DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-23)

Report of Reference Committee B

Richard A. Geline, MD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION**
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5 1. Board of Trustees Report 9 – Council on Legislation Sunset Review of 2013
6 House Policies
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8 2. Board of Trustees Report 11 – HPSA and MUA Designation for SNFs
9
10 3. Board of Trustees Report 12 – Promoting Proper Oversight and Reimbursement
11 for Specialty Physician Extenders and Non-Physician Practitioners
12
13 4. Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance
14 Providers
15
16 5. Resolution 225 – Regulation of “Cool/Non-Menthol” Tobacco Products
17
18 6. Resolution 241 – Allow Viewing Access to Prescription Drug Monitoring
19 Programs Through EHR for Clinical Medical Students and Residents
20
21 7. Resolution 246 – Modification of CMS Interpretation of Stark Law
22
23 8. Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance
24 Proceedings
25
26 **RECOMMENDED FOR ADOPTION AS AMENDED**
27
28 9. Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections
29
30 10. Resolution 206 – Tribal Public Health Authority
31
32 11. Resolution 207 – Ground Ambulance Services and Surprise Billing
33
34 12. Resolution 208 – Medicaid Managed Care for Indian Health Care Providers
35
36 13. Resolution 209 – Purchased and Referred Care Expansion
37

14. Resolution 211 – Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits

15. Resolution 213 – Telemedicine Services and Health Equity

16. Resolution 216 – Improved Foster Care Services for Children

17. Resolution 217 – Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools

18. Resolution 218 – Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners

19. Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations

20. Resolution 221 – Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool

21. Resolution 223 – Protecting Access to Gender Affirming Care

22. Resolution 226 – Vision Qualifications for Driver’s License

23. Resolution 227 – Reimbursement for Postpartum Depression Prevention

24. Resolution 228 – Reducing Stigma for Treatment of Substance Use Disorder

25. Resolution 230 – Address Disproportionate Sentencing for Drug Offenses

26. Resolution 235 – EMS as an Essential Service

27. Resolution 236 – AMA Support for Nutrition Research

28. Resolution 244 – Recidivism

29. Resolution 245 – Biosimilar/Interchangeable Terminology

30. Resolution 259 – Strengthening Supplemental Nutrition Assistance Program (SNAP)

RECOMMENDED FOR ADOPTION IN LIEU OF

31. Resolution 214 – Advocacy and Action for a Sustainable Medical Care System
    Resolution 234 – Medicare PFS Updates and Grassroots Campaign
    Resolution 257 – AMA Efforts on Medicare Payment Reform

32. Resolution 219 – Repealing the Ban on Physician-Owned Hospitals
    Resolution 222 – Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)
    Resolution 261 – Physician Owned Hospitals

33. Resolution 237 – Prohibiting Covenants Not-to-Compete in Physician Contracts
    Resolution 263 – Elimination of Non-Compete Clauses in Employment Contracts

34. Resolution 239 – Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians
    Resolution 262 - Alignment of Specialty Designations for Advanced Practice Providers With Their Supervising Physicians

35. Resolution 247 – Assessing the Potentially Dangerous Intersection Between AI and Misinformation
    Resolution 251 – Federal Government Oversight of Augmented Intelligence
    Resolution 256 – Regulating Misleading AI Generated Advice to Patients

RECOMMENDED FOR REFERRAL

36. Resolution 202 – Support for Mental Health Courts

37. Resolution 203 – Drug Policy Reform

38. Resolution 204 – Supporting Harm Reduction

39. Resolution 240 – Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

RECOMMENDED FOR REFERRAL FOR DECISION

40. Resolution 258 – Adjustments to Hospice Dementia Enrollment Criteria

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

41. Resolution 205 – Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness

42. Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico Border

43. Resolution 212 – Marijuana Product Safety

44. Resolution 215 – Supporting Legislative and Regulatory Efforts against Fertility Fraud

45. Resolution 231 – Equitable Interpreter Services and Fair Reimbursement

1 46. Resolution 260 – Advocate to the Centers for Medicare and Medicaid Services
2 and The Joint Commission to Redefine the Term “Provider” and Not Delete the
3 Term “Licensed Independent Practitioner”
4
5 Amendments
6 If you wish to propose an amendment to an item of business, click here: Submit
7 New Amendment

RECOMMENDED FOR ADOPTION

(1) BOT 9 - COUNCIL ON LEGISLATION SUNSET REVIEW OF 2013 HOUSE POLICIES

RECOMMENDATION:

Recommendation in Board of Trustees Report 9 be adopted and the remainder of the Report be filed.

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

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee considered Board of Trustees Report 9 and agrees with the recommendations for the policies in the Sunset Review. Your Reference Committee, therefore, recommends that the recommendations in Board of Trustees Report 9 be adopted and that the remainder of the report be filed.

(2) BOT 11 - HPSA AND MUA DESIGNATION FOR SNFS

RECOMMENDATION:

Recommendation in Board of Trustees Report 11 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 11 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following policies be reaffirmed in lieu of Resolution 224-A-22, and the remainder of the report be filed:

1. That our AMA reaffirm Policy H-465.981, which asks our AMA to: a. support legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status; b. encourage federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; c. explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; d. supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more

physician extenders; and e. undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-200.972, "Primary Care Physicians in Underserved Areas", which provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-280.979, which asks our AMA to support the following: a. continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services; b. continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home; c. efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and d. assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-200.980, which asks our AMA to advocate for the following: a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations; b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program; c. Adequate funding for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas; and d. Encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-200.954, which encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-465.988, which provides educational strategies for meeting rural health physician shortages. (Reaffirm HOD Policy)

Your Reference Committee heard positive testimony in support of BOT 11. Your Reference Committee heard testimony that emphasized the need for quality care and recognized the significant role that skilled nursing facilities (SNFs) play in providing such care. Your Reference Committee notes that our existing comprehensive approach to addressing physician shortages aligns perfectly with the issues raised in the report. Testimony stated that our AMA has long been committed to tackling physician shortages in various settings, including underserved populations and specialties. Your Reference Committee heard positive testimony reinforcing our AMA's ongoing efforts and highlighting the relevance of our existing strategies addressing the specific challenges faced by SNFs. Your Reference Committee heard testimony supporting scholarship and loan repayment

programs which our AMA already has policy on and which is noted in the report. Your Reference Committee recognizes the importance of these initiatives in incentivizing physicians and medical students to work in underserved areas. Testimony noted that by providing financial assistance and support, these programs effectively attract and retain healthcare professionals where they are most needed, including within SNFs. Your Reference Committee, therefore, recommends that the recommendations in Board of Trustees Report 11 be adopted and that the remainder of the report be filed.

(3) BOT 12 - PROMOTING PROPER OVERSIGHT AND REIMBURSEMENT FOR SPECIALTY PHYSICIAN EXTENDERS AND NON-PHYSICIAN PRACTITIONERS

RECOMMENDATION:

Recommendation in Board of Trustees Report 12 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 12 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 248-A-22 and that the remainder of the report be filed.
1. That our American Medical Association (AMA) reaffirm existing Policy H-35.965, “Regulation of Physician Assistants,” and H-35.989, “Physician Assistants.” (Reaffirm HOD Policy)

2. That Policy H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice” be amended by addition and deletion as follows:

(5) ~~Physicians should encourage~~ Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards ~~explore the feasibility of working together to coordinate their regulatory initiatives and activities.~~(Modify Current HOD Policy)

Your Reference Committee heard only positive testimony in support of BOT Report 12, including from the author of the original resolution. Your Reference Committee heard that medical boards in many states already license and regulate a variety of non-physicians, including physician assistants, and that medical boards in several states also jointly regulate nurse practitioners and other advanced practice registered nurses (APRN). Your Reference Committee heard support for both reaffirmation of existing AMA policy supporting regulatory oversight of physician assistants by state medical boards, and for joint licensure and regulation of APRNs by the state boards of medicine and nursing. Your Reference Committee also heard that our AMA’s “Model Act to Support Physician-Led Team Based Health Care” includes language to this effect. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted and that the remainder of the report be filed.

(4) RESOLUTION 224 - ADVOCACY AGAINST OBESITY-RELATED BIAS BY INSURANCE PROVIDERS

RECOMMENDATION:

Resolution 224 be adopted.

HOD ACTION: Resolution 224 adopted.

