and/or increase benefits in the subsequent year. However, your Reference Committee believes that the amendment is too prescriptive.

In addition, there was a proposed amendment to add language clarifying that transparency should also include all rebates paid to any party. However, your Reference Committee notes that the amendment is already addressed in existing Policy D-110.987, recommended for reaffirmation in Council on Medical Service Report 6. Your Reference Committee believes that the recommendations of Council on Medical Service Report 6 augment the policy of our AMA pertaining to the value-based management of drug formularies, and recommends their adoption.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) COUNCIL ON MEDICAL SERVICE REPORT 1 –OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM

1. That our American Medical Association (AMA) ~~support~~ advocate that any public option to expand health insurance coverage must meet the following standards:

RECOMMENDATION A:

Recommendation 1(b) in Council on Medical Service Report 1 be amended by addition to read as follows:

1(b) Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.

RECOMMENDATION B:

Recommendation 1(c) in Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

1(c) Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice ~~not be tied to Medicare and/or Medicaid rates~~.

RECOMMENDATION C:

Recommendation 1 in Council on Medical Service Report 1 be amended by addition of a new principle to read as follows:

The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

RECOMMENDATION D:

Recommendation 2(c) in Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

2(c) Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled ~~enrolling in health insurance coverage~~.

RECOMMENDATION E:

Recommendation 2(e) in Council on Medical Service Report 1 be amended by deletion to read as follows:

2(e) Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium ~~bronze~~ plans with the highest actuarial values.

RECOMMENDATION F:

Recommendation 2(f) in Council on Medical Service Report 1 be amended by addition to read as follows:

2(f) Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.

RECOMMENDATION G:

Recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted as amended and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 113-A-19, Resolution 114-A-19, the alternate resolution proposed by Reference Committee A, and the amendment offered during the House of Delegates' consideration of item 9 of the report of Reference Committee A, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support that a public option to expand health insurance coverage must meet the following standards:

- a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
- b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage.
- c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must not be tied to Medicare and/or Medicaid rates.
- d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
- e. The public option is financially self-sustaining and has uniform solvency requirements.
- f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. (New HOD Policy)

2. That our AMA support states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
- b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
- c. Individuals should have the opportunity to opt out from enrolling in health insurance coverage.
- d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
- e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium bronze plans with the highest actuarial values.

- f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze plans, to maximize the value of zero-premium plans to plan enrollees.
- g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
- h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.825, which states that the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan should be required to offer at least one silver-level marketplace plan as a condition of FEHBP participation. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-165.828, which encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy. (Reaffirm HOD Policy)

Your Reference Committee appreciates all of the testimony provided on the online member forum and during the live hearing, and all of the amendments proffered, on the recommendations of Council on Medical Service Report 1. Your Reference Committee underscores that our AMA establishing new policy on auto-enrollment in health insurance coverage and defining the minimum requirements for any proposed public option is critical to expanding the coverage reach of our AMA proposal for reform, as well as achieving the Association's longstanding goal of covering the uninsured. Specifically, the report proposes that a public option meet the criteria outlined in Recommendation 1, and your Reference Committee believes that utilizing the term "must" at the beginning of the recommendation is critical to stress the importance of each individual guardrail contained in Recommendation 1.

Your Reference Committee does understand that the term "public option" has several different meanings and is a politically charged term. However, the chair of the Council on Medical Service testified that it is absolutely essential – and timely – for our AMA to take ownership of the term and define what we as an organization want a potential public option to look like. In addition, developing policy specific to a public option will enable the AMA to participate fully – to be "at the table" – in any further discussions of proposals to establish a public option. Removing the term "public option" from Recommendation 1 would create confusion and ambiguity as the AMA pursues policy formation and advocacy in this space.

The Council on Medical Service offered amendments to its report both in the online member forum, and during the live hearing. A member of the Council on Legislation testified in support of the amendments offered by the Council on Medical Service, stating that the report recommendations with the proposed amendments of the Council on Medical Service will be very helpful as the COL evaluates legislative proposals in the future. In response to testimony posted on the online member forum addressing Recommendation 1(b), the Council on Medical Service offered amended language to ensure that individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits are eligible for financial assistance to purchase the public option. Testimony clarified that Recommendation 1(b) would not restrict all individuals with employer-sponsored insurance from accessing financial assistance to purchase the public option. Rather, only individuals with unaffordable employer-sponsored coverage, or those with employer-sponsored coverage that does not meet standards for minimum value of benefits, would be eligible for financial assistance. The Reference Committee underscores that, with the suggested amendment to 1(b) offered by the Council on Medical Service, eligibility for financial assistance to purchase the public option would be the same as what currently exists to purchase private ACA marketplace plans, thereby increasing competition in the health insurance marketplace. The Council on Medical Service in its report underscored that the public option will not be disadvantaged by the guardrails proposed in Recommendation 1 of its report. Rather, the public option may have an advantage in the ACA marketplaces, as it may be more likely to be the plan against which premium tax credit amounts are based.

A member of the Council on Medical Service testified that opening up eligibility for financial assistance to purchase the public option to anyone with employer-sponsored coverage would have devastating consequences for physician practices. The Council member highlighted that the Urban Institute stated that the number of people enrolled in employer coverage is more than nine times the number in non-group coverage, and because employer-based plans

tend to pay health care providers higher rates than do non-group insurers, introducing the public option could have far-reaching, substantial impacts on both spending and health care provider revenues. The Council member stressed that opening up eligibility for financial assistance to all individuals with employer-sponsored coverage to purchase the public option may in fact reduce the number of health plans available to patients, due to the public option becoming a dominant insurer, going against longstanding AMA policy in support of maximizing health plan choices for patients.

While Recommendation 1(b) stipulates that financial assistance should be made available to individuals to purchase the public option when employer-sponsored coverage is unaffordable, your Reference Committee heard testimony stressing that the public option would remain available for anyone to purchase. Only eligibility for financial assistance would be restricted – to purchase either the public option or private ACA marketplace plans. Financial assistance to purchase the public option, considering finite federal resources, would therefore be available to those who need it the most.

Building off of that premise, your Reference Committee also accepted an amendment to add a principle to Recommendation 1 offered by the Council on Medical Service, responding to testimony and amendments proffered in the online member forum, that stated that the public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid (2.3 million people in 2018) – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost. Your Reference Committee believes that covering this population – which has incomes of less than \$12,760 for an individual and \$26,200 for a family of four – is an essential step to fulfilling the goals of the AMA plan to cover the uninsured.

Your Reference Committee also accepted an amendment offered by the Council on Medical Service to Recommendation 1(c), which serves as an appropriate middle ground in guiding how payment rates under any public option should be established. The amendment maintains the ability of individual physician practices to meaningfully negotiate their payment levels and contracts. At the same time, the amendment opened the door for our AMA to support public option proposals that have physician payments higher than prevailing Medicare rates and importantly, at rates sufficient to sustain the costs of medical practice. Your Reference Committee believes that other amendments proffered to Recommendation 1(c) would have unintended consequences, ultimately removing the ability of individual physician practices to negotiate their own payment rates.

Principles 1(e) and 1(f) again highlight a goal of the Council on Medical Service for the public option to compete on a level playing field with private ACA marketplace plan offerings. Your Reference Committee did not accept an amendment made to 1(e) to require the public option to be “optimally” self-sustaining for that reason, as private ACA marketplace plans also must be financially self-sustaining. Concerning 1(f), under the policy for a public option proposed by the Council on Medical Service, the coverage of lower-income people who choose the public option would be subsidized in the same manner as currently afforded to private ACA marketplace plans – premium and cost-sharing subsidies based on one’s income. The public option would not receive advantageous government subsidies in comparison to those provided to other health plans. As outlined in the report, the Council on Medical Service believes that limited federal financial resources would be more effectively spent in expanding the eligibility for and increasing the size of premium tax credits and cost-sharing reductions.

The Council on Medical Service also offered three amendments to Recommendation 2 of the report, in response to testimony posted in the online member forum. While the amendment to Recommendation 2(c) was clarifying in nature, the amendments to Recommendations 2(e) and 2(f) support individuals being auto-enrolled into plans with the highest possible actuarial values. For some, a zero-premium plan into which they would be auto-enrolled would be a bronze plan. For others, it may be a silver plan, which covers more benefits costs, and would also enable qualifying individuals to receive cost-sharing reductions. As bronze and silver plans will be the most common plans into which people will be auto-enrolled, calling for more pre-deductible coverage in silver plans in addition to bronze plans serves as a prudent policy addition.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 1 should be adopted as amended, serving as a needed first step in our AMA having policy pertaining to a potential public option as well as auto-enrollment. Both of these policy options have tremendous potential to cover millions more patients

under the AMA proposal for reform. Your Reference Committee underscores that our House of Delegates can refine and add to this policy at future meetings, to best serve our patients and our physician members.

(5) COUNCIL ON MEDICAL SERVICE REPORT 7 – HEALTH PLAN INITIATIVES ADDRESSING SOCIAL DETERMINANTS OF HEALTH

RECOMMENDATION A:

Recommendation 5 in Council on Medical Service Report 7 be amended by addition to read as follows:

5. That our AMA support 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. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA), recognizing that social determinants of health encompass more than health care, encourage 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. (New HOD Policy)
2. That our AMA support continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs. (New HOD Policy)
3. That our AMA encourage 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. (New HOD Policy)
4. That our AMA reaffirm Policies D-478.972 and D-478.996 supporting proactive and practical approaches to promote interoperability at the point of care. (Reaffirm HOD Policy)
5. That our AMA support mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health. (New HOD Policy)
6. That our AMA support 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. (New HOD Policy)
7. That our AMA encourage 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. (New HOD Policy)

There was highly supportive testimony on Council on Medical Service Report 7. In response to an amendment proffered on the online member forum, the Council on Medical Service offered an amendment to Recommendation

5 of the report during the live hearing. Your Reference Committee agrees with the amendment, as minimizing burdens on patients and physicians in data acquisition initiatives is essential.

While your Reference Committee understands the importance of other amendments offered to the report which addressed the integration of social determinants of health with quality measurement, they were not germane to this report.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 7 as amended fulfill the need for our AMA to have additional policy to respond to innovative health plan initiatives that incorporate social determinants of health in health insurance benefit design and coverage. Your Reference Committee believes that the recommendations of Council on Medical Service 7 should be adopted.

(6) RESOLUTION 114 – ESTABLISHING A PROFESSIONAL SERVICES CLAIMS-BASED PAYMENT ENHANCEMENT FOR ACTIVITIES ASSOCIATED WITH THE COVID-19 PANDEMIC

RECOMMENDATION A:

Resolution 114 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with ~~other~~ interested ~~parties~~ national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services ~~claims-based~~ payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to help recognize the additional uncompensated costs enhanced, non-separately reimbursable work associated with COVID-19 incurred performed by physicians during the COVID-19 Public Health Emergency. (Directive to Take Action)

RECOMMENDATION B

Resolution 114 be amended by addition of new Resolves to read as follows:

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency (New HOD Policy)

RECOMMENDATION C:

Resolution 114 be adopted as amended.

RECOMMENDATION D:

Title of Resolution 114 be changed to read as follows:

PHYSICIAN PAYMENT ADVOCACY FOR ADDITIONAL WORK AND EXPENSES INVOLVED IN TREATING PATIENTS DURING THE COVID-19 PANDEMIC AND FUTURE PUBLIC HEALTH EMERGENCIES

HOD ACTION: Resolution 114 adopted as amended with a change in title.

RESOLVED, That our American Medical Association work with other interested parties to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services claims-based payment enhancement to help recognize the enhanced, non-separately reimbursable work performed by physicians during the COVID-19 Public Health Emergency. (Directive to Take Action)

Alternate language was submitted by the authors in response to feedback and concerns regarding the intent and implementation of original Resolution 114. The second and third suggested Resolve clauses were also put forth by a member of the Council on Medical Service, and these Resolves enjoyed widespread support among most speakers. Testimony conveyed that the second and third proffered Resolve clauses are consistent with AMA policy and advocacy, and that they support compensating physicians (including those on the front lines) for additional work and expenses involved in treating patients during the public health emergency. A member of the Council on Legislation expressed support for this language and spoke to the AMA's aggressive efforts to address the COVID-19 public health emergency as it pertains to funding and payment for health care-related expenses and losses. Testimony highlighted sign-on letters sent last week to the Centers for Medicare & Medicaid Services (CMS) and large private insurers asking them to implement and pay for CPT code 99072 to compensate practices for additional practice expenses included in an office visit or other non-facility service when performed during the public health emergency.

There was mixed testimony on the proffered amendment to the first Resolve clause which was very similar to original Resolution 114 but without the term "claims-based." Some speakers expressed concern that the proffered amendment to the first Resolve clause may not be aligned with longstanding AMA policy supporting the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) processes. A speaker also raised reservations about the optics of establishing a professional services payment enhancement for activities associated with the COVID-19 pandemic.

Several speakers offered strong support of the intent of the proffered amendment to the first Resolve clause and the need for the AMA to support the efforts of physicians to engage CMS to use CARES Act funds to support the increased level of physician work associated with caring for patients during the COVID-19 public health emergency. Testimony recognized that COVID-19 has been extremely challenging and that physicians are spending more time on patient care and performing additional activities associated with managing the pandemic. Supporters of the proffered amendment to the first Resolve also testified that it does not require a new CPT code. Accordingly, your Reference Committee recommends adoption of Resolution 114 as amended with a change in title.

RECOMMENDED FOR ADOPTION IN LIEU OF

(7) RESOLUTION 105 – ACCESS TO MEDICATION

RECOMMENDATION:

Alternate Resolution 105 be adopted in lieu of Resolution 105.

RESOLVED, That our American Medical Association advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies.
(New HOD Policy)

HOD ACTION: Alternate Resolution 105 adopted in lieu of Resolution 105

RESOLVED, That our American Medical Association seek regulations on a national level that would prohibit pharmacy benefit plans from limiting patient access to medications because an initial prescription was placed and/or filled by mail-order.

There was generally supportive testimony on Resolution 105. However, a member of the Council on Medical Service testified that prescription transfers fall under the jurisdiction of state boards of pharmacy, and therefore are not under the purview of federal regulations. As such, the member of the Council on Medical Service offered alternate language to fulfill the intent of the resolution. Your Reference Committee accepts the alternate language proffered by the Council on Medical Service, and recommends that it be adopted in lieu of Resolution 105.

RECOMMENDED FOR REFERRAL

(8) RESOLUTION 101 – END OF LIFE CARE PAYMENT

RECOMMENDATION:

Resolution 101 be referred.

