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<th>Tier</th>
<th>Ref Comm</th>
<th>Resolution/ Report</th>
<th>Title</th>
<th>Recommendation/Resolve</th>
<th>Support/Not Support/monitor/Comment</th>
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| 2    | Ref Comm A | CMS 01              | End-of-Life Care | 1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare’s hospice benefit. (New HOD Policy)  
2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare’s hospice and skilled nursing facility (SNF) benefits for the same condition. (New HOD Policy)  
3. That our AMA support increased access to palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)  
4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy)  
That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient. (Reaffirm HOD Policy)  
Fiscal Note: Less than $500 | Support |
| 1    | Ref Comm A | Res. 102  
(Senior Physicians Section) | Prevention of Hearing Loss-Associated-Cognitive-Impairment through | RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further  
RESOLVED, That our AMA promote, and encourage other stakeholders, | Support |
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<tr>
<th>Ref Comm A</th>
<th><strong>Res. 103</strong> (Senior Physicians Section)</th>
<th>Oral Healthcare IS Healthcare</th>
<th>Earlier Recognition and Remediation including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000</th>
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<td></td>
<td>Ref Comm</td>
<td>Res. 113</td>
<td>Supporting Medicare Drug Price Negotiation</td>
<td>RESOLVED, That our American Medical Association aggressively advocate for passage of legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it further RESOLVED, That our AMA amend Policy H-110.980, “Additional Mechanisms to Address High and Escalating Pharmaceutical Prices” to support indexing Medicare Part D drug prices to a reasonable percentage of the prices paid in other large western industrialized nations by addition and deletion to read as follows: H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices 2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles: a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls; b. Any international drug price index or average should not be used to determine or set a drug’s price, or determine whether a drug’s price is excessive, in isolation; a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug’s volume-weighted net average price in at least six large western industrialized nations; e. b. The use of any international drug price index or average should preserve patient access to necessary medications; d. c. The use of any international drug price index or average should limit burdens on physician practices; and e. d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly; and</td>
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<td>2</td>
<td>Ref Comm A</td>
<td>Res. 113 (California)</td>
<td>Supporting Medicare Drug Price Negotiation</td>
<td>RESOLVED, That our American Medical Association aggressively advocate for passage of legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it further RESOLVED, That our AMA amend Policy H-110.980, “Additional Mechanisms to Address High and Escalating Pharmaceutical Prices” to support indexing Medicare Part D drug prices to a reasonable percentage of the prices paid in other large western industrialized nations by addition and deletion to read as follows: H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices 2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles: a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls; b. Any international drug price index or average should not be used to determine or set a drug’s price, or determine whether a drug’s price is excessive, in isolation; a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug’s volume-weighted net average price in at least six large western industrialized nations; e. b. The use of any international drug price index or average should preserve patient access to necessary medications; d. c. The use of any international drug price index or average should limit burdens on physician practices; and e. d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly; and</td>
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<td>Res No.</td>
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<td>2</td>
<td>Ref Comm A</td>
<td>Medicare and Private Health Insurance for Hearing Aids</td>
<td>RESOLVED, That our American Medical Association support Congress expanding Medicare Coverage for medical grade hearing aids (New HOD Policy); and be it further</td>
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<td>Ref Comm B</td>
<td>Paying Physicians for Services According to the Physician Fee Schedule</td>
<td>RESOLVED, That our American Medical Association advocate for Congress to require Employee Retirement Income Security Act (ERISA) self-funded employer-sponsored plans, state-regulated plans, Medicare, Medicaid, and TRICARE to pay physicians appropriately for a covered service provided as a telemedicine service to an enrolled patient by a contracted physician at least the same as the contracted rate that would have been paid if the service were provided in an in-person setting (Directive to Take Action); and be it further</td>
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The American Medical Association (AMA) supports the resolution that requires Medicare Part D drug prices to be determined using an international drug price index that does not unnecessarily subsidize drug costs in other large Western industrialized nations. The AMA also supports legislation that limits Medicare annual drug price increases to the rate of inflation and reinvests a portion of any savings from negotiations into the Medicare physician fee schedule and other Medicare physician value-based payments.

The AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation (New HOD Policy).

The AMA supports legislation that renews a portion of any savings from Medicare drug price negotiations into the Medicare physician fee schedule and other Medicare physician value-based payments.

The AMA supports Congress expanding Medicare Coverage for medical grade hearing aids (New HOD Policy).

The AMA advocates for coverage with minimal copays or coinsurance for medical-grade hearing aids as medically necessary for all health insurance, including Medicaid.

Support
geographic and originating site restrictions should be eliminated to allow patients to receive appropriate telehealth services in their homes, residential facilities, and other locations (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services retain on a permanent basis the telehealth services added to the Medicare telehealth services list during the public health emergency. (Directive to Take Action)
Fiscal Note: Modest - between $1,000 - $5,000

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<th>Ref Comm</th>
<th>Res. 230</th>
<th>Medicare Advantage Plan Mandates</th>
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<td>2</td>
<td>Ref Comm B</td>
<td>RESOLVED, That our American Medical Association advocate for federal legislation to ensure that no person should be mandated to change from traditional Medicare to Medicare Advantage plans. (Directive to Take Action) Fiscal Note: Not yet determined</td>
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</table>
| 2        | Ref Comm B | RESOLVED, That our American Medical Association work with national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take Action); and be it further
RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose eye drop bottles post-operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take Action) Fiscal Note: Not yet determined | Support |

Fiscal Note: Between $1,000 - $5,000
The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians:
   a) Evidence-based: Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician’s competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.
   b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.
   c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians’ ability to perform the tasks specifically required in their practice environment.
   d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
   e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician’s practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.
   f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to the public and physicians.