RESOLVED, That our American Medical Association urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:

1. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
2. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider
3. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
4. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes (Directive to Take Action); and be it further

RESOLVED, That the AMA support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony for Resolution 224. Testimony noted how important access to care for those with obesity is and how insurance companies often are biased and do not want to authorize the care needed for those who are diagnosed with obesity. Your Reference Committee heard about the important health needs of those with obesity and the alternate care options they turn to if they are not granted the care that they and their physician decide is best for their health. Therefore, your Reference Committee recommends that Resolution 224 be adopted.

(5) RESOLUTION 225 - REGULATION OF "COOL/NON-MENTHOL" TOBACCO PRODUCTS

RECOMMENDATION:

Resolution 225 be adopted.

HOD ACTION: Resolution 225 adopted.

RESOLVED, That our American Medical Association advocate that tobacco products that use additives that create a "cooling effect" should be treated as a tobacco product with a characterizing flavor for legal and regulatory purposes. (Directive to Take Action)

Your Reference Committee heard testimony overwhelmingly in support of Resolution 225. Your Reference Committee heard that our AMA has strong policy in support of banning menthol cigarettes and other flavored tobacco products and joined with a coalition of tobacco control stakeholders in detailed comments to this effect in response to the U.S. Food and Drug Administration's (FDA) proposed rules banning menthol in cigarettes and cigars last year. Your Reference Committee also heard that after the state of California enacted legislation banning menthol cigarettes, tobacco companies immediately began introducing new products to the California market designed to appeal to the state's menthol smokers by replicating the "cooling" feel of menthol cigarettes in an attempt to circumvent the new law. Your Reference Committee also heard that in March of 2023, our AMA joined with a coalition of stakeholders in a letter to the FDA urging them to immediately begin an investigation of these new products and to ensure that appropriate enforcement proceedings are initiated to prevent their continued sale. Your Reference Committee further heard that, although our AMA has already implemented the resolution's request, Resolution 225 should be adopted so that this policy is added to our AMA's extensive policy compendium on tobacco control and regulation. Your Reference Committee therefore recommends that Resolution 225 be adopted.

(6) RESOLUTION 241 - ALLOW VIEWING ACCESS TO PRESCRIPTION DRUG MONITORING PROGRAMS THROUGH EHR FOR CLINICAL MEDICAL STUDENTS AND RESIDENTS

RECOMMENDATION:

Resolution 241 be adopted.

HOD ACTION: Resolution 241 adopted.

RESOLVED, That our American Medical Association amend Policy H-95.945, *Prescription Drug Diversion, Misuse and Addiction*, to include prescription drug monitoring program (PDMP) viewing access as a mainstay of appropriate and comprehensive medical training for clinical medical students and residents. (Modify Current HOD Policy)

Your Reference Committee heard support for Resolution 241. Your Reference Committee heard testimony that prescription drug monitoring programs (PDMP) can be helpful tools to show a patient's or physician's prescription history. Your Reference Committee reviewed testimony that noted the widespread use of PDMPs by physicians and other health care professionals who accessed PDMPs more than 1.1 billion times in 2021. Your Reference Committee heard that there are approximately 40 states that require physicians to use a PDMP prior to prescribing a controlled substance. Your Reference Committee heard that medical students and residents need to become accustomed to how PDMPs are incorporated into clinical practice. Your Reference Committee heard that this Resolution positions our AMA to help in whatever way necessary to remove medical students' and residents' barriers to using a PDMP. Your Reference Committee therefore recommends that Resolution 241 be adopted.

(7) RESOLUTION 246 - MODIFICATION OF CMS INTERPRETATION OF STARK LAW

RECOMMENDATION:

Resolution 246 be adopted.

HOD ACTION: Resolution 246 adopted.

RESOLVED, That our American Medical Association request that the Center for Medicare & Medicaid Services retract the determination that delivery of medicine to a patient using the Postal Service, a commercial package service, or by a trusted surrogate violates the in-office exception of the Stark Law (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislation to clarify that a surrogate may deliver medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law if the Center for Medicare & Medicaid Services does not change its position on disallowing the delivery of medicine to a patient using the Postal Service or a commercial package service. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 246. Testimony noted that this Resolution aligns with current AMA policy while adding a new aspect to our AMA advocacy by requesting that the Center for Medicare and Medicaid Services (CMS) retract its determination that delivery of medicine to a patient using the United States Postal Service, a commercial package service, or a trusted surrogate violates the in-office exception of the Stark Law. Testimony also supported advocacy for legislation to clarify that a surrogate may deliver medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law. Accordingly, your Reference Committee recommends that Resolution 246 be adopted.

(8) RESOLUTION 254 - ELIMINATING THE PARTY STATEMENT EXCEPTION IN QUALITY ASSURANCE PROCEEDING

RECOMMENDATION:

Resolution 254 be adopted.

HOD ACTION:

RESOLVED, That our American Medical Association reaffirm the importance of meaningful Quality Assurance proceedings that are unhindered by legal discovery concerns (New HOD Policy); and be it further

RESOLVED, That our AMA strongly support and advocate for eliminating the Party Statement Exception to confidentiality at Quality Assurance meetings in all applicable laws. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 254, highlighting the importance of addressing the challenges faced by quality assurance (QA) groups and the

1 impact of legal decisions on QA proceedings. Your Reference Committee heard testimony
2 emphasizing the need to protect the effectiveness of QA proceedings and the timeliness
3 of the issue at hand. Your Reference Committee heard participants express concerns
4 about the discoverability of statements, which can lead to a decrease in the efficacy of QA
5 processes and increase the risk of liability. Your Reference Committee heard recognition
6 for the need for peer review and QA to be conducted in good faith, with protections and
7 privileges afforded by law. Therefore, your Reference Committee recommends that
8 Resolution 254 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

(9) RESOLUTION 201 - PHARMACISTS PRESCRIBING FOR URINARY TRACT INFECTIONS

RECOMMENDATION A:

The first Resolve of Resolution 201 be amended by addition and deletion to read as follows:

Resolved, That our AMA collaborate with relevant stakeholders including state and specialty societies to oppose legislation or regulation allowing pharmacists to test, diagnose and treat ~~urinary tract infections~~ medical conditions (Directive to Take Action)

RECOMMENDATION B:

The second Resolve of Resolution 201 be deleted:

~~RESOLVED, That our AMA advocate that inappropriate treatment of urinary tract infections with antibiotics is a public health concern which can lead to further bacterial antibiotic resistance. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 201 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 201 be changed to read as follows:

OPPOSITION TO PHARMACISTS TESTING, DIAGNOSING, AND TREATING MEDICAL CONDITIONS

HOD ACTION: Resolution 201 adopted as amended with a change of title.

OPPOSITION TO PHARMACISTS TESTING, DIAGNOSING, AND TREATING MEDICAL CONDITIONS

RESOLVED, That our American Medical Association collaborate with relevant stakeholders including state and specialty societies to oppose legislation or regulation allowing pharmacists to test, diagnose, and treat urinary tract infections (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate that inappropriate treatment of urinary tract
2 infections with antibiotics is a public health concern which can lead to further bacterial
3 antibiotic resistance. (Directive to Take Action)
4
5 Your Reference Committee heard testimony largely in support of Resolution 201.
6 Testimony in support of the Resolution noted that legislation to allow pharmacists to test
7 for and treat urinary tract infections has been proposed across the country, and that
8 antimicrobial resistance associated with overuse or misuse of antibiotics used to treat
9 infections is a public health concern. Your Reference Committee also heard concerns that
10 pharmacists may not recognize comorbidities if allowed to diagnose and treat urinary tract
11 infections and that prescribing medications constitutes the practice of medicine and is
12 outside pharmacists' scope of practice. Some testimony recommended reaffirmation of
13 existing AMA policy that opposes the practice of medicine by nonphysicians and opposes
14 the prescribing of medications by pharmacists without a valid order by a physician or
15 without physician supervision. Further, your Reference Committee received a proposed
16 amendment that would expand the scope of this Resolution to oppose legislation and
17 regulation that allows pharmacists to test for, diagnose, and treat any medical condition,
18 to include infections. Recognizing that the diagnosis and treatment of any medical
19 condition constitutes the practice of medicine, and because this Resolution would
20 strengthen existing policy and align with our AMA's advocacy, your Reference Committee
21 recommends that Resolution 201 be adopted as amended.