HOD ACTION: Resolution 101 referred.

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services to allow hospice patients to cover the cost of housing (“room and board”) as a patient in a nursing home or assisted living facility (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that patients be allowed to use their skilled nursing home benefit while receiving hospice services. (Directive to Take Action)

Most of the testimony called for referral of Resolution 101. Comments highlighted the complex issues related to Medicare’s skilled nursing facility (SNF) and hospice benefits and concerns about end-of-life patients having to choose between SNF and hospice care. Additional testimony pointed out that Resolution 101 proposes a new Medicare room and board coverage benefit, which represents a significant change in Medicare coverage that requires further analysis before new AMA policy is adopted. Your Reference Committee agrees that Resolution 101 raises important policy issues worthy of further study and recommends that it be referred.

REPORT OF REFERENCE COMMITTEE B

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 5 –FDA CONFLICT OF INTEREST

RECOMMENDATION:

Recommendations in Board of Trustees Report 5 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 5 adopted and the remainder of the Report filed.

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 216-A-18 and the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-100.992, “FDA,” which supports that FDA conflicts of interest should not overrule scientific evidence in making policy decisions and the FDA should include clinical experts on advisory committees. (Reaffirm HOD 14 Policy)
2. That our AMA adopt the following new policy:
 - It is the position of the AMA that decisions of the Food and Drug Administration (FDA) must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that FDA decisions and the recommendations of FDA advisory committees are ethically and scientifically credible and derived through a process that is rigorous, independent, transparent, and accountable. Rigorous policies and procedures should be in place to minimize the potential for financial or other interests to influence the process at all key steps. These should include, but not necessarily be limited to: a) required disclosure of all relevant actual or potential conflicts of interest, both financial and personal; b) a mechanism to independently audit disclosures when warranted; c) clearly defined criteria for identifying and assessing the magnitude and materiality of conflicts of interest; and d) clearly defined processes for preventing or terminating the participation of a conflicted member, and mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when an individual’s participation cannot be terminated due to the individual’s unique or rare skillset or background that is deemed highly valuable to the process. Further, clear statements of COI policy and procedures, and disclosures of FDA advisory committee members’ conflicts of interest relating to specific recommendations, should be published or otherwise made public. Participation on advisory committees should be facilitated through appropriate balancing of the relative scarcity or uniqueness of an individual’s expertise and ability to contribute to the process, as compared to the feasibility and effectiveness of mitigation measures. Finally, our AMA urges the FDA to streamline the COI process to the greatest extent possible, thereby eliminating any unnecessary documentation, delays, or administrative barriers to qualified physicians’ participation on FDA advisory committees. (New HOD Policy)
3. That our AMA adopt the following new policy:
 - It is the position of the AMA that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after his or her initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue. (New HOD Policy)

Your Reference Committee heard overwhelming supportive testimony on Board of Trustees Report 5. The only reason that the HOD referred the previous version (Board of Trustees Report 19-A-19) of Board of Trustees Report 5 was the desire to make a minor revision, adding language that would call on our AMA to adopt policy that called

on the U.S. Food and Drug Administration to streamline its advisory committee conflict of interest process. Given this minor revision, and the strong testimonial support for Board of Trustees Report 5, your Reference Committee recommends that Board of Trustees Report 5 be adopted, and the remainder of the Report be filed.

(2) BOARD OF TRUSTEES REPORT 6 – COVENANTS NOT TO COMPETE

RECOMMENDATION:

Recommendation in Board of Trustees Report 6 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 6 adopted and the remainder of the Report filed.

In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 10-A-19 and the remainder of this report be filed:

Our AMA create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Board Report 6. Testimony indicated a growing concern that post-employment non-competes can be problematic for employed physicians and the patient-physician relationship, particularly where physicians may be employed by non-physician-owned entities such as large health systems. Testimony indicated that AMA members are on both sides of this issue, but that our AMA's providing a thoughtful informational resource in the form of a legislative template would be useful for physicians, regardless of their perspective on non-competes and their use.

During the hearing, your Reference Committee received testimony from the American College of Radiology (ACR) requesting that the recommendation in Board Report 6 be amended to encompass anti-disparagement and non-disclosure clauses in addition to non-competes. Your Reference Committee also heard testimony stating that the proposed amendment is beyond the scope of Board of Trustees Report 6 and could cloud the report's singular focus on covenants not to complete—an issue of great concern to many physicians that has been repeatedly raised in the House of Delegates. While your Reference Committee believes that the ACR amendment has merit, we agree with those who opined that it is beyond the scope of BOT 6. Therefore, your Reference Committee does not believe it should be adopted as part of BOT 6. Because the proposed amendment is not an item of business before the HOD, it is procedurally unable to be referred at this time. A representative from our AMA Board of Trustees indicated the Board is already aware of the issue. Your Reference Committee therefore recommends that Board of Trustees Report 6 be adopted and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 13 – MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) UPDATE

RECOMMENDATION:

Recommendations in Board of Trustees Report 13 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 13 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support 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. (Directive to Take Action)
2. That our AMA reaffirm Policy D-395.999, “Reducing MIPS Reporting Burden,” Policy D27 395.998, “Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program,” Policy H-390.838, “MIPS and MACRA Exemption,” Policy D-390.950, “Preserving a Period of Stability in Implementation of the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA),” Policy D-390.949, “Preserving Patient Access to Small Practices Under MACRA,” Policy H-385.913, “Physician-Focused Alternative Payment Models,” Policy H-385.913, “Physician-Focused Alternative Payment Models,” Policy H-450.931, “Moving to Alternative Payment Models,” and Policy H-385.908, “Physician-Focused Alternative Payment Models: Reducing Barriers.” (Reaffirm HOD Policy)

Your Reference Committee heard overwhelming supportive testimony on Board of Trustees Report 13. Your Reference Committee heard that our AMA has worked closely with Centers for Medicare & Medicare Services (CMS) and Congress on implementing the MIPS program, and our AMA advocacy efforts resulted in policies that have improved some, but not all, aspects of MIPS. Your Reference Committee heard that our AMA has strong policy discussing the MIPS issues, and has long articulated and advocated for policies to positively impact physician payment and reporting. Similarly, our AMA continues to advocate against systems that increase administrative burden, decrease reimbursement, and negatively impact patient care. Your Reference Committee heard that our AMA should have the ability and the flexibility to support legislation that would provide physicians with positive payment updates that could shift the budget neutrality dynamic of the current MIPS program. Your Reference Committee also heard testimony concerning our AMA’s continued work with stakeholders to improve MIPS, such as streamlining reporting requirements to decrease physician burden, increasing the performance threshold, and refining the MIPS methodology to reduce the total cost of care measures outside of physicians’ control. Your Reference Committee heard the concerns of small practices, their need for support, especially in light of COVID-19 and planned cuts, and the importance of Medicare funding. Accordingly, your Reference Committee recommends that Board of Trustees Report 13 be adopted and the remainder of the Report be filed.

(4) RESOLUTION 202 – CARES ACT EQUITY AND LOAN FORGIVENESS IN THE MEDICARE ACCELERATED PAYMENT PROGRAM

RECOMMENDATION:

Resolution 202 be adopted.

HOD ACTION: Resolution 202 adopted as amended.

RESOLVED, That our AMA and the federation of medicine work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;

Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and

Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period (Directive to Take Action); and be it further

RESOLVED, That, in the setting of the COVID-19 pandemic, our AMA advocate for additional financial relief ~~for~~ ~~to~~ ~~physicians~~ ~~to~~ ~~reduce~~ ~~via~~ ~~loan~~ ~~forgiveness~~ ~~for~~ medical school educational debt. (Directive to Take Action)

RESOLVED, That our AMA and the federation of medicine work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

- Restarting the suspended Medicare Advance payment program, including significantly reducing the repayment interest rate and lengthening the repayment period;
- Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and
- Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period (Directive to Take Action); and be it further

RESOLVED, That, in the setting of the COVID-19 pandemic, our AMA advocate for additional relief to physicians via loan forgiveness for medical school educational debt. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Resolution 202. Your Reference Committee heard that our AMA continues to work on the issues identified in Resolution 202, and that many aspects in Resolution 202 are being implemented by our AMA Advocacy Team. Your Reference Committee heard multiple examples demonstrating AMA's continued advocacy on this important issue. Your Reference Committee also heard testimony that there is considerable difficulty for physician practices with large pediatric or Medicaid patient populations in obtaining CARES funding or support similar to Medicare. Your Reference Committee heard testimony on the need to expand funding to all physicians, not just those who serve patients covered by Medicare.

Your Reference Committee heard a considerable amount of discussion on the second Resolve, and considered an amendment that would change the terminology from "loan forgiveness" to "temporary deferment of loan repayment, including suspension of interest accumulation during the deferment period." However, your Reference Committee heard opposition to the proposed change, and determined that keeping the term broader would best meet the needs of our membership, therefore affording our AMA the flexibility to advocate for physician educational debt relief. Your Reference Committee considered our AMA's advocacy relating to medical school debt and recognizes that our Advocacy Team is continuing to seek legislative solutions in COVID relief legislation. Accordingly, your Reference Committee recommends that Resolution 202 be adopted.

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

(5) BOARD OF TRUSTEES REPORT 7 – OPPOSITION TO INVOLUNTARY CIVIC COMMITMENT FOR SUBSTANCE USE DISORDER

RECOMMENDATION A:

Recommendations in Board of Trustees Report 7 be adopted and the remainder of the Report be filed.

RECOMMENDATION B:

The title of Board of Trustees Report 7 be changed to read as follows:

INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER

HOD ACTION: Recommendations in Board of Trustees Report 7 adopted with change in title and the remainder of the Report filed.

The Board recommends that Resolution 22-A-19 be amended by addition and deletion and the remainder of the report be filed.

1. That our AMA oppose civil commitment proceedings for patients with a substance use disorder unless: a) A physician or mental health professional determines that civil commitment is in the patient's best interest consistent with the AMA Code of Medical Ethics; b) Judicial oversight is present to ensure that the patient can exercise his or her right to oppose the civil commitment; c) The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by his or her physician; and d) The facility is separate and distinct from a correctional facility. (New HOD 47 Policy)
2. That our AMA continue its work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Board of Trustees Report 7. Your Reference Committee heard discussions that highlighted concerns associated with involuntary civil commitment, as well as many of the ethical and legal issues that must be considered. Your Reference Committee is thankful that our AMA Code of Medical Ethics can play a critical role to ensure that our policy recommendations are well-informed by the ethical standards guiding our profession. Your Reference Committee is also very pleased that our colleagues at the American Psychiatric Association have excellent guidance in place that is publicly available to help guide this discussion and our practice, and we acknowledge supportive testimony to this effect. The issue of involuntary civil commitment has many gray areas, but your Reference Committee is satisfied that the conditions laid out by our Board provide excellent guidance moving forward. Your Reference Committee is also pleased by the report's discussion of our AMA's ongoing advocacy to address gaps in access to care for mental illness and substance use disorders. Given the scope of the nation's overdose epidemic and massive treatment gap, it is unconscionable that health insurance companies still display their continued intransigence to impose prior authorization for medications to treat opioid use disorder and ongoing violations of mental health and substance use disorder parity. Your Reference Committee is deeply appreciative of the efforts of our Council on Legislation to help develop model legislation and our AMA to partner with so many in our House of Medicine to remove barriers to evidence-based care.

Your Reference Committee also heard testimony offering an amendment to change the title of the Resolution to better reflect the report to read "Involuntary Civil Commitment for Substance Use Disorder." For these reasons, your Reference Committee recommends that Board of Trustees Report 7 be adopted, with a change in title as indicated, and the remainder of the report filed.

(6) BOARD OF TRUSTEES REPORT 14 – ADVOCATING FOR THE
STANDARDIZATION AND REGULATION OF OUTPATIENT ADDICTION
REHABILITATION FACILITIES

RECOMMENDATION A:

Recommendations in Board of Trustees Report 14 be adopted and the remainder of the Report be filed.

RECOMMENDATION B:

The title of Board of Trustees Report 14 be changed to read as follows:

ENHANCED FUNDING FOR AND ACCESS TO OUTPATIENT ADDICTION REHABILITATION

HOD ACTION: Recommendations in Board of Trustees Report 14 adopted with change in title and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 201-I-19, and that the remainder of the report be filed.

1. That our AMA advocate for the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state’s adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition. (Directive to Take Action)
2. That our AMA advocate for sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. (Directive to Take Action)
3. That our AMA reaffirm Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction.” (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-95.922, “Substance Use and Substance Use Disorders.” (Reaffirm HOD Policy)
5. That our AMA reaffirm H-95.981, “Policy Federal Drug Policy in the United States.” (Reaffirm HOD Policy).

Your Reference Committee heard overwhelming supportive testimony on Board of Trustees Report 14. Testimony cited our AMA’s longstanding and extensive policy on addiction and substance use disorder treatment, and indicated that one of the primary challenges in ending the nation’s drug overdose epidemic remains the inability of most patients to obtain evidence-based care for a substance use disorder. Your Reference Committee heard that removing the barriers for patients to receive evidence-based treatment is critical to helping end the epidemic. Your Reference Committee also heard testimony that State and federal laws already govern outpatient treatment facilities and standardized evidence-based federal regulations are not the right approach. Your Reference Committee agrees with the testimony provided that the recommendations in the report acknowledge that medical specialties, such as the American Society of Addiction Medicine and the American Psychiatric Association, already have guidelines and standards to help ensure the provision of evidence-based care in treatment facilities for in-patient and out-patient care, and that the recommendations also acknowledge that sustained federal funding—rather than short-term grants—and a comprehensive framework to prevent and treat all substance use disorders are necessary to address the current epidemic.

Your Reference Committee also heard testimony offering an amendment to change the title of the Resolution to better reflect the content of the report to read “Enhanced Funding for and Access to Addiction Facilities.” Accordingly, your Reference Committee recommends that Board of Trustees Report 14 be adopted, with a change in title as indicated, and the remainder of the report filed.

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

(7) BOARD OF TRUSTEES REPORT 16 – ENABLING METHADONE TREATMENT OF OPIOID USE DISORDER IN PRIMARY CARE SETTINGS

RECOMMENDATION A:

Recommendation 2 in Board of Trustees Report 16 be amended by addition and deletion to read as follows:

That our AMA support further research to help define the population of patients who may be safely treated with methadone maintenance treatment via ~~primary care~~ office-based treatment, including primary care therapy.

RECOMMENDATION B:

Recommendations in Board of Trustees Report 16 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 16 adopted as amended and the remainder of the Report filed.