Support with suggested amendments to Recommendations:
1b) insert "especially Chapter 9, and in particular CEJA Opinion 9.3.2 following "medical ethics" on line 22, p 12
1e) insert "Legal," before "Fair and Equitable" on line 35, p 12
1h) Substitute "Non-cumbersome" for "Cost Conscious" on line 49, p 12, and delete "that are distinctly different from “for cause” assessments" on lines 49 and 50 p. 12
assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment.

g) Supportive: Education and/or remediation practices that result from screening and/or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
h) Cost conscious: Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)

2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action)

3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $1,000

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<tr>
<th>1</th>
<th>Ref Comm C</th>
<th>CME Report 4</th>
<th>Medical Student Debt and Career Choice</th>
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<td>The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:</td>
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<td>1. That our American Medical Association (AMA) encourage key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. (New HOD Policy)</td>
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<td>2. That our AMA monitor new policies and novel approaches to influence</td>
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Support
career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. (New HOD Policy)

3. That our AMA amend Policy H-305.925 (20), “Principles of and Actions to Address Medical Education Costs and Student Debt,” by addition and deletion, to read as follows:

“Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer’s PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; and (k) Undertake expanded federal advocacy, in the event denial rates for physician
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<tr>
<td>1</td>
<td>Ref Comm D</td>
<td>Res 401</td>
<td>Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post Acute Covid Syndrome</td>
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<td>RESOLVED, That our American Medical Association through its advocacy and public relations divisions promote and support all public health recommendations relating to the Covid-19 emergency that are consistent with sound scientific principles and law, and not inconsistent with evolving AMA policy (Directive to Take Action); and be it further resolved, That our AMA promote and encourage through all available means the further investigation of PACS, and third-party support for evaluation and care of COVID-19 long-hauler patients. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000</td>
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<td>2</td>
<td>Ref Comm F</td>
<td>BOT 19</td>
<td>Advocacy for Physicians with Disabilities</td>
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<td>1. That our American Medical Association (AMA) establish an advisory group composed of AMA members who themselves have a disability to work toward inclusion for physicians with disabilities in all AMA activities. (Directive to Take Action) 2. That our AMA promote and foster educational and training opportunities for AMA members and the medical community at large to</td>
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better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent. (Directive to Take Action)

3. That our AMA develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians to manage their own disability-related needs in the workplace. (Directive to Take Action)

4. That our AMA communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians with visible and invisible disabilities. (Directive to Take Action)

That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as having been accomplished by this report. (Modify Current HOD Policy) Fiscal Note: Convene advisory group and develop resources as directed at an estimated cost of $30,500.

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<th>Reference</th>
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<tr>
<td>1 Ref Comm F</td>
<td>Res. 601</td>
<td>&quot;Virtual Water Cooler&quot; for our AMA</td>
<td>RESOLVED, That our American Medical Association explore options facilitating the ability of members to identify and directly contact other members who are interested in participating in informal inter-member mentoring, in order that self-selected members may readily enter into collegial communications with one another; and shall report back such options to the HOD within 12 months. (Directive to Take Action) Fiscal Note: Minimal – less than $1,000</td>
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<td>2 Ref Comm G</td>
<td>CMS 02</td>
<td>Access to Health Plan Information regarding Lower-Cost Prescription Options</td>
<td>1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD Policy)</td>
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2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)

3. That our AMA develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (Directive to Take Action)

4. That our AMA amend Policy H-110.990[3] by addition, as follows:

Our AMA: … 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient’s medical condition. (Modify Current HOD Policy)

5. That our AMA amend Policy H-125.974 by addition and deletion as follows:

Our AMA will: …

(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
(56) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without minimal disruption to EHR usability and minimal to no cost to physicians and hospitals; and… (Modify Current HOD Policy)

That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates that cost data be delivered in a reasonable and useable manner by third-party payers and purchasers. The policy also calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. (Reaffirm HOD Policy)

Fiscal Note: Less than $2,500.

|   | Informational Rpt | CEJA Opinion 1-N-21 | Amendment to Opinion 9.3.2, “Physician Responsibilities to Impaired Colleagues” | As individuals, physicians should:
(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.
(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice. |
|---|---|---|---|---|
| 1 | Informational Rpt | CEJA Opinion 1-N-21 | Amendment to Opinion 9.3.2, “Physician Responsibilities to Impaired Colleagues” | As individuals, physicians should:
(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.
(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice. |
|   |   |   |   | The SPS GC firmly believes CEJA Opinion 1-N-21 to be integral to CME 1. |
(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law. Collectively, physicians should nurture a respectful, supportive professional culture by:
(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.
(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.
(h) Eliminating stigma within the profession regarding illness and disability.
(i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.
(j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency. (II)