(10) RESOLUTION 206 - TRIBAL PUBLIC HEALTH AUTHORITY

RECOMMENDATION A:

The first Resolve of Resolution 206 be deleted.

~~RESOLVED, That our American Medical Association advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~make a suggestion to~~ the Department of Health and Human Services ~~to~~ issuing ~~develop sub-agency~~ guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, ~~(e.g, CDC, IHS) guidance~~ on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers (New HOD Policy); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~encourage~~ support the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers. (New HOD Policy)

RECOMMENDATION D:

Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

RESOLVED, That our American Medical Association advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities (Directive to Take Action); and be it further

RESOLVED, That our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-

affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 206. Your Reference Committee heard that American Indian and Alaska Native (AI/AN) Tribes and Villages (Tribal Nations) and Tribal Epidemiology Centers (TECs) are "public health authorities" under federal law and, as such, have the legal authority to collect, receive, and disseminate public health data to respond to public health threats. Your Reference Committee further heard that, despite this legal authority, these entities have had difficulty accessing Centers for Disease Control and Prevention (CDC) and Indian Health Services (IHS) data, as well as state and local data, especially during the COVID-19 pandemic, when it was reported that county and state public health agencies refused to share case and mortality data with Tribal Nations and TECs in California and the Great Plains area. Testimony also stated that in a 2022 study, the US Government Accounting Office (GAO) reaffirmed TECs status as public health authorities. Your Reference Committee further heard that the first resolve asks our AMA to advocate to reaffirm AI/AN Tribal Nations and TECS' status as public health authorities; however, your Reference Committee also heard that our AMA does not need to advocate for reaffirmation of Tribal Nations and TECs' status as public health authorities, since existing law provides such authority, which the GAO study confirmed, and which Reference Committee testimony confirmed. Your Reference Committee also heard an amendment offered to slightly amend the language in resolves 2 and 3 for our AMA to support the issuance of Department of Health and Human Services guidance on data-sharing and to support the use of data-sharing agreements between local and state public health departments and AI/AN Tribal Nations and TECs. Your Reference Committee acknowledges the supplemental information provided by the CDC, including information that the CDC is currently working on guidance called for by the GAO report on data sharing. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

(11) RESOLUTION 207 - GROUND AMBULANCE SERVICES AND SURPRISE BILLING

RECOMMENDATION A:

Resolution 207 be adopted as amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~oppose surprise billing practices for~~ support full insurance coverage for all costs associated with ground ambulance services.

RECOMMENDATION B:

Resolution 207 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 207 be changed to read as follows:

INSURANCE COVERAGE OF GROUND AMBULANCE SERVICES

HOD ACTION: Resolution 206 adopted as amended with a change of title.

INSURANCE COVERAGE OF GROUND AMBULANCE SERVICES

RESOLVED, That our American Medical Association oppose surprise billing practices for ground ambulance services. (New HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 207, which focused on the need to extend patient protections to ground ambulance services and address surprise billing. Your Reference Committee heard testimony in favor of the Resolution, emphasizing that extending patient protections to ground ambulance services is timely and necessary. Your Reference Committee heard proponents testify that it is crucial to ensure that patients using emergency ground transportation are not burdened with exorbitant out-of-pocket costs. Your Reference Committee heard testimony in favor of aligning ground ambulance services with existing patient protection measures applied to other medical services. Your Reference Committee heard testimony about the urgency for our AMA to engage in advocacy. On the other hand, your Reference Committee heard opposing testimonies expressing concerns about the unintended consequences of the Resolution. Your Reference Committee heard arguments that excluding ground ambulances from the No Surprises Act was intentional due to the nature of services provided by municipal and local authorities. Your Reference Committee heard concerns that subjecting ground ambulances to the same regulations as other medical services could jeopardize access to emergency transportation, particularly in areas where alternate options are limited. Your Reference Committee heard additional concerns about the potential negative impact on patient care and access if the Resolution were to pass without

adequately addressing these issues. Your Reference Committee heard testimony in favor of amended language that advocates for full insurance coverage for ground ambulance services. Your Reference Committee heard testimony that the responsibility for addressing the issue of surprise billing should lie with insurance companies, narrow networks, and lack of coverage, rather than placing it on physicians or ground ambulance services. Your Reference Committee heard about the importance of ensuring that patients are protected from financial burdens of emergency medical services and that insurance companies should be held accountable for providing adequate coverage for ground ambulance services. Accordingly, your Reference Committee recommends that Resolution 207 be adopted as amended.

(12) RESOLUTION 208 - MEDICAID MANAGED CARE FOR INDIAN HEALTH CARE PROVIDERS

RECOMMENDATION A:

The first Resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~urge~~ support stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are in compliance ~~complying~~ with their legal obligations to Indian health care providers (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~collaborate with other stakeholders to~~ encourage state Medicaid agencies to follow the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers.~~ by, including, but not limited to:~~
~~1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid agencies.~~
~~2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian Managed Care Addendum.~~
~~3. Offering employee onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions.~~ (~~Directive to Take Action~~ New HOD Policy)

RECOMMENDATION C:

Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 adopted as amended.

RESOLVED, That our American Medical Association urge stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are complying with their legal obligations to Indian health care providers (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with other stakeholders to encourage state Medicaid agencies to follow the Center for Medicare and Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers by, including, but not limited to:

1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid agencies.

2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian Managed Care Addendum.

3. Offering employee onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony about Resolution 208. Your Reference Committee heard that state Medicaid programs or their contracted Managed Care Organizations (MCOs) must follow regulatory Indian Health Care Medicaid Managed Care Provisions that protect the rights of Indian Health Care Providers (IHCPs). Your Reference Committee also heard that a Managed Care Subcommittee of the Tribal Technical Advisory Group from the Centers for Medicare and Medicaid Services identified several issues negatively impacting the availability of health care services offered by IHCPs to American Indians/Alaska Natives covered by Medicaid, such as denial of claims, incorrect payment, and inadequate state oversight of MCOs. Your Reference Committee further heard that greater compliance with regulations governing Indian Health Care Medicaid Managed Care Provisions would improve the availability of services offered by IHCPs. Your Reference Committee heard that the Resolution as drafted was too prescriptive and suggested amendments would provide our AMA with more flexibility to implement the Resolution's goals of improving availability of health care services to American Indians and Alaska Natives covered under Medicaid. Accordingly, your Reference Committee recommends that Resolution 208 be adopted as amended.

(13) RESOLUTION 209 - PURCHASED AND REFERRED CARE EXPANSION

RECOMMENDATION A:

The first Resolve of Resolution 209 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate ~~to Congress to 1)~~ for increased funding to the Indian Health Service Purchased/Referred Care Program and to the Urban Indian Health Program to enable the programs to fully meet the healthcare needs of American Indian/Alaska Native (AI/AN) patients. ~~and 2) expand eligibility to patients served by Urban Indian Health Programs~~ (~~Directive to Take Action~~ New HOD Policy).~~; and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 209 be deleted.

~~RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars to increase access to specialty care to patients referred from Indian Health Service, Tribal Programs, and Urban Indian Health Programs. (New HOD Policy)~~

RECOMMENDATION C:

Resolution 209 be adopted as amended.

HOD ACTION: Resolution 209 adopted as amended.

RESOLVED, That our American Medical Association advocate to Congress to 1) increase funding to the Indian Health Service Purchased/Referred Care Program to enable the program to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served by Urban Indian Health Programs (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy)

Your Reference Committee heard mostly positive testimony in support of Resolution 209. Your Reference Committee heard that the Indian Health Service (IHS) is underfunded relative to other federal health programs, especially the Purchased/Referred Care Program and Urban Indian Health Program. Your Reference Committee also heard that the Purchased/Referred Care Program, a non-entitlement referral program that may cover medical and dental care provided away from an IHS or Tribal Health Program, has

1 numerous rules and restrictions that prevent Urban Indian Health Programs from
2 participating. Your Reference Committee further heard that IHS, Tribal, and Urban Indian
3 Health Programs are often limited to primary care services due to funding limitations,
4 facility constraints, and other factors and that American Indian/Alaska Native (AI/AN)
5 health care needs, particularly specialty care, are not being adequately met. Your
6 Reference Committee heard testimony offering an amendment to the first resolve. Your
7 Reference Committee also heard that community benefit dollars from non-profit hospitals
8 have the potential to increase access to comprehensive, high-quality specialty care for
9 AI/AN patients in states with large AI/AN populations. However, your Reference
10 Committee heard opposition to the second resolve noting that our AMA does not have a
11 history of involvement in directing nonprofit hospitals how to allocate community benefit
12 dollars. Your Reference Committee further heard that our AMA has existing policy urging
13 Congress to take all necessary action to immediately restore full and adequate funding to
14 the Indian Health Service. Testimony also noted that our AMA's advocacy should not be
15 limited "to Congress" and that this phrase should be deleted to allow greater flexibility.
16 Accordingly, your Reference Committee recommends that Resolution 209 be adopted as
17 amended.