The Board recommends that the following be adopted in lieu of the second recommendation of Board Report 2-I-19, and that the remainder of the report be filed:

1. That our AMA research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment. (New HOD Policy)
2. That our AMA support further research to help define the population of patients who may be safely treated with methadone maintenance treatment via primary care office-based therapy. (New HOD Policy)
3. That our AMA urge all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment. (Directive to Take Action)

Your Reference Committee heard compelling testimony in support of adopting the recommendations in Board of Trustees Report 16. Methadone Maintenance Treatment (MMT) is both a highly stigmatized yet a highly successful form of treatment for opioid use disorder. Your Reference Committee commends the efforts of our AMA Opioid Task Force to work with its partners to remove stigma from evidence-based treatment and acknowledges that this work must continue. Your Reference Committee agrees with testimony highlighting the challenges and benefits of patients receiving primary care services alongside MMT. Your Reference Committee appreciates the Board's explanations of the many requirements that would be imposed upon primary care practices should they seek to provide MMT. Your Reference Committee agrees with the Board that there should be continued research into best practices as well as further advocacy to remove existing barriers to MMT.

Your Reference Committee also heard that primary care physicians are not the only physicians who can effectively use MMT to treat patients, and that the report as written may inadvertently restrict office-based treatment only to primary care physicians. Your Reference Committee agrees with this testimony and consequently agrees with the noted proffered amendment. Accordingly, your Reference Committee recommends that Board of Trustees Report 16 be adopted as amended, and the remainder of the report be filed.

(8) RESOLUTION 203 – COVID-19 EMERGENCY AND EXPANDED
TELEMEDICINE REGULATIONS
RESOLUTION 205 – TELEHEALTH POST SARS-COV-2

RECOMMENDATION:

That Alternate Resolution 203 be adopted in lieu of Resolutions 203 and 205.

RESOLVED, That our AMA 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA 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 ~~permanently~~:

1. provide equitable coverage that allows patients to access telehealth services wherever they are located;
- ~~2. promote continuity of care by preventing payors from using cost sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from their physician;~~
- ~~3-2.~~ provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients (New HOD Policy); and be it further;
- ~~4. provide equitable payment for telehealth services that are comparable to in-person services;~~
- ~~5. ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment; (New HOD Policy); and be it further~~

RESOLVED, That our AMA 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.

RESOLVED, that our AMA support the use of telehealth to reduce health disparities and promote access to health care.

HOD ACTION: Alternate Resolution 203 adopted as amended in lieu of Resolutions 203 and 205.

The Second Clause in the Second Resolved referred as amended.

2. promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from ~~their physician~~ the physician of the patient's choice;

The Fourth Clause in the Second Resolved referred for decision.

4. provide equitable payment for telehealth services that are comparable to in-person services;

The Fifth Clause in the Second Resolved referred.

5. ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment;

Amendment B4, to add a Sixth Clause to the Second Resolved, referred for decision.

6. promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact;

Resolution 203

RESOLVED, That, with the expanded use of telemedicine during the Covid-19 pandemic, our AMA continue to advocate for a continuation of coverage for the full spectrum of technologies that were made available during the pandemic and that physicians be reimbursed by government and private payers for time and complexity (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the current emergency regulations for improved access to and payment for telemedicine services be made permanent with respect to payment parity and use of commonly accessible devices for connecting physicians and patients, without reference to the originating site, while ensuring qualifications of duly licensed physicians to provide such services in a secure environment (Directive to Take Action); and be it further

RESOLVED, That our AMA propose that all insurance carriers provide coverage for telemedicine visits with any physician licensed and registered to practice in the United States. (Directive to Take Action)

Resolution 205

RESOLVED, That our AMA advocate to facilitate the widespread adoption of telehealth services in the practice of medicine for physicians or physician-led teams post SARS-COV-2 (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services, health insurance industry, and Federal/State government agencies to adopt uniform, clear regulations as well as equitable coverage and reimbursement mechanisms that promote physician-led telehealth services (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for equitable access to telehealth services especially for the most at risk and under resourced patient populations and communities. (Directive to Take Action)

Your Reference Committee heard largely positive testimony on Resolutions 203 and 205. Your Reference Committee heard that our AMA currently has strong policy regarding the expansion and coverage of telehealth. Your Reference Committee heard that our AMA has robust advocacy efforts on telehealth expansion, including comments to Centers for Medicare & Medicaid Services (CMS), outreach in Congress, and state-level activity. In addition, your Reference Committee heard that Resolutions 203 and 205 have significant overlap. Your Reference Committee heard testimony regarding the importance of telehealth in maintaining the continuity of care within the medical home. Your Reference Committee believes that current AMA policy sufficiently addresses those comments, including H-480.946, Coverage of and Payment for Telemedicine, and H-160.919, Principles of the Patient-Centered Medical Home; your Reference Committee also believes that Alternate Resolution 203 sufficiently addresses those concerns. Your Reference Committee heard testimony regarding appropriate terminology. Your Reference Committee acknowledges that the term “telehealth,” defined as real-time, audio-visual visits between a clinician and patient, is the appropriate terminology as it is used by CMS, and in Current Procedural Terminology (CPT) codes. Your Reference Committee heard some testimony that audio-only services should be covered. Our AMA’s position on audio-only services is addressed in separate AMA policies D-70.993, Reimbursement for Telephonic and Electronic Communications, and H-390.859, Reimbursement for Telephonic and Electronic Communications. Your Reference Committee believes that the substitute recommendations address inequities in access to telehealth services, including the inability to access devices without internet capability. Your Reference Committee also heard largely positive testimony in support of an amendment that would direct our AMA to advocate for equity in broadband access, including supporting increased funding for broadband infrastructure. In addition, your Reference Committee heard testimony that highlighted the worsening of health disparities and access to care during the SARS-COV-2 pandemic, especially for underserved and rural populations, and the importance of

ensuring that telehealth be used to help provide care for patients. Accordingly, your Reference Committee recommends adoption of Alternate Resolution 203 in lieu of Resolutions 203 and 205.

(9) RESOLUTION 206 – STRENGTHENING THE ACCOUNTABILITY OF HEALTH CARE REVIEWERS

RECOMMENDATION A:

The First Resolve of Resolution 206 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA continue to advocate ~~for the repeal of the Employee Retirement Income Security Act (ERISA) as it pertains to prior authorization decisions;~~ that all health plans, including self-insured plans, be subject to state prior authorization reforms that align with AMA policy.

RECOMMENDATION B:

The Second Resolve of Resolution 206 be deleted.

~~RESOLVED, That our AMA advocate for legislation to require physicians contracted by health insurers or pharmacy benefit managers to possess an active license in the states where they review prior authorizations and be subject to the rules, statutes, medical board, and peer review of the state in which the prior authorization request is made (Directive to Take Action); and be it further~~

RECOMMENDATION C:

That AMA Policies H-320.968 and H-285.915 be reaffirmed.

RECOMMENDATION D:

That Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

RESOLVED, That our AMA advocate for legislation to require physicians contracted by health insurers or pharmacy benefit managers to possess an active license in the states where they review prior authorizations and be subject to the rules, statutes, medical board, and peer review of the state in which the prior authorization request is made (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the repeal of the Employee Retirement Income Security Act (ERISA) as it pertains to prior authorization decisions. (Directive to Take Action)

Your Reference Committee heard mixed discussion on Resolution 206. Your Reference Committee heard testimony supporting the First Resolve, calling for greater accountability for physicians contracted with health insurers making adverse determinations for health plans and Pharmacy Benefit Managers, including requiring licensure of the physician in the state in which the determination is being requested. Your Reference Committee also heard testimony that our AMA has existing policy in alignment with the First Resolve, as well as aligned legislative language in our AMA's state prior authorization model bill, and that our AMA has been advocating on this issue at the federal and state levels of government on behalf of AMA Members. Further, your Reference Committee heard testimony concerning the Second Resolve because of the ERISA preemption of state laws addressing prior authorization is frustrating to physicians and stands as a barrier to broader and consistent reform. However, your Reference Committee also heard testimony that the wording of the Second Resolve would undo many protections in ERISA and its regulations that also serve as a floor for prior authorization reform efforts, including in those states where their legislatures have not enacted reform. Your Reference Committee also heard testimony requesting referral on this item. However, your Reference Committee heard compelling testimony that there is sufficient AMA policy on this topic. As such, your Reference Committee recommends reaffirmation of H-320.968 and H-285.915 and that Resolution 206 be adopted as amended.

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

AMA Policy on ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally

accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured health plans from state insurance laws consistent with current AMA policy.

(10) RESOLUTION 211 – CREATING A CONGRESSIONALLY-MANDATED BIPARTISAN COMMISSION TO EXAMINE THE U.S. PREPARATIONS FOR AND RESPONSE TO THE COVID-19 PANDEMIC TO INFORM FUTURE EFFORTS

RECOMMENDATION A:

Resolution 211 be amended by addition to read as follows:

RESOLVED, That our AMA advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness (Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 211 be adopted as amended.

HOD ACTION: Resolution 211 adopted as amended.

RESOLVED, That our AMA advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform future public policy and health systems preparedness (Directive to Take Action); and be it further

RESOLVED, That, in advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables. (Directive to Take Action)

Your Reference Committee heard overwhelming supportive testimony on Resolution 211. Testimony was provided about the challenges that patients, physicians, hospitals, other health care facilities, the entire health care system, communities, and schools have experienced and continue to experience due to the COVID-19 pandemic. Your Reference Committee heard testimony strongly in support of commissioning a bipartisan task force under the direction of the United States Congress to complete a comprehensive review and report on the United States' preparedness and immediate response to the COVID-19 pandemic to inform preparation and response to future pandemics. Further testimony stated that we need to prevent the problems experienced during COVID-19 regarding effective testing strategies, timely directives on appropriate utilization of social distancing, evidence-

supported efforts to maintain strategic stockpiles of Personal Protective Equipment (PPE), ventilators, and other supplies, and to inform future health system preparedness. Further testimony was provided in support but with an amendment in the First Resolve to add “support” after “inform.” Your Reference Committee agrees, and accordingly recommends adoption of Resolution 211 as amended.

(11) RESOLUTION 218 – CRISIS PAYMENT REFORM ADVOCACY

RECOMMENDATION A:

The First Resolve of Resolution 218 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19, and continue to advocate for reforms that support and sustain physician medical practices that will disrupt healthcare availability to many patients (Directive to Take Action); ~~and be it further~~

RECOMMENDATION B:

That the Second Resolve of Resolution 218 be deleted.

~~RESOLVED, That our AMA: (1) promote reform in our health care payment system that supports and sustains physician medical practices not only under routine circumstances but also in an extended crisis situation such as COVID-19; (2) advocate for, as a priority directive, a blueprint for action along those lines to the newly installed Presidential administration and Congress in early 2021 and beyond; and (3) monitor and aim to improve, along with other stakeholders, any new health care initiative(s) in a contemporaneously effective manner. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 218 be adopted as amended.

HOD ACTION: Resolution 218 adopted as amended.

RESOLVED, That our AMA promote national awareness of the loss of physician medical practices due to COVID-19 that will disrupt healthcare availability to many patients (Directive to Take Action); and be it further

RESOLVED, That our AMA: (1) promote reform in our health care payment system that supports and sustains physician medical practices not only under routine circumstances but also in an extended crisis situation such as COVID-19; (2) advocate for, as a priority directive, a blueprint for action along those lines to the newly installed Presidential administration and Congress in early 2021 and beyond; and (3) monitor and aim to improve, along with other stakeholders, any new health care initiative(s) in a contemporaneously effective manner. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Your Reference Committee heard examples of how our AMA has worked aggressively on the issues raised in this Resolution regarding physician payment during the COVID-19 public health emergency. Our AMA’s advocacy efforts include letters to Anthem, UnitedHealth Group, Blue Cross Blue Shield Association (BCBSA), Centers for Medicare & Medicaid Services (CMS), and other health plans (for use of Current Procedural Terminology (CPT) code 99072 which will help address the significant fiscal pressures placed on physicians by the COVID-19 pandemic and to compensate practices for the additional supplies and new staff activities required to provide safe patient care during the public health emergency), an extensive library of AMA Advocacy efforts posted to the [website](#) (noting more than \$175 billion from Congress for COVID-19 health-related funding to hospitals and providers), and written comments on the Medicare Physician Fee Schedule and the Medicare Accelerated and Advance Payment Program (both addressing financial issues listed in the Resolution). Your Reference Committee heard testimony that our AMA is in frequent communication with Congress, the Department of Health and Human Services, CMS, the Centers for

Disease Control and Prevention, the Food and Drug Administration, and other government agencies to drive the messages encompassed in the resolution and to advance towards solutions that positively impact physicians and our patients.

Your Reference Committee heard testimony that the resolution does not take into consideration our AMA's advocacy efforts included in our AMA's COVID-19 Advocacy Progress Report, which lays out over 70 COVID-related advocacy efforts in which our AMA has been engaged since the beginning of the pandemic. Furthermore, your Reference Committee heard testimony that our AMA is already engaging in conversations with the incoming Administration. Your Reference Committee therefore agrees with an amendment offered by the Council on Legislation that would be consistent with our AMA's continued effort to promote national awareness of the loss of physician medical practices and patient access to care and to continue to advocate for reforms that support and sustain physician medical practices. Your Reference Committee heard proffered amendments to the Second Resolve; however, given the active advocacy that our AMA is doing around this topic, built on extensive and multifaceted AMA Policy, your Reference Committee does not believe the current Second Resolve or amendments would add substantively to current AMA Policy. Thus, your Reference Committee believes that the resolution as amended encompasses the spirit of the original resolution. Accordingly, your Reference Committee recommends Resolution 218 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(12) RESOLUTION 212 – COPAY ACCUMULATOR POLICIES

RECOMMENDATION A:

That AMA Policy D-110.986 be amended by addition.

Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.

RECOMMENDATION B:

That amended Policy D-110.986 be adopted in lieu of Resolution 212.

HOD ACTION: Amended Policy D-110.986 adopted in lieu of Resolution 212.