(14) RESOLUTION 211 - AMENDING POLICY H-80.999, “SEXUAL ASSAULT SURVIVORS”, TO IMPROVE KNOWLEDGE AND ACCESS TO NO-COST RAPE TEST KITS

RECOMMENDATION A:

Resolution 211 be adopted as amended by addition and deletion to read as follows:

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

Sexual Assault Survivors, H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will ~~(a)~~ advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations; ~~(b) support and advocate that appropriate stakeholders, such as the Health Resources and Services Administration, the United States Government Accountability Office, and the Office on Violence Against Women, create and implement a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.~~

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 211 be adopted as amended.

HOD ACTION: Resolution 211 adopted as amended.

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

Sexual Assault Survivors, H-80.999

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

facilitate the timely testing of sexual assault evidence kits. (Modify Current HOD Policy)

Your Reference Committee heard mostly positive and passionate testimony on Resolution 211. Your Reference Committee heard that sexual violence is a public health concern that affects every community and often has lasting impacts on health and well-being. Your Reference Committee further heard that despite the intention of the Violence Against Women Act (VAWA) to provide no-cost rape kits to all survivors of sexual violence, some survivors still face out-of-pocket charges for minimum standard rape kit services as well as other medical care that takes place following a sexual assault. Your Reference Committee heard that the cost of rape test kits is not covered by all states if the provider administering the examination is not a registered Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE), and that only a fraction of hospitals in the U.S. have a trained forensic examiner such as a SANE. Your Reference Committee further heard that information about the availability of SANEs/SAFEs is currently limited and existing databases are only available in certain areas. Your Reference Committee also heard that creating and ensuring accessibility to a national database of SANE/SAFE providers would allow all victims to quickly access information on where and how to receive a time-sensitive, no-cost medical forensic examination, especially for historically minoritized and underserved populations. Your Reference Committee also heard that current AMA policy should be amended to add AMA support for such a database. However, your Reference Committee heard that the change to existing policy that this Resolution asks for was included in last year's reauthorization of VAWA, which was enacted as part of the 2022 Consolidated Appropriations Act. Your Reference Committee heard that the reauthorized VAWA supports the creation of the first government-sanctioned database that would identify where Sexual Assault Nurse Examiners are located. Your Reference Committee further heard that the law also requires the U.S. Department of Health and Human Services to establish a grant program to promote the training of sexual assault forensic examiners and to establish a National Continuing and Clinical Education Pilot Program for sexual assault forensic examiners, sexual assault nurse examiners, and other individuals who perform medical forensic examinations. Therefore, your Reference Committee recommends that Resolution 211 be adopted as amended.

(15) RESOLUTION 213 - TELEMEDICINE SERVICES AND HEALTH EQUITY

RECOMMENDATION A:

The first Resolve of Resolution 213 be deleted.

~~RESOLVED, That our American Medical Association advocate for preservation of the physician telemedicine waiver and reimbursement at parity with in-person visits beyond December 31, 2024 (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 213 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage policymakers to recognize ~~research to determine~~ the scope and circumstances for underserved populations including seniors and patients with complex health conditions with the aim to ensure that these patients have the technology-use training needed to maximize the benefits of telehealth and its potential to improve health outcomes ~~of telehealth improved health outcomes, especially for underserved populations and seniors with complex health conditions that includes how best to ensure patients have the training in the use of technology needed to maximize its benefits~~. (Directive to Take Action)

RECOMMENDATION C:

Resolution 213 be adopted as amended.

RECOMMENDATION D:

That AMA Policies H-480.937 and H-480.946 be reaffirmed.

HOD ACTION: Resolution 213 adopted as amended and AMA Policies H-480.937 and H-480.946 reaffirmed.

RESOLVED, That our American Medical Association advocate for preservation of the physician telemedicine waiver and reimbursement at parity with in-person visits beyond December 31, 2024 (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage research to determine the scope and circumstances of telehealth improved health outcomes, especially for underserved populations and seniors with complex health conditions that includes how best to ensure

patients have the training in the use of technology needed to maximize its benefits. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 213. Your Reference Committee heard testimony that our AMA remains on the forefront on permanent widespread equitable solutions as it relates to the delivery of telehealth services. Advocacy efforts are occurring simultaneously at both the federal and state levels. Testimony highlighted that our AMA has advocated tirelessly and continues to lead on pushing for permanent telehealth flexibilities beyond the expiration of the Public Health Emergency and was pleased to see a clean extension of telehealth flexibilities granted until December 31, 2024, included in the Consolidated Appropriations Act (CAA) of 2023. Prior to the passage of the CAA, our AMA was also pleased to see successful advocacy efforts in the final published Physician Fee Schedule for CY 2023, wherein similar extensions were granted. Your Reference Committee also heard testimony in support of the importance of payment parity for telehealth services. Your Reference Committee also heard testimony that based on existing AMA policy, our AMA will continue advocating for improved digital literacy efforts such that patients of varying ages, educational levels, ability levels, and cultural backgrounds may be able to fully embrace and appreciate the usefulness of telemedicine. Your Reference Committee heard that our AMA already has stronger existing policy that addresses the asks in the first resolve clause and as such existing AMA policy should be reaffirmed. Therefore, your Reference Committee recommends that Resolution 213 be adopted as amended and that existing AMA policies H-480.937 and H-480.946 be reaffirmed.

Addressing Equity in Telehealth H-480.937

Our AMA:

(1) recognizes access to broadband internet as a social determinant of health;

(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;

(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;

(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;

(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;

(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;

(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Coverage of and Payment for Telemedicine H-480.946
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

1 j) The patient's medical history must be collected as part of the provision of any
2 telemedicine service.
3 k) The provision of telemedicine services must be properly documented and should
4 include providing a visit summary to the patient.
5 l) The provision of telemedicine services must include care coordination with the
6 patient's medical home and/or existing treating physicians, which includes at a
7 minimum identifying the patient's existing medical home and treating physicians
8 and providing to the latter a copy of the medical record.
9 m) Physicians, health professionals and entities that deliver telemedicine services
10 must establish protocols for referrals for emergency services.
11 2. Our AMA believes that delivery of telemedicine services must abide by laws
12 addressing the privacy and security of patients' medical information.
13 3. Our AMA encourages additional research to develop a stronger evidence base
14 for telemedicine.
15 4. Our AMA supports additional pilot programs in the Medicare program to enable
16 coverage of telemedicine services, including, but not limited to store-and-forward
17 telemedicine.
18 5. Our AMA supports demonstration projects under the auspices of the Center for
19 Medicare and Medicaid Innovation to address how telemedicine can be integrated
20 into new payment and delivery models.
21 6. Our AMA encourages physicians to verify that their medical liability insurance
22 policy covers telemedicine services, including telemedicine services provided
23 across state lines if applicable, prior to the delivery of any telemedicine service.
24 7. Our AMA encourages national medical specialty societies to leverage and
25 potentially collaborate in the work of national telemedicine organizations, such as
26 the American Telemedicine Association, in the area of telemedicine technical
27 standards, to the extent practicable, and to take the lead in the development of
28 telemedicine clinical practice guidelines.

(16) RESOLUTION 216 - IMPROVED FOSTER CARE SERVICES FOR CHILDREN

RECOMMENDATION A:

The first Resolve of Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage and support state, territorial~~y~~, and tribal~~e~~ activities to implement changes to the child welfare system directed toward ~~safely~~ keeping children with their families when appropriate and the children's safety is assured (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support federal and state efforts to expand access to evidence-based treatment, counseling, mental health services, substance use disorder treatment, in-home parent skills-based services, and other services ~~which can prevent~~ foster care and ~~to keep families safely together in lieu of foster care~~ for at-risk families in an effort to prevent family separation~~, including mental health, substance use disorder treatment, and in-home parent skills-based services~~ (~~Directive to Take Action~~New HOD Policy); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 216 be deleted.