RESOLVED, That our AMA with all haste directly engage and advocate for the adoption of proposed state legislation or regulation that would ban copay accumulator policies in state regulated health care plans, including Medicaid (Directive to Take Action); and be it further

RESOLVED, That our AMA with all haste directly engage and advocate for the adoption of proposed federal legislation or regulation that would ban copay accumulator policies in federally regulated ERISA plans. (Directive to Take Action)

Your Reference Committee heard testimony that our AMA has strong policy surrounding the increase in prescription medication prices that have continued to grow inexorably year-over year. Your Reference Committee acknowledges that physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have imposed on our patients, on physician practices, and the broader health care system. Your Reference Committee also heard that our AMA has advocated with the Administration to eliminate copay accumulators since payers' growing use of copay accumulator benefit designs limits the success of other copay mechanisms, like copay coupons, in improving overall medication affordability for patients. Under copay accumulator programs, payers' do not apply the manufacturer's copay coupon to the patient's deductible or out-of-pocket maximum. When the copay coupon expires or runs out, or the patient exhausts all other forms of co-pay assistance, the patient is faced with a sudden—and often massive—increase in financial responsibility for the drug, as the coupons have not counted toward his/her deductible. Your Reference Committee heard testimony that our AMA has existing policy and is engaged in advocacy efforts to ban co-pay accumulators. Your Reference Committee heard testimony in support of amending Policy D-110.986 to better reflect and support our AMA's ongoing advocacy efforts at the state and federal levels. Accordingly, your Reference Committee recommends that amended AMA Policy D-110.986, Co-Pay Accumulators, be adopted in lieu of Resolution 212.

RECOMMENDED FOR REFERRAL

(13) RESOLUTION 213 – PHARMACIES TO INFORM PHYSICIANS WHEN
LOWER COST MEDICATION OPTIONS ARE ON FORMULARY

RECOMMENDATION:

Resolution 213 be referred.

HOD ACTION: Resolution 213 referred.

RESOLVED, That our AMA support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 213. Your Reference Committee heard testimony in support of the intent of Resolution 213. However, your Reference Committee also heard that the potential consequences of the policy proposed by this resolution are unclear, including the potential for unintended consequences of introducing unnecessary administrative burdens on physicians, creating confusion for patients trying to fill prescriptions, and possibly opening the door for pharmacy scope of practice issues. Therefore, your Reference Committee recommends that Resolution 213 be referred.

REPORT OF REFERENCE COMMITTEE C

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – AN UPDATE ON CONTINUING BOARD CERTIFICATION (RESOLUTIONS 301-A-19 AND 308-A-19)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted and the remainder of the report filed.

The Council on Medical Education therefore recommends that the following recommendation be adopted in lieu of Resolutions 301-A-19 and 308-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA), through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission’s recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency. (New HOD Policy)

Your Reference Committee heard testimony in support of the Council on Medical Education’s comprehensive report to the House of Delegates. The Council reminded delegates that this report is issued annually; strengthening of this report can be considered in the next iteration. Online testimony noted appreciation for the useful information contained in the report such as the increase in specialty board alternatives to the high-stakes 10-year exam; the expanded list of activities that meet the Improvement in Medical Practice (IMP) requirements; and the useful bibliography of recent studies describing new assessment models and IMP activities. The Council continues to actively follow the recommendations of the ABMS “Continuing Board Certification: Vision for the Future Commission.” The Council is committed to ensuring that continuing board certification supports physicians’ ongoing learning and practice improvement and will continue to identify and suggest improvements to CBC programs. Your Reference Committee recommends that the report be adopted.

- (2) COUNCIL ON MEDICAL EDUCATION REPORT 2 – GRADUATE MEDICAL EDUCATION AND THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION:

Recommendations in Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted and the remainder of the report filed.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That Policy H-310.904, “Graduate Medical Education and the Corporate Practice of Medicine,” be amended by addition and deletion to read as follows: “Our AMA: ... (3) will study continue to monitor issues, including waiver of due process requirements, created by corporate-~~owned~~ ~~lay~~ ~~entity~~ control of graduate medical education sites.” (Modify Current HOD Policy)

2. That our AMA reaffirm Policy H-310-904 (2), “Graduate Medical Education and the Corporate Practice of Medicine.” (Reaffirm HOD Policy)

Your Reference Committee heard testimony in favor of adoption, in light of the growing influence of corporate interests in medical education and practice, along with the need for our AMA to continue to monitor this trend and take appropriate actions, as needed. Testimony noted that, in the probable absence of additional federal support for graduate medical education programs, it is likely that private entities will continue to increase their support for residency training. It was also noted that the fiscal note of \$1,000 may be insufficient for a problem of this scope; our AMA may need to invest additional resources on this issue. As no negative testimony was heard, your Reference Committee accordingly recommends that Council on Medical Education Report 2 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (3) COUNCIL ON MEDICAL EDUCATION REPORT 3 – PROTECTION OF RESIDENT AND FELLOW TRAINING IN THE CASE OF HOSPITAL OR TRAINING PROGRAM CLOSURE

RECOMMENDATION A:

Recommendation 3 in Council on Medical Education Report 3 be amended by addition, to read as follows:

3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure. (Directive to Take Action)

RECOMMENDATION B:

Recommendation 4 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:

~~4. That our AMA study the mechanisms for, and the consequences of, encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger. (Directive to Take Action)~~

4. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger. (Directive to Take Action)

RECOMMENDATION C:

Recommendation 5 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:

5. That our AMA work with ~~encourage~~ the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), ~~and the~~ Accreditation Council for Graduate Medical Education (ACGME), ~~and relevant state and specialty societies~~ to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity. (Directive to Take Action)

RECOMMENDATION D:

Council on Medical Education Report 3 be amended by the addition of a seventh Recommendation, to read as follows:

7. That our AMA continue to work with the Accreditation Council for Graduate Medical Education (ACGME) to monitor issues related to training programs run by corporate entities and the effect on medical education. (Directive to Take Action)

RECOMMENDATION E:

Recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations 3 and 5 in Council on Medical Education Report 3 adopted as amended, Recommendation 1, 2, 4 and 6 adopted, Additional Recommendation 7 adopted, and the remainder of the report filed.

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA rescind Policy H-310.943 (2), "Closing of Residency Programs," as having been fulfilled by this report. (Rescind HOD Policy)
2. That our AMA ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution. (Directive to Take Action)
3. That our AMA encourage the Association of American Medical Colleges (AAMC) and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure. (Directive to Take Action)
4. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger. (Directive to Take Action)
5. That our AMA encourage the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity. (Directive to Take Action)
6. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure. (Directive to Take Action)

Your Reference Committee heard testimony in unanimous support of Council on Medical Education Report 3, specifically, the second, third, and fifth recommendations. Online testimony and speakers noted support for expanding options and streamlining the approval of residency slots as well as highlighting the need to support international medical graduates, who may be unduly affected by closures due to their immigrant visa status. There was concern expressed regarding potential negative consequences for safety net hospitals to recruit talent if they are required to disclose their financial standing, and it was noted that such disclosure would not provide a comprehensive understanding regarding an institution's fiscal stability. It was also suggested that hospitals have a fiduciary responsibility as stewards of a public resource. Due to the complexity of issues surrounding the fourth recommendation, your Reference Committee felt additional study was needed regarding evaluation of the fiscal stability of a training program. The Reference Committee heard testimony regarding a concern that corporate entities were attempting to profit from the closure of residency/fellowship programs, and recommends addition of a seventh recommendation to monitor the situation. Therefore, your Reference Committee encourages that Council on Medical Education Report 3 be adopted as amended.

- (4) RESOLUTION 306 – RETIREMENT OF THE NATIONAL BOARD OF MEDICAL EXAMINERS STEP 2 CLINICAL SKILLS EXAM FOR US MEDICAL GRADUATES: CALL FOR EXPEDITED ACTION BY THE AMERICAN MEDICAL ASSOCIATION

RECOMMENDATION A:

The First Resolve of Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) ~~COCA~~ to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 ~~CS~~ Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 – Performance Evaluation PE Exam (Directive to Take Action); and be it further

RECOMMENDATION B:

Policy H-295.988 (2) be reaffirmed in lieu of the Second Resolve of Resolution 306.

RECOMMENDATION C:

The Third Resolve of Resolution 306 be amended by addition and deletion, to read as follows:

That our AMA, in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency examination process as those offered at US medical schools be made available on a contract basis to foreign medical graduates. (Directive to Take Action); and be it further

RECOMMENDATION D:

Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

RESOLVED, That our American Medical Association take immediate, expedited action to encourage the NBME, FSMB and COCA to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 CS Exam and the COMLEX Level 2 PE Exam (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that a replacement examination process be administered within the medical schools that verifies each medical student's competence in key clinical skills required to be a physician (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for an equivalent examination process as those offered at US medical schools be made available on a contract basis to foreign medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly encourage all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the

Federation of State Medical Boards, their medical schools and other interested credentialing bodies to encourage the elimination of these centralized, costly and low-value exams (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside. (Directive to Take Action)

Your Reference Committee reviewed mostly supportive testimony on Resolution 306, which calls for the retirement of the National Board of Medical Examiners Step 2 Clinical Skills (CS) Exam for U.S. medical graduates. Online testimony from the Federation of State Medical Boards did express that the Step 2 CS examination is needed by state licensing boards as an “external audit” of physicians’ skills for independent, unsupervised practice. However, speakers who testified in support of the resolution expressed that the exam has an extremely high pass rate and has not identified any serious deficiencies in students’ education and training used to justify the expenditure of resources needed to take the exam. Additionally, there was testimony to support the rigorous evaluations of medical schools by relevant bodies as an appropriate alternative to examination of physicians’ skills. Therefore, your Reference Committee encourages that Resolution 304 be adopted as amended.

Policy recommended for reaffirmation:

D-295.988, “Clinical Skills Assessment During Medical School”

2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.

(5) RESOLUTION 309 – PRESERVE AND INCREASE GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION A:

Resolution 309 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~work with~~ advocate to appropriate federal agencies the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and other ~~interested~~ relevant stakeholders to ~~encourage the U.S. Government Accountability Office to oppose and refrain from further consideration of~~ the diversion of direct and indirect funding away from ACGME-accredited graduate medical education funding programs to non-physicians. (Directive to Take Action)

RECOMMENDATION B:

Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 adopted as amended.

RESOLVED, That our AMA work with the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and other interested stakeholders to encourage the U.S. Government Accountability Office to oppose and refrain from further consideration of the diversion of direct and indirect graduate medical education funding to non-physicians. (Directive to Take Action)

Your Reference Committee heard testimony in unanimous support of this resolution, which noted urgent concern regarding the Government Accountability Office (GAO) report in late 2019, [“Views on Expanding Medicare](#)

[Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants.](#)” Your Reference Committee was informed that the AMA was interviewed for this report, the only physician-focused organization interviewed by the GAO, and advocated strongly against any diversion of funds from GME to nonphysician training. Testimony highlighted great concern regarding scope of practice and differentials in training and pay. Your Reference Committee thanks the Council on Medical Education for pointing out that this resolution aligns with AMA Policy H-310.916, “Funding to Support Training of the Health Care Workforce”; however, testimony indicated that while this policy is potent, the AMA needs to do more to act upon it. Your Reference Committee incorporated an amendment to strengthen the original resolution and clarified that funding should not be diverted from ACGME-accredited residency programs for MDs and DOs.

While your Reference Committee considered an amendment related to defining the terms “trainee,” “resident,” “physician,” and “nurse practitioner,” and encouraging study of the educational and accreditation structure of non-physician residency education, it was decided that these amendments were not germane to the original resolution and distracted from the important goal of preventing the diversion of federal GME dollars from ACGME-accredited residency programs. Given the present concerns facing GME funding, your Reference Committee recommends that Resolution 309 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(6) RESOLUTION 307 – USMLE STEP EXAMINATION FAILURES DURING THE COVID-19 PANDEMIC

RECOMMENDATION A:

Alternative Resolution 307 be adopted in lieu of Resolution 307, to read as follows:

RESOLVED, That our AMA advocate to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) that students at allopathic and osteopathic schools of medicine and residents in accredited residency programs in the United States scheduled between March 1, 2020 and May 31, 2021 to sit for any examination step/level in the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) sequence be allowed the opportunity to be re-examined, if they failed one of these examinations, one time at no additional charge to the student or resident. (Directive to Take Action)

RECOMMENDATION B:

The title of Resolution 307 be changed, to read as follows:

USMLE AND COMLEX EXAMINATION FAILURES DURING THE COVID-19 PANDEMIC

HOD ACTION: Alternate Resolution 307 adopted with change in title.

RESOLVED, That our AMA advocate to the NBME that students at allopathic schools of medicine who failed the USMLE Step 1 Examination or the USMLE Step 2-CK Examination that was scheduled between March 1, 2020 and September 30, 2020 be allowed the opportunity to be re-examined one time at no additional examination fee charged to the student. (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association ask that the various state and territorial medical boards, through outreach to the National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB), not require students who failed any USMLE Step 1 or USMLE Step 2 CK examination, between March 1 and September 30, 2020 to reveal this information to state medical licensure boards during the processes of obtaining or renewing state licensure. (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to the National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB) that such failures not count toward the total number of exam attempts by a potential licensee. (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to hospital accreditation organizations such as, but not limited to, The Joint Commission and American Hospital Association, that those who have failed any USMLE Step 1 or USMLE Step 2-CK examination between March 1 and September 30, 2020 not be required to disclose this information to hospital boards and other accrediting bodies that determine a physician's fitness to practice at or admit patients to hospitals in the United States. (Directive to Take Action).

Your Reference Committee heard favorable testimony on this important topic, as our medical students and trainees face ongoing challenges and disruptions to testing and advancement through medical education during the pandemic. The Academic Physicians Section, as cosponsor of this item (along with its delegate, the original author), developed the proposed substitute language during its meeting, in close collaboration with other key stakeholders, including the Council on Medical Education. Some testimony was in opposition to adoption or recommended

referral for further study, due to a lack of concrete data as to the pandemic's effects on test takers. Testimony from the Federation of State Medical Boards was against adoption, in that, as the legal entities empowered to license physicians for medical practice in the U.S., the United States Medical Licensing Examination cannot withhold relevant information on the examination history of individuals pertinent to the decision to issue a full, unrestricted medical license. This testimony, however, is germane to the Second Resolve of the original item, which is not reflected in the amended item. The new language proposed above provides financial relief to those students (and resident physicians as well, as now reflected in the revision), who, due to the significant disruptions in exam study and administration schedules brought on by the pandemic, failed the examinations. Although students and resident/fellow physicians have experienced varying levels of disruption from the pandemic depending on their geographic location, this resolution would allow those who were most affected some respite. There was some sentiment expressed in testimony for offering complimentary reexaminations to all students/residents, not just those who failed. Your Reference Committee carefully considered this concept but believes that opening this door could have unintended consequences, including potential displacement from examination slots of the very individuals who were the resolution's original focus. As the AMA does not have policy regarding the impact of the pandemic on medical education, your Reference Committee believes this first step is a needed action, and therefore recommends that Alternative Resolution 307 be adopted in lieu of Resolution 307.

REPORT OF REFERENCE COMMITTEE D

RECOMMENDED FOR ADOPTION AS AMENDED

(1) BOARD OF TRUSTEES REPORT 9 – BULLYING IN THE PRACTICE OF MEDICINE (RESOLUTION 915-I-18)

RECOMMENDATION A:

Recommendation 3 in Board of Trustees Report 9 be amended by addition to read as follows:

That our AMA adopt the following guidelines for the establishment of workplace policies to prevent and address bullying in the practice of medicine: (New HOD Policy)

Health care organizations, including academic medical centers, should establish policies to prevent and address bullying in their workplaces. An effective workplace policy should:

- Describe the management’s commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
- Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
- Specify to whom the policy applies (i.e., medical staff, students, administration, patients, employees, contractors, vendors, etc.).
- Define both expected and prohibited behaviors.
- Outline steps for individuals to take when they feel they are a victim of workplace bullying.
- Provide contact information for a confidential means for documenting and reporting incidents.
- Prohibit retaliation and ensure privacy and confidentiality.
- Document training requirements and establish clear expectations about the training objectives.

In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Organized medical staffs should work with all interested stakeholders to lead the effort in ensuring safe work environments within their institutions. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure and confident in their roles and professions. Tactics to help create this type of organizational culture include:

- Surveying staff, and medical students in academic settings, anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients. Use the results to inform the development of programs and resources, showing the respondents that their feedback is taken seriously.
- Encouraging open discussions in which staff can talk freely about problems and/or encounters with behavior that may constitute bullying.
- Establishing programs for staff, faculty, and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of bullying.

- Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.

RECOMMENDATION B:

Recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report filed.

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 402-A-19 4 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
 - a. H-215.978, “Workplace Violence Prevention”
 - b. H-295.955, “Teacher-Learner Relationship In Medical Education”
 - c. H-515.966, “Violence and Abuse.” (Reaffirm HOD Policy)
2. That our AMA define “workplace bullying” as repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target. (New HOD Policy)
3. That our AMA adopt the following guidelines for the establishment of workplace policies to prevent and address bullying in the practice of medicine: (New HOD Policy)

Health care organizations, including academic medical centers, should establish policies to prevent and address bullying in their workplaces. An effective workplace policy should:

- Describe the management’s commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
- Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
- Specify to whom the policy applies (i.e., medical staff, students, administration, patients, contractors, etc.).
- Define both expected and prohibited behaviors.
- Outline steps for individuals to take when they feel they are a victim of workplace bullying.
- Provide contact information for a confidential means for documenting and reporting incidents.
- Prohibit retaliation and ensure privacy and confidentiality.
- Document training requirements and establish clear expectations about the training objectives.

In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure and confident in their roles and professions. Tactics to help create this type of organizational culture include:

- Surveying staff, and medical students in academic settings, anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients. Use the results to inform the development of programs and resources, showing the respondents that their feedback is taken seriously.
- Encouraging open discussions in which staff can talk freely about problems and/or encounters with behavior that may constitute bullying.
- Establishing programs for staff and students, such as Employee Assistance Programs, that provide a place to confidentially address personal experiences of bullying.

- Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.

Your Reference Committee heard testimony in strong support of the report and recommendations. It was noted that the report thoughtfully defines and addresses a prevalent issue in medicine that disproportionately impacts medical trainees. An amendment was proposed to include the definition of ‘microaggressions’ and additional related language. Your Reference Committee believes that this addition goes beyond what was addressed in the report and including this definition warrants further discussion in a stand-alone resolution. Additionally, no additional testimony related to this amendment was heard. Therefore, your Reference Committee recommends that recommendation in Board of Trustees Report 9 be adopted as amended and the remainder of the report filed.

(2) BOARD OF TRUSTEES REPORT 10 - COMPASSIONATE RELEASE FOR INCARCERATED PATIENTS (RESOLUTION 430-A-19)

RECOMMENDATION A:

Recommendation in Board of Trustees Report 10 be amended by addition to read as follows:

Our American Medical Association supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

RECOMMENDATION B:

Recommendation in Board of Trustees Report 10 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 10 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 430- 4 A-19 and the remainder of this report be filed.

Our American Medical Association supports policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

Your Reference Committee heard testimony in strong support of this report. It was noted that the report is timely, especially considering the current COVID-19 pandemic and its disproportionate impact on persons who are incarcerated. Testimony emphasized the importance of developing evidence-based medical guidelines in collaboration with appropriate healthcare and correctional stakeholders. A minor amendment was suggested to add clarity that compassionate release is referring to incarcerated persons. Your Reference Committee agrees and recommends that Board of Trustees Report 10 be adopted as amended.

(3) RESOLUTION 407 – FULL COMMITMENT BY OUR AMA TO THE BETTERMENT AND STRENGTHENING OF PUBLIC HEALTH SYSTEMS

RECOMMENDATION A:

Resolution 407 be amended by addition of a second resolve to read as follows:

RESOLVED, that our AMA 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. (Directive to Take Action)

RECOMMENDATION B:

Resolution 407 be adopted as amended.

HOD ACTION: Resolution 407 adopted as amended.

RESOLVED, That our American Medical Association 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. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 407. There was broad recognition regarding the need to strengthen our nation’s public health infrastructure and that the AMA should provide a leadership role in ensuring our nation has a robust public health system, through sustained funding, leadership, and strengthened data and information systems. While some testimony urged for public health to become a “fourth strategic pillar,” your Reference Committee agrees with those who noted that as a matter of governance, it is the purview of the Board to set our AMA’s strategic direction. Several commentors also requested the formation of an AMA task force dedicated to reviewing public health-related issues. While your Reference Committee supports this concept, we think it would be more prudent to first have our Council on Science and Public Health study this issue by speaking to relevant stakeholders, including our AMA BOT, and make appropriate recommendations to guide the AMA’s activities on this topic moving forward. Therefore, your Reference Committee recommends that Resolution 407 be adopted as amended

(4) RESOLUTION 408 – AN URGENT INITIATIVE TO SAFEGUARD COVID-19 VACCINE PROGRAMS

RECOMMENDATION A:

Resolution 408 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA institute a program to ~~safeguard~~promote the integrity of a ~~eoronavirus~~COVID-19 vaccination program by: (1) educating physicians on speaking with patients about ~~eoronavirus~~ COVID-19 vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the ~~lifesaving nature~~ safety and efficacy of a ~~eoronavirus~~ COVID-19 vaccines ~~program aimed at~~, by countering misinformation and addressing public anxieties building public confidence; ~~and~~ (3) forming a coalition of ~~medical~~ health care and public health organizations inclusive of those respected in communities of color ~~to include, but not limited to, the American Public Health Association, American Hospital Association, American Nurses Association, National Medical Association,~~ committed to developing and implementing a joint

public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations. (Directive to Take Action)

RECOMMENDATION B:

Resolution 408 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 408 be changed.

AN URGENT INITIATIVE TO SUPPORT COVID-19 VACCINATION PROGRAMS

HOD ACTION: Resolution 408 adopted as amended with change in title.

RESOLVED, That our AMA institute a program to safeguard the integrity of a coronavirus vaccination program by: (1) educating physicians on speaking with patients about coronavirus vaccination and providing patient education materials; (2) educating the public about the lifesaving nature of a coronavirus vaccine program aimed at countering misinformation and addressing public anxieties; and (3) forming a coalition of medical organizations to include, but not limited to, the American Public Health Association, American Hospital Association, American Nurses Association, National Medical Association, committed to developing and implementing a joint public education program promoting the facts about, the need for and encouraging the acceptance of COVID-19 vaccination. (Directive to Take Action)

Your Reference Committee heard testimony largely supportive of this resolution. Testimony highlighted the importance of physicians providing evidence-based guidance to patients related to vaccines as well as dispelling misinformation and building trust, particularly among populations that have been disproportionately affected by COVID-19. A strong unified voice from health care and public health professionals will play a key role in addressing patients concerns and building public confidence in COVID-19 vaccine candidates that are determined to be safe and effective. Amendments were suggested to clarify the wording, as there are a number of coronaviruses, and to encourage ongoing safety monitoring. Your Reference Committee agrees with these amendments and therefore recommends that Resolution 408 be adopted as amended.

(5) RESOLUTION 411 – SUPPORT FOR EVICTION AND UTILITY SHUT-OFF MORATORIUMS DURING PUBLIC HEALTH EMERGENCIES

RECOMMENDATION A:

The first Resolve of Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for policies that prevent ~~prohibit~~ evictions during public health emergencies (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for prevention of shut-off moratoria on termination of life-essential utilities during public health emergencies.
(Directive to Take Action)

RECOMMENDATION C:

Resolution 411 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 411 be changed.

SUPPORT FOR THE PREVENTION OF EVICTION AND THE
TERMINATION OF LIFE-ESSENTIAL UTILITY SERVICES DURING
PUBLIC HEALTH EMERGENCIES

HOD ACTION: Resolution 411 adopted as amended with change in title.

RESOLVED, That our American Medical Association advocate for policies that prohibit evictions during public health emergencies (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for shut-off moratoria on life-essential utilities during public health emergencies. (Directive to Take Action)

Your Reference Committee heard limited but passionate testimony related to this resolution and the issues it addresses. The majority of those who testified supported the intent of this resolution and noted that it is a top priority during the current pandemic. Evidence demonstrates that housing stability and utility access are essential to health, and evictions and utility shut-offs pose immediate health risks to households affected while also endangering the population at large by limiting their ability to maintain hygiene and social distancing standards. It was also noted that this is an urgent issue since the CDC eviction moratorium expires on December 31, 2020, several state policies are also set to expire 2021 have already, and many others still lack polices. Without these policies, many people will be at risk of eviction during a worsening pandemic and winter months. Your Reference Committee agrees that a friendly amendment offered clarified the language. An amendment related to grants for property owners was also offered, but your Reference Committee does not feel that those economic issues are the purview of Our AMA. Your Reference Committee agrees that protecting vulnerable households now and in future public health emergencies is important and therefore, recommends that Resolution 411 be adopted as amended.

(6) RESOLUTION 413 – PROTECTING HEALTHCARE PROFESSIONALS IN SOCIETY

RECOMMENDATION A:

The first Resolve of Resolution 413 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association acknowledge and act to reduce the incidence of antagonistic actions against physicians as well as other health care workers professionals including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as a health care workers professional (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 413 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers professionals including first responders, and public health officials, outside as well as within the workplace, ~~including physical, outside as well as within the workplace~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

Resolution 413 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 413 be changed.

PROTECTING PHYSICIANS AND OTHER HEALTHCARE WORKERS
IN SOCIETY

HOD ACTION: Resolution 413 adopted as amended with change in title.

RESOLVED, That our American Medical Association acknowledge and act to reduce the incidence of antagonistic actions against health care professionals outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as a health care professional (Directive to Take Action); and be it further

RESOLVED, That our AMA educate the general public on the prevalence of violence and personal harassment against health care professionals, outside as well as within the workplace (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals (Directive to Take Action).

Your Reference Committee heard testimony in support of this resolution. Several amendments were suggested, including one that would broaden the first and second resolves beyond health care professionals to be inclusive of first responders and public health officials. Therefore, your Reference Committee recommends that Resolution 413 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (7) RESOLUTION 404 – EARLY VACCINATION FOR CORRECTIONAL WORKERS AND INCARCERATED PERSONS
RESOLUTION 415 - SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT OF CONTAGIOUS DISEASES IN CORRECTIONAL FACILITIES

RECOMMENDATION A:

Alternate Resolution 404 be adopted in lieu of Resolution 404 and Resolution 415.

SUPPORT PUBLIC HEALTH APPROACHES FOR THE PREVENTION AND MANAGEMENT OF CONTAGIOUS DISEASES IN CORRECTIONAL AND DETENTION FACILITIES

RESOLVED, That our American Medical Association, in collaboration with state and national medical specialty societies and other relevant stakeholders, advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens, (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association support expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation (Directive to Take Action).

RECOMMENDATION B:

That Policy H-430.989 be amended by addition and deletion to read as follows:

H-430.989, Disease Prevention and Health Promotion in Correctional Institutions

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public

health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, ~~and~~ hepatitis, ~~and highly contagious~~ other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. (Modify Current HOD Policy)

RECOMMENDATION C:

That Policy H-430.989 be adopted as amended.

HOD ACTION: Alternate Resolution 404 adopted in lieu of Resolution 404 and Resolution 415 and Policy H-430.989 adopted as amended.

RESOLVED, That our American Medical Association advocate that conditions of incarceration in correctional facilities be improved to allow for the generally accepted CDC COVID-19 safety precautions to take place (Directive to Take Action); and be it further

RESOLVED, That our AMA support that inmates and correctional workers should be considered in a high-risk classification, along those other persons vulnerable for contacting and spreading COVID-19 infection (Directive to Take Action); and be it further

RESOLVED, That our AMA support the National Academies of Sciences, Engineering, and Medicine (NASEM) recommendation that correctional workers and incarcerated persons be considered in high risk groups and provided with a safe, effective, FDA-approved COVID-19 vaccine in Phase 1b (for those with comorbid and underlying conditions, including age and frailty) or Phase 2 (for all other correctional workers and incarcerated persons) of any vaccination campaign. (Directive to Take Action)

RESOLVED, That our American Medical Association collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious pathogens in the setting of prisons and jails, including, but not limited to: (a) Universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated, (b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies, (c) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens, (d) Adherence to use of personal protective equipment for incarcerated individuals and staff, and (e) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to decarcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious pathogens within correctional facilities and communities (New HOD Policy); and be it further

RESOLVED, That our AMA support prioritizing COVID vaccine access for justice-involved populations (New HOD Policy); and be it further

RESOLVED, That our AMA will amend Policy H-430.989 by insertion as follows: H-430.989, Disease Prevention and Health Promotion in Correctional Institutions

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, ~~and~~ hepatitis, ~~and highly contagious~~ infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase

in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. (Modify Current HOD Policy)

Your Reference Committee heard testimony supportive of both Resolution 404 and Resolution 415. Populations in high-density congregate settings are high risk for infection with the SARS-CoV-2 virus. Across the U.S. there have been several outbreaks of infectious disease linked to correctional facilities. Due to this risk, strong infection prevention and control policies and COVID-19 vaccination should be prioritized for this population when a safe vaccine becomes available. It was noted by the Board of Trustees that the AMA has already provided input into the allocation of COVID-19 vaccines and that outlining specific phases of allocation could be problematic. Furthermore, compassionate release is addressed in Board of Trustees Report 10. Therefore, your Reference Committee recommends that alternate Resolution 404 be adopted in lieu of Resolution 404 and 415.