~~RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement (New HOD Policy); and be it further~~

RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement (New HOD Policy); and be it further

RECOMMENDATION D:

The fourth Resolve of Resolution 216 be deleted.

~~RESOLVED, That our AMA support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family (New HOD Policy); and be it further~~

RESOLVED, That our AMA support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family (New HOD Policy); and be it further

RECOMMENDATION E:

The fifth Resolve of Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~urge the development and promotion of~~support government maintenance of a continuously updated and comprehensive list of evaluated and tested prevention services and programs for families at risk for entry into the child welfare system. (New HOD Policy)

RECOMMENDATION F:

Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended.

RESOLVED, That our AMA encourage and support state, territory, and tribe activities to implement changes to the child welfare system directed toward safely keeping children with their families when appropriate (New HOD Policy); and be it further

RESOLVED, That our AMA support federal and state efforts to expand access to evidence -based services which can prevent foster care and keep families safely together, including mental health, substance use disorder treatment, and in-home parent skills-based services (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement (New HOD Policy); and be it further

RESOLVED, That our AMA support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional

services to families that will safely prevent child separation from the family (New HOD Policy); and be it further

RESOLVED, That our AMA urge the development and promotion of a continuously updated and comprehensive list of evaluated and tested prevention services and programs for families at risk for entry into the child welfare system. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 216. Your Reference Committee heard that the goal of the 2018 federal law (the Family First Prevention Services Act) on the child welfare system is to keep children safely with their families to avoid the trauma that results when children are placed in out-of-home care. Your Reference Committee further heard that implementation of this Act has been varied and additional funding is required for administration of the Act in addition to adoption of improved foster care placement avoiding residential placement where possible. Your Reference Committee heard however, that while well-intentioned, parts of this Resolution are already supported through AMA policy and advocacy activities, are outside our AMA's area of expertise, or are already called for in federal legislation, and that amendments are in order to reflect this. Testimony noted the need for amendments to Resolution 216 and specifically highlighted that the asks contained in the second resolve clause are already covered by the asks in the first resolve clause. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

(17) RESOLUTION 217 - INCREASE ACCESS TO NALOXONE IN SCHOOLS INCLUDING BY ALLOWING STUDENTS TO CARRY NALOXONE IN SCHOOLS

RECOMMENDATION A:

The first Resolve of Resolution 217 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage states, ~~including~~ communities, and educational settings ~~school districts therein~~, to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications ~~naloxone~~ readily accessible to ~~school~~ staff~~,~~ and teachers~~, and students~~ to prevent opioid overdose deaths in educational settings ~~on school campuses~~ (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 217 be deleted.

~~RESOLVED, that our AMA encourage states, including communities and school districts therein, to eliminate barriers that preclude students from carrying naloxone in school. (New HOD Policy)~~

RESOLVED, that our AMA encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.

RECOMMENDATION C:

Resolution 217 be amended by addition of a new Resolve clause.

RESOLVED, that our AMA study and report back on issues regarding student access to safe and effective overdose reversal medications.

RECOMMENDATION D:

Resolution 217 be adopted as amended.

RECOMMENDATION E:

The title of Resolution 217 be changed to read as follows:

INCREASE ACCESS TO SAFE AND EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN EDUCATIONAL SETTINGS

HOD ACTION: Resolution 217 adopted as amended with a change of title.

INCREASE ACCESS TO SAFE AND EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN EDUCATIONAL SETTINGS

RESOLVED, that our AMA encourage states, including communities and school districts therein, to adopt legislative and regulatory policies that allow schools to make naloxone readily accessible to school staff, teachers, and students to prevent opioid overdose deaths on school campuses (New HOD Policy); and

RESOLVED, that our AMA encourage states, including communities and school districts therein, to eliminate barriers that preclude students from carrying naloxone in school. (New HOD Policy)

Your Reference Committee heard strong support for the underlying intent of Resolution 217 to increase access to naloxone to help prevent opioid-related overdose. Your Reference Committee heard that AMA policy (Increasing Availability of Naloxone H-95.932) already provides for support of naloxone in schools “where permitted by law.” Testimony highlighted that, with the trajectory of the epidemic killing young people, there is a great need to increase access to naloxone. Your Reference Committee heard about the importance of expanding the scope of this Resolution to include other substances for which there are safe and effective reversal agents and your Reference Committee was offered amendments to this effect. Your Reference Committee considered additional background information that acknowledged CDC data showing that “15% of high school students reported having ever used select illicit or injection drugs (i.e., cocaine, inhalants, heroin, methamphetamines, hallucinogens, or ecstasy); and “14% of students reported misusing prescription opioids.” Your Reference Committee heard strong support for increasing access to naloxone in all educational settings—vocational schools, trade schools, colleges, and universities. However, your Reference Committee heard testimony expressing concern about the age children of who might be authorized to carry naloxone. Your Reference Committee heard supportive testimony for “children” and other young people to be trained on how to use naloxone before being able to carry it in schools. Your Reference Committee also heard testimony expressing concern about whether states permit young people to carry naloxone. Your Reference Committee did not hear testimony about the appropriate age for carrying naloxone, the role of parental consent, the training that would be most beneficial or other considerations that may be different for young people compared to adults. Your Reference Committee received amendments to 217 that would broaden access to additional educational institutions. However, due to the mixed testimony received, your Reference Committee recommends that the question of age, education, and training considerations for those under 18 years of age requires further

study. Therefore, your Reference Committee recommends that Resolution 217 be adopted as amended.

(18) RESOLUTION 218 - HOLD ACCOUNTABLE THE REGULATORY BODIES, HOSPITAL SYSTEMS, STAFFING ORGANIZATIONS, MEDICAL STAFF GROUPS, AND INDIVIDUAL PHYSICIANS SUPPORTING SYSTEMS OF CARE PROMOTING DIRECT SUPERVISION OF EMERGENCY DEPARTMENTS BY NURSE PRACTITIONERS

RECOMMENDATION A:

Resolution 218 to be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association~~, in accordance with CMS Regulations and standards of practice for emergency medicine as defined by American College of Emergency Physicians and American Association of Emergency Medicine,~~ advocate for the establishment and enforcement of legislation and/or ~~CMS~~ regulations ~~and the adoption of standards set by national organizations of emergency medicine physicians, and hold accountable hospital systems, staffing organizations, medical staff groups, and individual physicians supporting systems of care that promote direct supervision of~~ that ensure only physicians supervise the provision of emergency care services in an emergency department~~s by nurse practitioners~~. (Directive to Take Action)

RECOMMENDATION B:

Resolution 218 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 218 be changed to read as follows:

PROMOTING SUPERVISION OF EMERGENCY CARE SERVICES IN EMERGENCY DEPARTMENTS BY PHYSICIANS

HOD ACTION: Resolution 218 adopted as amended with a change of title.

PROMOTING SUPERVISION OF EMERGENCY CARE SERVICES IN EMERGENCY DEPARTMENTS BY PHYSICIANS

1 RESOLVED, That our American Medical Association, in accordance with CMS
2 Regulations and standards of practice for emergency medicine as defined by American
3 College of Emergency Physicians and American Association of Emergency Medicine,
4 advocate for the enforcement of CMS regulations and the adoption of standards set by
5 national organizations of emergency medicine physicians, and hold accountable hospital
6 systems, staffing organizations, medical staff groups, and individual physicians supporting
7 systems of care that promote direct supervision of emergency departments by nurse
8 practitioners. (Directive to Take Action)
9
10 Your Reference Committee heard an amendment proposed by the author of Resolution
11 218 and heard testimony in support of the proposed amendment. The amended language
12 expands the breadth of the Resolution by calling upon our AMA to advocate for laws and
13 regulations ensuring that physicians supervise emergency services and removes
14 statements requiring that our AMA take enforcement action against entities like health
15 systems and individual physicians. Testimony in support of the amended Resolution cited
16 concerns regarding the growing trend of nurse practitioners supervising emergency
17 departments, including that such practices put patients at risk because the education and
18 training of nurse practitioners does not prepare them to supervise emergency services
19 outside the context of physician-led teams. Your Reference Committee heard that
20 Resolution 218 is supported by AMA's existing scope of practice policy, which opposes
21 the independent practice of medicine by nonphysicians in all practice settings. Your
22 Reference Committee agrees with the proposed amendment, however notes that AMA
23 policy generally does not reference the policies of external organizations, as such policies
24 may change. Your Reference Committee therefore recommends that Resolution 218 be
25 adopted as amended.