(8) RESOLUTION 406 – FACE MASKING IN HOSPITALS DURING FLU SEASON

RECOMMENDATION:

Alternate Resolution 406 be adopted in lieu of Resolution 406.

RESOLVED, that our AMA: (1) encourage the CDC to study and issue guidance on the most effective infection prevention and control strategies to reduce the spread of influenza in hospital settings, including immunization, source control, and other public health strategies and (2) encourage the National Institute for Occupational Safety and Health and other relevant federal agencies to study the comparative disease-reduction effectiveness of various types of facemasks and respirators to inform future infection control guidance.

HOD ACTION: Alternate Resolution 406 adopted in lieu of Resolution 406.

RESOLVED, That our American Medical Association encourage The Joint Commission and other hospital accreditation organizations recognized by major insurers to stipulate that all hospitals require hospital employees, physicians, patients, and visitors to wear a facial mask that completely covers the mouth and nose while within hospital walls (unless they are consuming food while “socially distanced,” or unless they are patients in their own rooms while “socially distanced”) (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage publication of commentaries supportive of such regulations and standards in scientific journals and other publications (Directive to Take Action); and be it further

RESOLVED, That our AMA study the comparative disease-reduction effectiveness of various types of masks (N-95 masks versus “surgical” masks versus simple cloth facial coverings), toward potentially refining or making more specific any future mandates for facial coverings for persons while in-hospital as a visitor, patient or health care worker. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this resolution. While the importance of wearing masks during the COVID-19 pandemic is certainly well understood, this resolution is inconsistent with current Centers for Disease Control and Prevention (CDC) guidelines for the prevention of seasonal influenza in health care settings. It was appropriately noted in testimony that these guidelines may also vary based on the level of acute respiratory infections in the community. It was also noted in testimony that the National Institute of Occupational Safety and Health and the FDA are involved in clearing or certifying facemasks or respirators. They are more appropriately positioned to study the effectiveness of various types of facemasks. Your Reference Committee supports encouraging the CDC to study appropriate infection control and prevention measures and updating their guidelines based on the best available evidence. Therefore, Reference Committee recommends that alternate Resolution 406 be adopted in lieu of 406.

- (9) RESOLUTION 412 – AVAILABILITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)
RESOLUTION 414 – AVAILABILITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

RECOMMENDATION A:

Alternate Resolution 412 be adopted in lieu of Resolution 412 and Resolution 414.

AVAILABILITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

RESOLVED, That our AMA affirm that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises (New HOD Policy); and be it further

RESOLVED, That our AMA support evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need (Directive to Take Action); and be it further

RESOLVED, That our AMA support physicians and health care professionals in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty (Directive to Take Action); and be it further

RESOLVED, That our AMA support a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster. (Directive to Take Action) and be it further

RESOLVED, that our AMA work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies. (Directive to Take Action)

HOD ACTION: Alternate Resolution 412 adopted in lieu of Resolution 412 and Resolution 414.

RESOLVED, That our American Medical Association actively support that physicians and healthcare professionals are empowered to use workplace modifications to continue professional patient care when they determine such action to be appropriate and in the best interest of patient and physician wellbeing. Physicians and healthcare professionals must be permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty (Directive to Take Action); and be it further

RESOLVED, That our AMA affirm that the medical staff of each healthcare institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises (New HOD Policy); and be it further

RESOLVED, That our AMA support a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster. (Directive to Take Action)

RESOLVED, That our American Medical Association advocate that it is the responsibility of healthcare facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need (Directive to Take Action); and be it further

RESOLVED, That our AMA support minimum evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that physicians and healthcare professionals must be permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided PPE without penalty (Directive to Take Action); and be it further

RESOLVED, That our AMA affirm that the medical staff of each health care institution should be meaningfully involved in disaster planning, strategy and tactical management of ongoing crises (New HOD Policy); and be it further

RESOLVED, That our AMA work with The Joint Commission, the American Nurses Credentialing Center, the Center for Medicare and Medicaid Services, and other regulatory and certifying bodies to ensure that credentialing processes for healthcare facilities include consideration of adequacy of PPE stores on hand as well as processes for rapid acquisition of additional PPE in the event of a pandemic (Directive to Take Action); and be it further

RESOLVED, That our AMA study a physician's ethical duty to serve in a pandemic including but not limited to the following considerations: 1. The availability and adequacy of institution-supplied PPE and whether inadequate PPE modifies a physician's duty to act; 2. Whether a physician's duty to act is modified by the personal health of the physician and/or those with whom the physician has regular extended contact; 3. Whether a physician's duty to their personal and population safety allows them to speak with local and national media about the safety of their work environment as it relates to the risk it places on themselves, their immediate family and regular social contacts, and the public at large; 4. How medical students, residents, and fellows are affected in the setting of a pandemic in terms of their ethical obligation to care for patients, ramifications to their education, and the protections necessary given their vulnerable status; and 5. The ethical obligation of healthcare institutions and the federal government to protect the physical and emotional wellbeing of physicians and other healthcare workers during and after a pandemic. (Directive to Take Action)

Your Reference Committee heard testimony in support of the intent of Resolutions 412 and 414. Many of the Resolve statements are consistent with actions that the AMA has already taken throughout the course of the COVID-19 pandemic, but it was noted that they should be formally outlined in policy for future pandemics or public health emergencies. Your Reference Committee heard some concerns about requiring health care facilities to have a process for rapid acquisition of PPE as it may limit PPE in other health care settings. Your Reference Committee agreed with testimony on the need for better understanding the supply chain and the ensuring the adequacy of the Strategic National Stockpile. Your Reference Committee is also aware that the AMA has posted significant medical ethics guidance on the AMA's COVID-19 resource center, which addresses the issues raised for study in Resolution 414 and felt further study was not warranted at this time. Therefore, your Reference Committee recommends that alternate Resolution 412 be adopted in lieu of Resolution 412 and 414.

RECOMMENDED FOR REFERRAL

(10) RESOLUTION 409 – PROTESTOR PROTECTIONS

RECOMMENDATION:

Resolution 409 be referred for report back at the next meeting of the House of Delegates.

HOD ACTION: Resolution 409 referred for report back at the next meeting of the House of Delegates.

RESOLVED, That our American Medical Association advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm. (Directive to Take Action)

Your Reference Committee heard passionate and divided testimony on this resolution. Several commentors noted strong support for the intent of this resolution, but questioned the appropriateness and accuracy of some of the language. Other commentors expressed opposition to the resolution because they do not think the role of the AMA is to advise law enforcement officers on how best to perform their job duties. Still others noted that strong support for the resolution as written, and believe that physicians should have an opinion on this matter. Your Reference Committee agrees that this is an important issue, that the use of the appropriate words and terminology matter, and that referral for study and report back in expeditious manner is the best option to fully evaluate and understand issues associated with this resolution. Therefore, your Reference Committee recommends that Resolution 409 be referred for report back at the next meeting of the House of Delegates.

(11) RESOLUTION 410 – POLICING REFORM

RECOMMENDATION A:

That the first Resolve of Resolution 410 be adopted.

RECOMMENDATION B:

That the second, Resolve of Resolution 410 be adopted.

RECOMMENDATION C:

That the third Resolve of Resolution 410 be referred.

RECOMMENDATION D:

That the fourth Resolve of Resolution 410 be referred.

RECOMMENDATION E:

That the fifth Resolve of Resolution 410 be adopted.

RECOMMENDATION F:

That the sixth Resolve of Resolution 410 be referred.

RECOMMENDATION G:

That the seventh Resolve of Resolution 410 be adopted.

RECOMMENDATION H:

That the eighth Resolve of Resolution 410 be referred.

HOD ACTION: The first, second, fifth, and seventh Resolves of Resolution 410 adopted.

The third, fourth, sixth, and eighth Resolves of Resolution 410 referred.

RESOLVED, That our American Medical Association recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color (New HOD Policy); and be it further

RESOLVED, That our AMA 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons (New HOD Policy); and be it further

RESOLVED, That our AMA advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the prohibition of the use of sedative/hypnotic agents, such as ketamine, by first responders for non-medically-indicated, law enforcement purposes; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for legislation and regulations which promote trauma- informed, community-based safety practices (Directive to Take Action); and be it further

RESOLVED, That our AMA support the creation of independent, third party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence. (New HOD Policy)

Your Reference Committee heard passionate testimony in support of the intent of this resolution, but there was also significant support for referral to ensure that the AMA gets the language correct on this important and timely issue. There were particularly concerns raised around the resolve statements addressing qualified immunity and demilitarization of law enforcement agencies. It was suggested that these items be referred to assure that each item is given thorough analysis and that our goals of improved public health are not construed as a lack of support for our law enforcement and EMS colleagues. Your Reference Committee encourages report back in June of 2021. The Council on Science and Public Health requested referral of the sixth resolve as they are working on a report on the topic of excited delirium and ketamine. However, your Reference Committee notes that some of these resolve statements are consistent with statements that the AMA has already issued on police brutality, trauma-informed care, and law enforcement-related violence. Your Reference Committee supports adoption of these Resolves to further AMA policy on this important public health issue.

REPORT OF REFERENCE COMMITTEE E

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – DIETARY SUPPLEMENTS: UPDATE ON REGULATION, INDUSTRY, AND PRODUCT TRENDS

RECOMMENDATION A:

Recommendations in Council on Science and Public Health Report 3 be adopted.

HOD ACTION: Council on Science and Public Health Report 3 adopted.

The Council on Science and Public Health recommends that the following be adopted and The remainder of the report be filed:

1. That Policy H-150.954, “Dietary Supplements and Herbal Remedies” be amended by addition and deletion to read as follows:

- (1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
- (2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
- (3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
- (4) Our AMA will work with the FDA to educate physicians and the public about FDA's ~~MedWatch program~~ Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
- (5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
- (6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
 - (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
 - (b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
 - (c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary

- ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
- (d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers; and
- (7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.
- (8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
- (9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
- (10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for supports that the product labeling of dietary supplements and herbal remedies to:
- (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: “This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease.” This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product;
 - (a) not include structure/function claims that are not supported by evidence from robust human studies;
 - (b) should not contain prohibited disease claims;
 - (c) eliminate “proprietary blends” and list and accurately quantify all ingredients contained in the product;
 - (d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
 - (e) include accurate and useful disclosure of ingredient measurement.
- (11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
- (12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
- (13) Our AMA will continue its efforts to educate patients and physicians about the possible ramifications risks associated with the use of dietary supplements and herbal remedies; and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.
2. That Policy H-120.926, “Expedited Prescription Cannabidiol Drug Rescheduling,” be amended by addition and deletion to read as follows:

Regulation of Cannabidiol Products

Our AMA will: (1) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; ~~and~~ (2) advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products; and (3) support comprehensive FDA regulation of cannabidiol products and practices necessary to ensure product quality, including identity, purity, and potency.

3. That Policy D-150.991, “Herbal Products and Drug Interactions,” that notes our AMA’s support of FDA efforts to create a publicly accessible database of adverse event and drug interaction information on dietary supplements, be reaffirmed.

Your Reference Committee heard unanimously supportive testimony for this report. Commentors lauded the work of the Council, the completeness of the policy updates, and are appreciative of the work of the AMA on bringing attention to this issue. A few comments posted online proposed amendments to include additional language related to cannabidiol (CBD). The Council testified online that they prefer their original language, and your Reference Committee agrees that the additional language related to CBD is beyond the scope of the current report. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 3 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 –DRUG SHORTAGES: 2020 UPDATE

RECOMMENDATION A:

Recommendation in Council on Science and Public Health Report 1 be amended by addition and deletion to read as follows:

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually ~~at least annually~~ to the House of Delegates ~~when warranted~~ on progress made in addressing drug shortages.

RECOMMENDATION B:

The recommendation in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends the following be adopted and the remainder of the report be filed:

That Policy H-100.956, “National Drug Shortages” be amended by addition and deletion to read as follows:

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates when warranted on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the development of a comprehensive independent report on the root causes of drug shortages that includes consideration of. ~~Such an analysis should consider federal actions, the~~

~~number of evaluation of manufacturer, Group Purchasing Organization (GPO), and distributor practices, as well as contracting practices by market participants on competition, access to drugs, and pricing, and. In particular, further transparent. In particular, a further analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.~~

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

Your Reference Committee heard nearly unanimous testimony on the AMA's work, including this comprehensive report, related to drug shortages. Several commentators noted concern about changing language related to the frequency at which the Council reports back to the HOD. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended to return to original, yearly reporting, language.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 –
NEUROPATHIC PAIN AS A DISEASE UPDATE

RECOMMENDATION A:

Recommendation 1 in Council on Science and Public Health Report 2 be amended by addition to read as follows:

1. That a new policy, Neuropathic Pain, be adopted:
Our AMA:
 - a. Supports the designation of neuropathic pain as a disease state distinct from nociceptive pain, encompassing metabolic, toxic, mechanical, and other injuries to nerve cells, as well as neuroplastic and neuroimmune adaptations to nerve cells in response to chronic pain.
 - b. Encourages research related to neuropathic pain, payer coverage of treatment options for neuropathic pain, and improved resources for patients suffering with neuropathic pain.
 - c. Encourages physicians to engage in meaningful conversation with their patients about what is known about the pathology of neuropathic pain and to set appropriate expectations collaboratively with their patients.
 - d. Cautions that a neuropathic pain disease designation should only be used when appropriate, not overused, and that the cause of the neuropathic pain be carefully elucidated and documented.

RECOMMENDATION B:

The recommendations in Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends that the following and the remainder of the report be filed:

1. That a new policy, Neuropathic Pain, be adopted:
Our AMA:
 - a. Supports the designation of neuropathic pain as a disease state distinct from nociceptive pain, encompassing metabolic, toxic, mechanical, and other injuries to nerve cells, as well as neuroplastic and neuroimmune adaptations to nerve cells in response to chronic pain.
 - b. Encourages research related to neuropathic pain, payer coverage of treatment options for neuropathic pain, and improved resources for patients suffering with neuropathic pain.
 - c. Encourages physicians to engage in meaningful conversation with their patients about what is known about the pathology of neuropathic pain and to set appropriate expectations collaboratively with their patients.
 - d. Cautions that a neuropathic pain disease designation should only be used when appropriate, not overused, and that the cause of the neuropathic pain be carefully elucidated.
2. That part (d) of Policy D-160.922, "Future of Pain Care," which called for the AMA Pain Care Task Force to evaluate the merits of declaring neuropathic pain as a distinct disease state and provide a recommendation to the Council on Science and Public Health, be rescinded.