(19) RESOLUTION 220 - COVERAGE OF ROUTINE COSTS IN CLINICAL TRIALS BY MEDICARE ADVANTAGE

RECOMMENDATION A:

Resolution 220 be amended by addition of a second Resolve clause to read as follows:

RESOLVED, That our AMA advocate for the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage Organizations (MAOs) to communicate and coordinate the payment for services associated with participation in clinical trials, covered under the Clinical Trials National Coverage Determination 310.1, and to ensure that physicians and non-physician providers are paid directly in order to eliminate the requirement that patients seek reimbursement for billed services; and be it further

RECOMMENDATION B:

Resolution 220 be amended by addition of a third Resolve clause to read as follows:

RESOLVED, That our AMA takes the position that Medicare Advantage Organizations (MAOs) and their participating physicians shall actively encourage patients to enroll in clinical trials.

RECOMMENDATION C:

Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

RESOLVED, That our American Medical Association advocate that the Centers for Medicare and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine costs for services that are provided as part of clinical trials covered under the Clinical Trials National Coverage Determination 310.1, just as the MAO would have been required to do so had the patient not enrolled in the qualified clinical trial. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 220 as amended, which focuses on addressing the confusion and delays faced by patients when transitioning from commercial insurance to Medicare and the impact it has on patients' access to clinical trials. Your Reference Committee heard testimony that emphasized the need to address this policy issue to ensure timely access to clinical trials for patients. Your Reference Committee heard testimony highlighting the confusion surrounding the switch to Medicare, with the initial consultation being out of pocket and causing delays. This delay often causes problems that impact the ability for patients to participate in clinical trials. The testimonies emphasized that this needs to be addressed to prevent such delays. Your

1 Reference Committee heard broad support for mitigating these challenges and ensuring
2 patients have the opportunity to participate in clinical trials. Accordingly, your Reference
3 Committee recommends that Resolution 220 be adopted as amended.

(20) RESOLUTION 221 - FENTANYL TEST STRIPS AS A HARM REDUCTION AND OVERDOSE PREVENTION TOOL

RECOMMENDATION A:

Resolution 221 be adopted as amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend AMA Policy D-95.987, "Prevention of Drug-Related Overdose," by addition to read as follows:

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: advocate for the removal of fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia.
3~~2~~. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
4~~3~~. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
5~~4~~. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

6~~5~~. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
7~~6~~. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction by supporting ~~both~~ legalization of, and education and training on, the use of FTS ~~use by patients, as well as training in FTS use, by pertinent professionals~~.
(Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 221 be adopted as amended.

HOD ACTION: Resolution 221 adopted as amended.

RESOLVED, That our American Medical Association amend AMA Policy D-95.987, "Prevention of Drug-Related Overdose," by addition to read as follows:

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: advocate for the removal of FTS from the legal definition of drug paraphernalia.
3. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
4. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
5. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
6. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

7. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction by supporting both legalization of FTS use by patients, as well as training in FTS use, by pertinent professionals. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 221. Your Reference Committee agrees with testimony that this Resolution is a positive extension of current AMA policy. Your Reference Committee was pleased to hear of our AMA's ongoing support for harm reduction initiatives, including for decriminalization of fentanyl test strips. Testimony noted that policy should account for additional adulterants, such as xylazine, that might contaminate the illicit drug supply and that Resolution 221 should be amended to account for these additional adulterants. Your Reference Committee heard that more robust surveillance of the illicit drug supply would help identify where harm reduction initiatives could be enhanced to save lives. Your Reference Committee, therefore, recommends that Resolution 221 be adopted as amended.

(21) RESOLUTION 223 - PROTECTING ACCESS TO GENDER AFFIRMING CARE

RECOMMENDATION A:

The first Resolve of Resolution 223 be <u>deleted</u>.

~~RESOLVED, That our American Medical Association work with state and specialty societies and other interested organizations to oppose any and all criminal and other legal penalties against patients seeking gender-affirming care and against parents and guardians who support minors seeking and receiving gender-affirming care; including the penalties of loss of custody and the inappropriate characterization of gender-affirming care as child abuse (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 223 be <u>deleted</u>.

~~RESOLVED, That our AMA advocate for protections from violence, criminal or other legal penalties, adverse medical licensing actions, and liability, including responsibility for future medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and other healthcare providers who provide gender-affirming care; and (c) patients seeking and receiving gender-affirming care (Directive to Take Action); and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 223 be <u>deleted</u>.

~~RESOLVED, That our AMA work with state and specialty societies and other interested organizations to advocate against state and federal legislation that would prohibit or limit gender-affirming care (Directive to Take Action); and be it further~~

RECOMMENDATION D:

The fourth Resolve of Resolution 223 be deleted.

~~RESOLVED, That our AMA work with other interested organizations to communicate with the Federation of State Medical Boards about the importance of preserving gender-affirming care despite government intrusions (Directive to Take Action); and be it further~~

RECOMMENDATION E:

The fifth Resolve clause of Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-185.927, "Clarification of Medical Necessity for 16 Treatment of Gender Dysphoria," by insertion and deletion as follows:

Clarification of ~~Medical Necessity~~ Evidence-Based Gender-Affirming Care ~~for Treatment of Gender Dysphoria~~, H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will work with state and specialty societies and other interested stakeholders to:

A) advocate for federal, state, and local laws and policies to protect access to evidence-based ~~provide medically necessary~~ care for gender dysphoria and gender incongruence; ~~and (3) opposes the criminalization and otherwise undue restriction of evidence based gender-affirming care will support legislation, ballot initiatives and state and federal policies to protect access to gender affirming care.~~

B) Oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;

C) Support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and

D) Communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence. (Modify Current HOD Policy)

RECOMMENDATION F:

Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended.

RESOLVED, That our American Medical Association work with state and specialty societies and other interested organizations to oppose any and all criminal and other legal penalties against patients seeking gender-affirming care and against parents and guardians who support minors seeking and receiving gender-affirming care; including the penalties of loss of custody and the inappropriate characterization of gender-affirming care as child abuse (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for protections from violence, criminal or other legal penalties, adverse medical licensing actions, and liability, including responsibility for future medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and other healthcare providers who provide gender-affirming care; and (c) patients seeking and receiving gender-affirming care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with state and specialty societies and other interested organizations to advocate against state and federal legislation that would prohibit or limit gender-affirming care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other interested organizations to communicate with the Federation of State Medical Boards about the importance of preserving gender-affirming care despite government intrusions (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-185.927, “Clarification of Medical Necessity for 16 Treatment of Gender Dysphoria,” by insertion and deletion as follows:

Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria and gender incongruence; and (3) ~~opposes the criminalization and otherwise undue restriction of evidence based gender-affirming care~~ will support legislation, ballot initiatives and state and federal policies to protect access to gender affirming care. (Modify Current HOD Policy)

Your Reference Committee heard testimony supporting the goals of Resolution 223. Testimony expressed frustration at recent legislative actions that threaten the care and health of transgender and gender diverse patients and urged our AMA to continue to

oppose the criminalization of evidence-based care. Your Reference Committee heard testimony in support of amended language to help refine the Resolution while maintaining the integrity of the original requests. Testimony also asked for there to be an emphasis on evidence-based care. Therefore, your Reference Committee recommends that Resolution 223 be adopted as amended.

(22) RESOLUTION 226 - VISION QUALIFICATIONS FOR DRIVER'S LICENSE

RECOMMENDATION A:

Resolution 226 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association ~~engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on~~ <u>support efforts to</u> ~~make recommendations on~~ standardize~~d~~ vision requirements for unrestricted and restricted driver's licensing privileges. ~~(Directive to Take Action)~~ (<u>New HOD Policy)</u>

RECOMMENDATION B:

Resolution 226 be <u>adopted as amended</u>.

HOD ACTION: Resolution 226 <u>adopted as amended</u>.

RESOLVED, That our American Medical Association engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements for unrestricted and restricted driver's licensing privileges. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 226. Your Reference Committee heard that current vision requirements for operating motor vehicles may be outdated. Your Reference Committee further heard that there are data to recommend reconsideration of visual acuity standards in many states and studies have shown that drivers with visual acuity less than 20/50 can be safe and competent drivers. Testimony also highlighted that having an automatic reporting of a failed vision test to the Department of Motor Vehicles could cause individuals to not go and see their ophthalmologist resulting in negative health outcomes. Your Reference Committee also heard, however, that simplifying the Resolution to make it a policy statement would provide more flexibility to staff while still meeting the goals of the Resolution. Therefore, your Reference Committee recommends that Resolution 226 be adopted as amended.

(23) RESOLUTION 227 - REIMBURSEMENT FOR POSTPARTUM DEPRESSION PREVENTION

RECOMMENDATION A:

Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-420.95, “Improving Mental Health Services for Pregnant and Postpartum Mothers,” by addition and deletion to read as follows:

Improving Mental Health Services for ~~Pregnant and Postpartum Mothers~~ Persons Who are Pregnant or in a Postpartum State H-420.953

Our AMA: (1) supports improvements in current mental health services ~~for women~~ during pregnancy and postpartum periods; (2) supports advocacy for inclusive insurance coverage of and sufficient payment for mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; ~~and~~ (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) will advocate for evidence-based postpartum depression screening and prevention services to be recognized as the standard of care for all federally-funded health care programs for persons who are pregnant ~~women~~ or in a postpartum state. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 227 be adopted as amended.

HOD ACTION: Resolution 227 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-420.95, “Improving Mental Health Services for Pregnant and Postpartum Mothers,” by addition and deletion to read as follows:

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of

mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; ~~and~~ (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) will advocate for evidence based postpartum depression prevention services to be recognized as the standard of care for all federally-funded health care programs for pregnant women. (Modify Current HOD Policy)

Your Reference Committee heard mostly supportive on Resolution 227. Your Reference Committee heard about the maternal health crisis that is currently happening in this country and the importance of providing coverage for postpartum mental health care services, including postpartum depression. However, strong testimony highlighted that our AMA already has existing policy in this space that is broad and has allowed our AMA to effectively advocate for postpartum mental health coverage. Testimony stated that our AMA has supported legislation that would provide additional research and coverage for maternal mental health. Moreover, your Reference Committee heard that our AMA has effectively and consistently advocated for additional coverage and support for maternal health care with Congress and the Administration. However, your Reference Committee heard that amendments to current policy were needed to expand policy to ensure more inclusive language and to highlight the importance of making postpartum depression screening and prevention services the standard of care. Therefore, your Reference Committee recommends that Resolution 227 be adopted as amended.

(24) RESOLUTION 228 - REDUCING STIGMA FOR TREATMENT OF SUBSTANCE USE DISORDER

RECOMMENDATION A:

AMA Policy D-95.968 be amended by addition and deletion to read as follows:

Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders ~~Medication-Assisted Treatment for Substance Use Disorder~~ D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder (MOUD) and other evidence-based options as ~~medication-assisted treatment is a~~ first-line treatments for this chronic medical disease.

2. Our AMA supports further research into how primary care practices can implement MOUD ~~medication-assisted treatment (MAT)~~ into their practices and disseminate such research in coordination with primary care specialties.

3. The AMA Substance Use and Pain Care ~~Opioid~~ Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

5. Our AMA supports increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders.

RECOMMENDATION B:

AMA Policy D-95.968 be adopted as amended in lieu of Resolution 228.

HOD ACTION: AMA Policy D-95.968 adopted as amended in lieu of Resolution 228.

RESOLVED, That our American Medical Association support and advocate for coverage for transportation costs for all Medicaid or Medicare health care services without a “carve out” for patients diagnosed with a substance use disorder who are being treated with medication for opioid use disorder. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony for Resolution 228. Your Reference Committee heard that access to affordable transportation is a barrier to evidence-based treatment for individuals with a substance use disorder (SUD)—and many other use disorders or mental illness. Testimony stated that transportation to primary care and medical services, in general, is a challenge for many of our patients. Your Reference Committee heard that many states have options for non-emergency transportation for SUD care. Testimony stated that while the intent of the Resolution is positive, it is too limited. Your Reference Committee heard that our AMA should support all efforts to increase access to evidence-based care for SUD treatment. Testimony highlighted that if health insurers offer transportation for medical care, they should be required to provide comparable coverage for behavioral health care, including for mental health and substance use disorders. Testimony also noted that our AMA already has existing AMA policy that is on point and that should be expanded to fulfil the requests contained in this Resolution. Therefore, your Reference Committee recommends that existing AMA policy D-95.968 be adopted as amended in lieu of Resolution 228.

(25) RESOLUTION 230 - ADDRESS DISPROPORTIONATE SENTENCING FOR DRUG OFFENSES

RECOMMENDATION A:

The first Resolve of Resolution 230 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~actively lobby~~ support ~~for~~ federal and state ~~legislation~~ efforts ~~aimed at~~ to eliminate~~ing~~ the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply them ~~it~~ retroactively to those already convicted or sentenced (Directive to Take Action)~~; and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 230 be deleted.

~~Resolved, that our AMA collaborate with appropriate stakeholders, including, but not limited to, courts, government agencies, professional organizations, and criminal/social justice organizations to advocate for addressing excessive legal punishments for low-level, nonviolent drug crimes at state and federal levels. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 230 be adopted as amended.

HOD ACTION: Resolution 230 adopted as amended.

RESOLVED, That our American Medical Association actively lobby for federal and state legislation aimed at eliminating the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply it retroactively to those already convicted or sentenced (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders, including, but not limited to, courts, government agencies, professional organizations, and criminal/social justice organizations to advocate for addressing excessive legal punishments for low-level, nonviolent drug crimes at state and federal levels. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 230. Testimony highlighted support for the first resolve of this Resolution. Your Reference Committee heard about the fundamental unfairness regarding the disproportionate and inequitable nature of judicial sentencing of individuals convicted of crimes relating to crack cocaine compared to powdered cocaine. Your Reference Committee also heard that the US Attorney General has already taken action to remove disparities. Your Reference Committee heard that the first resolve is sound policy to reduce inequities—and that such inevitably have adverse public health effects. However, your Reference Committee heard that the second resolve goes beyond the expertise of our AMA. Your Reference Committee heard that our AMA's experience does not provide us with the necessary expertise to properly reach a decision as to what constitutes "excessive" or what the specific parameters are for "low-level" drug crimes. Your Reference Committee was not sure whether these questions merited referral given the mixed testimony on one hand and the limited testimony about criminal sentencing specifics on the other. Your Reference Committee is mindful that specific detail is essential for our AMA to appropriately implement such a policy. Your Reference Committee, therefore, recommends that Resolution 230 be adopted as amended.

(26) RESOLUTION 235 - EMS AS AN ESSENTIAL SERVICE

RECOMMENDATION A:

The third Resolve of Resolution 235 be deleted.

~~RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an essential service. (Directive to Take Action)~~

RECOMMENDATION B:

Resolution 235 be adopted as amended.

HOD ACTION: Resolution 235 adopted as amended.

RESOLVED, That our American Medical Association recognize that the provision of Emergency Medical Services is an essential service of government and is best overseen by physicians with specialized training in medical direction for Emergency Medical Services (New HOD Policy); and be it further

RESOLVED, That our AMA work with the American College of Emergency Physicians (ACEP), the National Registry of Emergency Medical Technicians (NREMT), the National Association of EMS Physicians (NAEMSP), the National Association of State EMS Officials (NASEMSO), and other relevant stakeholders to create model legislation at the state level to establish funding for Emergency Medical Services as an essential service (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an essential service. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 235. Your Reference Committee heard support for the first two resolve clauses, specifically that emergency medical services (EMS) should be considered an essential service given the critical role of EMS in providing life-saving care and transportation to patients. Your Reference Committee also heard that there is an impending shortage of EMS which can be addressed by declaring EMS an essential service and providing funding at the state and federal level. However, your Reference Committee also heard that the third resolve clause should not be adopted. Essential health services are broad categories and do not mention specific services. As such, a single service should not be placed here. Testimony stated that advocating for emergency medical services to be an essential health benefit will be limiting and will place one service over others that are also universally needed. Additionally, your Reference Committee heard that funding should be advocated for across the board not just for one specialty. Your Reference Committee heard that the author of the resolution supported a proffered amendment to strike the third resolve clause. As such, your Reference Committee recommends that Resolution 235 be adopted as amended.