Your Reference Committee heard testimony unanimously supportive of the recommendations put forth by the Pain Care Task Force and the Council and thanked them for their excellent analysis and work on the issue. Testimony also requested a minor amendment to the policy to include documentation of neuropathic pain disease by physicians; your Reference Committee found this amendment appropriate. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted as amended.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – PUBLIC HEALTH IMPACTS OF CANNABIS LEGALIZATION

RECOMMENDATION A:

Recommendation in Council on Science and Public Health Report 4 be amended by addition to read as follows:

That Policy H-95.924, “Cannabis Legalization for Recreational Use,” be amended by addition and deletion to read as follows:

Cannabis Legalization for ~~Recreational~~ Adult Use (commonly referred to as recreational use)

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 ~~recreational adult~~, defined as age 21 and older, use should not be legalized; (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 ~~recreational 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) ~~that~~ laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5~~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; (6~~7~~) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (7,8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (8,9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (9,10) 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 (10~~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.

RECOMMENDATION B:

Council on Science and Public Health Report 4 be amended by addition of a second Recommendation to read as follows:

That our AMA study the expungement, destruction, and sealing of criminal records for legal offenses related to cannabis use or possession.

RECOMMENDATION C:

The recommendation in Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 4 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends that the following statement be Adopted in lieu of Resolution 408-A-19, Resolution 411-A-19, and the additional proposed resolve from Alternate Resolution 913-I-19 and the remainder of the report be filed:

That Policy H-95.924, “Cannabis Legalization for Recreational Use,” be amended by addition and deletion to read as follows:

Cannabis Legalization for ~~Recreational Adult~~ Adult Use (commonly referred to as recreational use)
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 ~~recreational adult~~ use should not be legalized; (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 ~~recreational 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) ~~that~~ laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5~~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, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (6~~7~~) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (7,8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (8,9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (9,10) 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 (10~~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.

Your Reference Committee heard substantial and passionate testimony on Council and Science and Public Health Report 4. The majority of the testimony was in favor of the Council’s report. There were several amendments proffered, some of which your Reference Committee agreed were beneficial and should be included in AMA policy. These amendments include defining the age of an adult as 21 years of age and older. This definition is consistent with the majority of current state laws legalizing the adult use of cannabis. Your Reference Committee also

supported the inclusion of workplace impairment and worker-related injuries and safety among the issues for which local, state, and federal public health agencies should be encouraged to improve surveillance efforts.

Your Reference Committee also heard testimony in support of an amendment on the expungement of criminal records for cannabis-related offenses. The Council on Legislation testified that this amendment has legal implications and should not be included in this report. The Council on Science and Public Health suggested that this topic requires further study to ensure that the language of any policy related to expungement of records is accurate. Your Reference Committee agrees that this is an important, though complex issue and recommends further study.

Additional testimony was heard suggesting that AMA policy be amended to address the use of cannabis in public spaces, Your Reference Committee thinks this topic is outside of the scope of this report, and that it could be considered as a possible future resolution. We also note that the US Public Health Service encouraged future reports to more accurately reflect the legal distinctions between the terms “hemp” and “marijuana” where appropriate.

Limited testimony was heard in support of the AMA changing our current stance on the issue of cannabis legalization for adult use to a neutral position, and not one of opposition. Your Council on Science and Public Health just completed a review on the public health impacts of legalization of adult use in this report, which identified concerning trends, which include an increase in report poison control exposures, cannabis-related hospitalization, increasing traffic crashes and fatalities, and increasing use by pregnant women. Therefore, Your Reference Committee does not support changing our organization’s position on legalization at this time. However, a member of the Board of Trustees noted that the AMA has created a Cannabis Task Force, including representatives from more than 20 state and national medical specialty societies, that will evaluate and disseminate relevant scientific evidence to health care professionals and the public on this issue. Your Reference Committee encourages this issue be re-visited upon the completion of additional evidence reviews.

Some individuals that testified supported referral of this entire report to the Cannabis Task Force or holding off on this report until the Cannabis Task Force completes its work. However, a member of the Board of Trustees testified that the task force will not be engaging in policy development, though their work may inform it. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 4 be adopted as amended.

(5) RESOLUTION 508 – HOME INFUSION OF HAZARDOUS DRUGS

RECOMMENDATION A:

The first Resolve of Resolution 508 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association update its existing home infusion policy, H-55.986, “Home Chemotherapy and Antibiotic Infusions,” by addition and deletion to read as follows:

Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including ~~chemotherapy and/or antibiotic therapy~~) for appropriate patients under physicians' recommendation and supervision if requested as a result of informed, shared decision making between the physician and patient; and (2) only considers extension of discourages the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health unless emergency when circumstances are present such that where the benefits of doing so to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement for such treatment; and (4) supports educating legislators and administrators about the risks and benefits of ~~such home infused antibiotics and supportive care treatments~~ in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide emphasize ensure patient and provider safety when considering emergency at home infusions for such treatment as access to such treatments biologic, immune

modulating, and anti-cancer therapy; and (5) advocates for ~~by~~ appropriate reimbursement policies when for home infusions are utilized. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 508 be adopted as amended.

HOD ACTION: Resolution 508 adopted as amended to read as follows:

RESOLVED, That our American Medical Association update its existing home infusion policy, H-55.986, “Home Chemotherapy and Antibiotic Infusions,” by addition and deletion to read as follows:
 “Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; and (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; and (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to provide ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; and (5) advocates for ~~by~~ appropriate reimbursement policies for home infusions. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA oppose any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings. (New HOD Policy)

RESOLVED, That our American Medical Association update its existing home infusion policy, H-55.986, “Home Chemotherapy and Antibiotic Infusions,” by addition and deletion to read as follows:

“Our AMA (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including ~~chemotherapy and/or~~ antibiotic therapy) for appropriate patients under physicians' supervision if requested as a result of informed, shared decision making between the physician and patient; ~~and~~ (2) discourages the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy unless emergency circumstances are present where the benefits of doing so outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement for such treatment; ~~and~~ (4) supports educating legislators and administrators about the risks and benefits of ~~such~~ home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ~~provide~~ emphasize patient and provider safety when considering emergency at home access to such treatments biologic, immune modulating, and anti-cancer therapy; and (5) advocates for ~~by~~ appropriate reimbursement policies when home infusion services are utilized. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA oppose extension of the temporary flexibility related to home infusion for Part B drugs, specifically biologics and anti-cancer drugs, that was approved as part of the response to the public health emergency (New HOD Policy); and be it further

RESOLVED, That our AMA oppose any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment for other settings. (New HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 508 and its intent to protect the safety of patients and physicians. Amendments to the original resolution were offered to allow for clinician judgment regarding risks and benefits of permitting home infusion in lieu of being completely opposed to these services. Further amended language addresses payers' policy/flexibility to dictate infusion setting and are consistent with the goals of the resolution. Therefore, your Reference Committee recommends that Resolution 508 be adopted as amended.

RECOMMENDED FOR NOT ADOPTION

(6) RESOLUTION 509 – HYDROXYCHLOROQUINE AND COMBINATION THERAPIES – OFF-LABEL USE

RECOMMENDATION A:

Resolution 509 not be adopted.

RECOMMENDATION B:

Policy H-120.988 be reaffirmed.

HOD ACTION: Policy H-120.988 reaffirmed.

RESOLVED, that our American Medical Association rescind its statement calling for physicians to stop prescribing hydroxychloroquine and chloroquine until sufficient evidence becomes available to conclusively illustrate that the harm associated with use outweighs benefit early in the disease course. Implying that such treatment is inappropriate contradicts AMA Policy H-120.988 that addresses off label prescriptions as appropriate in the judgement of the prescribing physician; (New HOD Policy) and be it further

RESOLVED, that our AMA rescind its joint statement with the American Pharmacists Association and American Society of Health System Pharmacists, and update it with a joint statement notifying patients that further studies are ongoing to clarify any potential benefit of hydroxychloroquine and combination therapies for the treatment of COVID-19; (New HOD Policy) and be it further

RESOLVED, that our AMA reassure the patients whose physicians are prescribing hydroxychloroquine and combination therapies for their early-stage COVID-19 diagnosis by issuing an updated statement clarifying our support for a physician's ability to prescribe an FDA-approved medication for off label use, if it is in her/his best clinical judgement, with specific reference to the use of hydroxychloroquine and combination therapies for the treatment of the earliest stage of COVID-19; (New HOD Policy) and be it further

RESOLVED, that our AMA take the actions necessary to require local pharmacies to fill valid prescriptions that are issued by physicians and consistent with AMA principles articulated in AMA Policy H-120.988, including working with the American Pharmacists Association and American Society of Health System Pharmacists. (New HOD Policy)

Your Reference Committee reviewed passionate and mixed testimony from both the online testimony and in the live hearing on this resolution.

Your AMA Board of Trustees (BOT) provided testimony in opposition of this Resolution and supportive of the AMA statement. The BOT noted that several commentators misconstrued the language in the statement and outlined that it very clearly says, "Novel off-label use of FDA-approved medications is a matter for the physician's or other prescriber's professional judgment" and also emphasized the need for physicians to rely on their professional judgment and medical evidence for any potential COVID-19 treatment option. The statement further notes that any use of these medications should be coordinated with a treating physician with full understanding of the potential risks and benefits. The statement was accurate at the time it was issued and took the best evidence available into account. The BOT, CSAPH, and the majority of those who testified noted that while hydroxychloroquine has demonstrated benefits for multiple chronic autoimmune and rheumatologic diseases, the benefit for treatment of COVID-19, at the time of the statement, had not been established, and that the AMA should base statements and policy on evidence and science. Many commentators, including the BOT and CSAPH noted that since the release of the statement several well-designed studies have failed to find benefit in the use of hydroxychloroquine for treatment of COVID-19 in multiple settings. Several who testified also noted that it would be an embarrassment to the AMA and call the credibility of the AMA into question to rescind a statement that was evidence-based and accurate.

Those supportive of Resolution 509 noted that the statement was offensive to physicians and could undermine the patient-physician relationship. Your Reference Committee understands, and agrees with the need for physician autonomy, but also agrees with the BOT testimony that the AMA statement does not infringe on physician autonomy and thus should not be rescinded. Your Reference Committee feels that AMA Policy H-120.988, “Patient Access to Treatments Prescribed by Their Physicians,” very clearly articulates the AMA’s strong support for autonomous clinical decision-making authority of physicians. Therefore, your Reference Committee recommends that Resolution 509 not be adopted and Policy H-120.988 be reaffirmed.

H-120.988, “Patient Access to Treatments Prescribed by Their Physicians”

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited, or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

REPORT OF REFERENCE COMMITTEE F

RECOMMENDED FOR ADOPTION

(1) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON
COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Recommendations in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Report of the House of Delegates Committee on Compensation of the Officers adopted and the remainder of the Report filed.

The Committee on Compensation of the Officers recommends that there be no changes to the Officers' compensation for the period beginning July 1, 2021 through June 30, 2022 and the remainder of the report filed. (Directive to Take Action)

Your Reference Committee wishes to extend its appreciation to the House of Delegates Committee on Compensation of the Officers for its report. Testimony in response to the report was limited, but supportive.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
REPORT 1 – INTERNATIONAL MEDICAL GRADUATES SECTION FIVE-
YEAR REVIEW

RECOMMENDATION:

Recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section through 2025 with the next review no later than the 2025 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

On behalf of our AMA House of Delegates, your Reference Committee wishes to extend its appreciation to the Council on Long Range Planning and Development and the International Medical Graduates Section for their cooperative and collaborative efforts thereby allowing the Council to present a thorough review of the Section's status. Having received no negative testimony, your Reference Committee supports the Council's conclusion.

During testimony, a comment on changing the five-year timeline for evaluating delineated sections was shared. While the Council provided a statement on the rationale for the delineated section review process, your Reference Committee wishes to note that changes to this process are beyond the scope of this report.

(3) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
2 – ORGANIZED MEDICAL STAFF SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendation in Council on Long Range Planning and Development Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 2 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2025 with the next review no later than the 2025 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

As was stated in the previous item of business, your Reference Committee is appreciative of the collaboration that has occurred between the Council on Long Range Planning and Development and the Organized Medical Staff Section, which has resulted in a comprehensive review of the Section. Testimony favored the recommendation of the Council.

(4) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
3 – ESTABLISHMENT OF THE PRIVATE PRACTICE PHYSICIANS
SECTION

RECOMMENDATION:

Recommendations in Council on Long Range Planning and Development Report 3 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 3 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association transition the Private Practice Physicians Congress to the Private Practice Physicians Section as a delineated section. (Directive to Take Action)
2. That our AMA develop bylaw language to recognize the Private Practice Physicians Section. (Directive to Take Action)

Your Reference Committee wishes to extend its appreciation to the Council on Long Range Planning and Development for a very comprehensive analysis of the Private Practice Physicians Congress' request for a change in status to that of a new AMA section. The report prompted only positive testimony.

Your Reference Committee emphasizes that according to the Council on Long Range Planning and Development's recommendation, the Private Practice Physicians Section would be created as a delineated section, subject to a five-year sunset rule and will be reappointed to that status by normal majority vote of the House of Delegates. Your Reference Committee also believes that there is great value in allowing for representation of physicians currently underrepresented in our AMA and that now is the ideal time to be supportive of colleagues who are struggling to maintain their private practices during the hardships of a pandemic.

Your Reference Committee wishes to acknowledge testimony calling for the new Section to be renamed the "Independent Practice Physician Section." In response to this suggestion, the leadership of the Private Practice Physicians Congress reported that the group does not support the name change because they have a 12-year identity as the PPP Caucus/Congress, which has granted the group cache and an alliterate presence easy to remember and instantly identified by our AMA membership. Your Reference Committee believes that if a name change is to be made, it should come from within the group via internal procedures.

- (5) RESOLUTION 606 – ADOPTING THE USE OF THE MOST RECENT AND UPDATED EDITION OF THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT

RECOMMENDATION:

Resolution 606 be adopted.

HOD ACTION: Resolution 606 referred.

RESOLVED, That our American Medical Association support the adoption of the most current edition of the AMA Guides in all jurisdictions in order to provide fair and consistent impairment evaluations for patients and claimants including injured workers. (New HOD Policy)

Your Reference Committee wishes to announce that a member of our committee, Stuart J. Glassman, MD, MBA disclosed he served a role in the development of Resolution 606. For this reason, Dr. Glassman recused himself from our deliberations and our recommendation on this item.

AMA Guides to the Evaluation of Permanent Impairment® (*AMA Guides*®) provide a measurement framework for permanent impairment in patients who have suffered an injury or illness resulting in long-term loss of a body part or reduction of body function. Once a patient has reached Maximum Medical Improvement, *AMA Guides* is used to assess a patient's impairment and document findings. A properly completed impairment rating report produced using the appropriate *AMA Guides* content is the gold standard for documenting permanent impairment to support insurance and legal proceedings.

Our AMA currently supports the use of the most recent edition of *AMA Guides* given it is an AMA product that is promoted and continues to be maintained, including a pending transformation to an online version that will allow for regular updates. For this reason, your Reference Committee concurs with the intent of Resolution 606 and those providing testimony that it is appropriate for AMA to augment its support through the adoption of this new House of Delegates policy. In response to the few who testified before the Committee in opposition to this resolution, your Reference Committee wishes to highlight that the intent of Resolution 606 is to achieve uniformity to the greatest extent possible. We believe that is an appropriate position for our AMA and the path to achieving broader acceptance of updated editions.

RECOMMENDED FOR REFERRAL

- (6) RESOLUTION 602 – TOWARDS DIVERSITY AND INCLUSION: A GLOBAL NONDISCRIMINATION POLICY STATEMENT AND BENCHMARK FOR OUR AMA

RECOMMENDATION:

Resolution 602 be referred with report back at the 2021 Annual Meeting.

HOD ACTION: Resolution 602 referred with report back at the 2021 Annual Meeting.

RESOLVED, That our American Medical Association adopt an overarching nondiscrimination policy on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities that applies to members, employees and patients. (New HOD Policy)

RESOLVED, That our AMA demonstrate its commitment to complying with laws, rules or regulations against discrimination on the basis of protected characteristics. (Directive to Take Action)

RESOLVED, That our AMA reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040, “Principles on Corporate Relationships,” in its overarching non-discrimination policy. (Reaffirm HOD Policy)

RESOLVED, That our AMA reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment.” (Reaffirm HOD Policy)

RESOLVED, That our AMA study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy, and report back to the AMA House of Delegates within 18 months. (Directive to Take Action)

RESOLVED, That our AMA provide an update on its comprehensive diversity and inclusion strategy to the AMA House of Delegates within 24 months. (Directive to Take Action)

Resolution 602 calls upon our AMA to adopt an overarching nondiscrimination policy; reaffirm current AMA policy; study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy; and provide an update on our AMA’s comprehensive diversity and inclusion strategy.

Your Reference Committee received testimony supportive of the intent of Resolution 602 but noted there were several amendments proffered to broaden inclusiveness, as well as to strengthen the language contained in existing AMA policy. Still others advocated for referral of this item due to the complexity of the requests and the need to develop an integrated response.

Your Reference Committee supports referral of this item to allow our AMA House of Delegates to receive a report back that codifies policies and activities and optimizes the language contained in an overarching nondiscrimination policy. There was limited, but supportive, testimony for a report back to the House of Delegates by the 2021 Annual Meeting. We recognize the investment of time and resources that our AMA has expended thus far and recommend referral to ensure we get this right. Because of the importance of this issue, your Reference Committee recommends that the report be brought back at the 2021 Annual Meeting.

Finally, your Reference Committee draws your attention to Board of Trustees Report 15 (November 2020), “Plan for Continued Progress Toward Health Equity,” which is included in the Handbook for this meeting among the informational materials.

REPORT OF REFERENCE COMMITTEE G

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 17 - HOSPITAL WEBSITE VOLUNTARY PHYSICIAN INCLUSION

RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 17 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 819-I-19 and that the remainder of the report be filed:

1. That our AMA (1) work with relevant stakeholders to encourage decision-makers at all appropriate levels that all credentialed physicians be included in healthcare organizations' website listings and search functions in a fair, equal, and unbiased fashion; and (2) support efforts to ensure that physicians, through their medical staffs, are able to provide input on what information is published. (Directive to Take Action)
2. That our AMA work with relevant stakeholders to encourage healthcare organizations to notify credentialed physicians when a website is about to be changed if there is reason to believe that such a change could affect how physicians are listed or if they are listed at all. (Directive to Take Action)
3. That our AMA, through its Organized Medical Staff Section, produce and promote educational materials, trainings, and any other relevant components to help physicians advocate for their own inclusion on facilities' websites and search functions. (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of Board of Trustees Report 17. In introducing the report, a member of the Board of Trustees explained that the issue raised by Resolution 819-I-19 is complicated by the lack of any identifiable local, state, or federal regulatory requirement around listing physicians on websites, outside of reporting on quality metrics. Moreover, a review of the ten largest hospitals failed to return any actionable information about their internal policies for listing physicians on websites. At the same time, the issue raised by Resolution 819-I-19 is a matter of fairness and importance to many independent physicians and found to be an issue in many localities across the country; the report recommendations were thought to alleviate the concerns raised in Resolution 819-I-19. Several delegates testified in support of the report. One amendment proposing an addition to recommendation 1, asking for distinctions relevant to practice availability, was proffered, but your Reference Committee believes that the addition is unnecessary. The articulated intention of the amendment is well-addressed by the current report recommendations, specifically in recommendation 1, part 2, which allows physicians to provide input on what information is published. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted.

- (2) COUNCIL ON MEDICAL SERVICE REPORT 2 - MITIGATING THE NEGATIVE EFFECTS OF HIGH-DEDUCTIBLE HEALTH PLANS

RECOMMENDATION:

Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 125-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients. (New HOD Policy)
2. That our AMA encourage employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. (New HOD Policy)
3. That our AMA encourage state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care. (New HOD Policy)
4. That our AMA reaffirm Policy D-185.979, which supports health plans designed to respect individual patient needs and legislative and regulatory flexibility to accommodate innovations in health plan design that expand access to affordable care, and which encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-165.828, which supports education regarding deductibles, cost-sharing, and health savings accounts (HSAs), and encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. (Reaffirm HOD Policy)

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 2. In introducing the report, a member of the Council on Medical Service highlighted that the recommendations of the report would expand the AMA's leadership in mitigating the negative impacts of high-deductible health plans (HDHPs) by encouraging ongoing research, advocacy, and collaboration. Testimony explored Resolution 125-A-19's requested exemption of outpatient evaluation and management services from deductible payments. An author of Resolution 125-A-19 testified in favor of CMS Report 2, stating that the report is well-written and provides a strong explanation of the potential for unintended consequences if certain services are exempt from deductibles. While amendments were offered regarding delivery system collaboration, network adequacy, and fair and equitable compensation, a member of the Council on Medical Service explained that the offered amendments focused on concerns that are addressed by other AMA policy, and the offered amendments would detract from the specific goals of the report. Your Reference Committee agrees that strong AMA policy responds to concerns raised in the proposed amendments (e.g. AMA Policies D-385.963 Health Care Reform Physician Payment Models and H-285.908 Network Adequacy), and that the recommendations set forth in CMS Report 2 are appropriately crafted in broad terms to provide enduring advocacy guidance. Therefore, your Reference Committee recommends that Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - ECONOMIC DISCRIMINATION
IN THE HOSPITAL PRACTICE SETTING

RECOMMENDATION:

Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 718-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. (New HOD Policy)
2. That our AMA recognize that physician onboarding, credentialing and peer review should not be tied in a discriminatory manner to hospital employment status. (New HOD Policy)
3. That our AMA reaffirm Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-230.953, which encourages the Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-230.975, which strongly opposes economic credentialing and believes that physicians should attempt to assure provisions in hospital medical staff bylaws of an appropriate role of the medical staff in decisions to grant or maintain exclusive contracts. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-230.976, which opposes use of economic criteria not related to quality to determine a physician's qualification for the granting or renewal of medical staff membership or privileges. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 4 was unanimously supportive. A member of the Council on Medical Service introduced the report stating that its report recommends actively opposing any policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. Additionally, having heard broader concerns about fairness and the need to protect physicians serving on medical staffs, the Council also recommends new policy recognizing that physician onboarding, credentialing, and peer review should not be tied to hospital employment status.

An amendment was offered to the first recommendation to add language stating that the AMA oppose policies that limit a physician's access to hospital services based on the number of procedures performed beyond those needed to ensure clinical competence and quality outcomes. The stated rationale for the amendment was to provide a baseline of competency and quality in the interest of patient safety. The Council on Medical Service responded to the amendment asking that the report's original language be retained and not amended. The Council noted that questions of clinical competence and quality are valid but are assessed in other ways besides volume. The Council went on to state that the proposed amendment and qualifications in the language can be used as loopholes for economic credentialing and can disproportionately harm access in rural and community hospitals. Additional testimony echoed the Council's concerns with the amended language, and your Reference Committee finds this testimony persuasive.

Additional testimony noted that, at times, a relationship exists between volume and outcomes. Your Reference Committee agrees. However, a physician's work and therefore volume may be spread across multiple hospitals. Moreover, your Reference Committee notes that this report applies not only to those physicians practicing in large systems but also those practicing in rural areas and that many factors influence patient safety and outcomes. Therefore, your Reference Committee recommends that Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) RESOLUTION 712 - INCREASE INSURANCE COMPANY HOURS FOR PRIOR AUTHORIZATION FOR INPATIENT ISSUES

RECOMMENDATION A:

Resolution 712 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association advocate that all insurance companies and benefit managers that require prior authorization ~~for patients in acute care hospitals have prior authorization~~ staff available to process ~~do~~ approvals ~~for hospitalized patients 24 hours a day~~, every day of the year, including holidays and weekends. (Directive to Take Action)

RECOMMENDATION B:

Resolution 712 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 712 be changed to read:

~~INCREASE INSURANCE COMPANY HOURS FOR PRIOR AUTHORIZATION~~
PROCESSING PRIOR AUTHORIZATION DECISIONS

HOD ACTION: Resolution 712 adopted as amended with change in title.

RESOLVED, That our American Medical Association advocate that all insurance companies that require prior authorization for patients in acute care hospitals have prior authorization staff available to do approvals for hospitalized patients every day of the year, including holidays and weekends. (Directive to Take Action)

Testimony on Resolution 712 was unanimously supportive. A few amendments were made to increase the scope of the resolution, which received widespread support. A member of the Council on Medical Service testified to broaden the resolution to include benefit managers and not only health insurers in the proposed policy. Additionally, the Council suggested an amendment that all insurance companies requiring prior authorization should have staff available to do approvals 24/7. Testimony highlighted that health care is 24/7. As such, it is imperative that health insurers who require prior authorization enable this to be obtained 24/7. Current limitations in operating hours lead to delays in prior authorization, impede timely transitions of care, delay approval for interventions, and can result in adverse outcomes. Your Reference Committee agrees and recommends these amendments be adopted.

The Council on Medical Service also called to broaden this resolution by striking the mention of acute care hospitals and hospitalized patients thereby broadening the resolution to apply to both inpatient and outpatient settings. This amendment garnered considerable support. A few speakers questioned whether the broadening of the resolution beyond inpatient prior authorization was necessary. In response, a member of the Council on Medical Service highlighted that the lines between inpatient and outpatient are not always clearly delineated and that care status can exist on a continuum. For example, some speakers stated that hospitalized patients may have “outpatient” status while in psychiatric observation or those patients in extended recover after surgery, among other examples. Your Reference Committee believes that the designation between inpatient and outpatient is far less important than the issue of whether prior authorization is provided in a timely manner due to its affect on patient safety and quality, which your Reference Committee finds to be the underlying principle of Resolution 712. Accordingly, your Reference Committee recommends accepting the Council on Medical Service’s amendment to broaden Resolution 712 to include all prior authorizations.

Further testimony asked that the Reference Committee consider the issue of prior authorization appeals. However, your Reference Committee finds this issue outside of the scope of Resolution 712 and highlights significant AMA policy on the issue of prior authorization appeals (See AMA Policies H-320.939 Prior Authorization and Utilization Management Reform, H-390.982 Payer Accountability, D-320.988 Preauthorization, and H-285.998 Managed Care). Another speaker brought up the issue of Peer Review Prior Authorization, and the Reference Committee notes that the Council on Medical Service has a forthcoming report on peer review prior authorization and therefore does not need to be addressed in Resolution 712. In addition, one speaker testified for model legislation on this issue. However, your Reference Committee notes that there is significant ongoing advocacy by the AMA regarding prior authorization, including at a state level.

Your Reference Committee agrees with the overwhelming supportive testimony on Resolution 712 and the proposed amendments to broaden its scope because all health care delivery is 24/7. Accordingly, your Reference Committee recommends that Resolution 712 be adopted as amended with a change in title to reflect the recommended amendments.

RECOMMENDED FOR REFERRAL

(5) RESOLUTION 710 - A RESOLUTION TO AMEND THE AMA'S PHYSICIAN AND MEDICAL STAFF BILL OF RIGHTS

RECOMMENDATION:

Resolution 710 be referred.

HOD ACTION: Resolution 710 referred.

RESOLVED, That our American Medical Association amend Policy H-225.942, "Physician and Medical Staff Member Bill of Rights" by addition to read as follows:

Physician and Medical Staff Member Bill of Rights H-225.942

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patient's best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

The AMA recognizes the responsibility to provide for the delivery of high quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body, and relies on accountability and inter-dependence with government and public health agencies that regulate and administer to these organizations.

The AMA supports the right to advocate without fear of retaliation by the health care organization's administrative or governing body including the right to refuse work in unsafe situations without retaliation.

The AMA believes physicians should be continuously provided with the resources necessary to continuously improve patient care and outcomes and further be permitted to advocate for planning and delivery of such resources not only with the health agency but with supervising and regulating government agencies.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes.

- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staffs ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organizations governing body.
- f. The right to engage the health care organizations administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
- e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each members ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
- b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
- c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body.

- d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
- e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
- f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy)

Your Reference Committee heard testimony that overwhelmingly supported referral of Resolution 710, including the Resolution author, the Organized Medical Staff Section delegate, and a member of the Council on Medical Service. Other testimony was in support of Resolution 710 or offered amendments, but most speakers urged referral of Resolution 710. In recommending referral of Resolution 710, several delegates highlighted the complexity of the issues raised, including the fact that physicians practice in settings that assume varying degrees of inherent risk, and that while these issues are especially timely during the COVID-19 pandemic, the Physician and Medical Staff Member Bill of Rights is much broader and will endure into the future. Therefore, your Reference Committee recommends that Resolution 710 be referred so that this issue can be further studied and the resulting policy language be crafted with precision.