(27) RESOLUTION 236 - AMA SUPPORT FOR NUTRITION RESEARCH

RECOMMENDATION A:

Resolution 236 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~seek national legislation in~~ support ~~of the President's FY24 Budgetary request that the~~ additional funding for National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) ~~receive at least $121,000,000, as this level of funding would~~ to enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission~~.~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 236 be amended by addition of a second Resolve to read as follows:

RESOLVED, That our AMA encourage the NIH to prioritize research with maximal applicability to human health conditions, and that it seek input from physicians and the public regarding research priorities and maintain transparency in its planning processes.

RECOMMENDATION C:

Resolution 236 be adopted as amended.

HOD ACTION: Resolution 236 adopted as amended.

RESOLVED, That our American Medical Association seek national legislation in support of the President's FY24 Budgetary request that the National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) receive at least $121,000,000, as this level of funding would enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony for Resolution 236. Your Reference Committee heard testimony around the importance of increased funding for nutrition-based research that promotes access to healthy diet and lifestyle choices that prevent disease and overcome systemic health inequities. However, your Reference Committee heard that this resolution needs to be amended so that it is not tied to the President's 2024 budget since it will limit the amount of time that this policy is relevant for. To ensure the policy remains relevant and applicable well into the future, we have recommended amending the language so that the resolution supports general increased funding levels for nutrition-based research without denoting a particular budgetary cycle.

Moreover, testimony noted that the Resolution language should be broadened beyond legislation in recognition that there are several effective ways to advocate for increased funding levels, including for example submitting programmatic requests through the federal appropriations process. Additional testimony noted that nutrition research alone was not enough, and that the research needed to be put into action to truly have the desired impact. As such, this testimony proffered an amendment that our AMA should encourage the NIH to prioritize research with maximal applicability to human health conditions. Therefore, your Reference Committee recommends that Resolution 236 be adopted as amended.

(28) RESOLUTION 244 - RECIDIVISM

RECOMMENDATION A:

The first Resolve of Resolution 244 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association advocate and encourage federal, state, and local legislators and officials to increase <u>access to</u> ~~the number of~~ community mental health facilities<u>, community drug rehabilitation facilities, appropriate clinical care, and social support services (e.g., housing, transportation, employment, etc.)</u> to meet the need<u>s</u> of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 244 be <u>deleted</u>.

~~RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to increase the number of community drug rehabilitation facilities to meet the needs of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 244 be <u>deleted</u>.

~~RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure there are enough residential/rehabilitation facilities for formerly incarcerated persons to live (Directive to Take Action); and be it further~~

RECOMMENDATION D:

The fourth Resolve of Resolution 244 be deleted.

~~RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure that correctional facilities have adequate well-trained personnel who can ensure that those incarcerated persons released from their facility are able to immediately have access to mental health, drug and residential rehabilitation facilities at an appropriate level (Directive to Take Action); and be it further~~

RECOMMENDATION E:

AMA Policy H-430.986(2) be amended by addition to read as follows:

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

RECOMMENDATION F:

Resolution 244 be adopted as amended.

RECOMMENDATION G:

The title of Resolution 218 be changed to read as follows:

IMPROVING CARE TO LOWER THE RATE OF RECIDIVISM

HOD ACTION: Resolution 244 adopted as amended with a change of title.

IMPROVING CARE TO LOWER THE RATE OF RECIDIVISM

RESOLVED, That our American Medical Association advocate and encourage federal, state, and local legislators and officials to increase the number of community mental health facilities to meet the need of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to increase the number of community drug rehabilitation facilities to meet the needs of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure there are enough residential/rehabilitation facilities for formerly incarcerated persons to live (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure that correctional facilities have adequate well-trained personnel who can ensure that those incarcerated persons released from their facility are able to immediately have access to mental health, drug and residential rehabilitation facilities at an appropriate level (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities. (Directive to Take Action)

Your Reference Committee heard supportive testimony for the spirit of Resolution 244. Your Reference Committee heard that AMA policies already cover many areas relating to support for ensuring care for mental health and substance use disorder treatment for those in carceral settings. Your Reference Committee, however, heard that this Resolution contains nuances that are not as explicit in current AMA policy. Your Reference Committee heard supportive testimony that our AMA should support access to evidence-based treatment for mental health and substance use disorders upon release from a correctional setting and for those previously incarcerated. Your Reference Committee also heard support for our AMA to promote increased access to housing, rehabilitation facilities, and government or commercial insurance upon release from a correctional setting. Your Reference Committee also heard support from a representative from the Centers for Disease Control and Prevention for referrals to appropriate clinical care and social support services, including but not limited to housing, transportation, and employment. Your Reference Committee heard that our AMA has multiple, related policies covering most of the resolution, but not all of the nuances. Therefore, your Reference Committee recommends that Resolution 244 be adopted as amended and that existing AMA policy H-430.986 be adopted as amended.

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local

1 departments of corrections, prisons, and jails to assist incarcerated juveniles and
2 adults who may not have been enrolled in Medicaid at the time of their
3 incarceration to apply and receive an eligibility determination for Medicaid.
4 5. Our AMA advocates for states to suspend rather than terminate Medicaid
5 eligibility of juveniles and adults upon intake into the criminal legal system and
6 throughout the incarceration process, and to reinstate coverage when the
7 individual transitions back into the community.
8 6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965
9 Social Security Act that bars the use of federal Medicaid matching funds from
10 covering healthcare services in jails and prisons.
11 7.Our AMA advocates for Congress and the Centers for Medicare & Medicaid
12 Services (CMS) to revise the Medicare statute and rescind related regulations
13 that prevent payment for medical care furnished to a Medicare beneficiary who is
14 incarcerated or in custody at the time the services are delivered.
15 8. Our AMA advocates for necessary programs and staff training to address the
16 distinctive health care needs of women and adolescent females who are
17 incarcerated, including gynecological care and obstetrics care for individuals who
18 are pregnant or postpartum.
19 9. Our AMA will collaborate with state medical societies, relevant medical
20 specialty societies, and federal regulators to emphasize the importance of
21 hygiene and health literacy information sessions, as well as information sessions
22 on the science of addiction, evidence-based addiction treatment including
23 medications, and related stigma reduction, for both individuals who are
24 incarcerated and staff in correctional facilities.
25 10. Our AMA supports: (a) linkage of those incarcerated to community clinics
26 upon release in order to accelerate access to comprehensive health care,
27 including mental health and substance use disorder services, and improve health
28 outcomes among this vulnerable patient population, as well as adequate funding;
29 (b) the collaboration of correctional health workers and community health care
30 providers for those transitioning from a correctional institution to the community;
31 (c) the provision of longitudinal care from state supported social workers, to
32 perform foundational check-ins that not only assess mental health but also
33 develop lifestyle plans with newly released people; and (d) collaboration with
34 community-based organizations and integrated models of care that support
35 formerly incarcerated people with regard to their health care, safety, and social
36 determinant of health needs, including employment, education, and housing.
37 11. Our AMA advocates for the continuation of federal funding for health
38 insurance benefits, including Medicaid, Medicare, and the Children’s Health
39 Insurance Program, for otherwise eligible individuals in pre-trial detention.
40 12. Our AMA advocates for the prohibition of the use of co-payments to access
41 healthcare services in correctional facilities.

(29) RESOLUTION 245 - BIOSIMILAR/ INTERCHANGEABLE TERMINOLOGY

RECOMMENDATION A:

The first Resolve of Resolution 245 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association rescind ~~repeal~~ policy H-125.976, Biosimilar Interchangeability Pathway (Rescind HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 245 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for continued evidence development pertaining to the interchangeability designation and the necessity for such designation, in state and federal regulations. ~~state and federal laws and regulations that support patient and physician choice of biosimilars and remove the "interchangeable" designation from the FDA's regulatory framework.~~ (Directive to Take Action)

RECOMMENDATION C:

Resolution 245 be adopted as amended.

HOD ACTION: Resolution 245 referred.

RESOLVED, That our American Medical Association repeal policy H-125.976, *Biosimilar Interchangeability Pathway* (Rescind HOD Policy); and be it further

RESOLVED, That our AMA advocate for state and federal laws and regulations that support patient and physician choice of biosimilars and remove the "interchangeable" designation from the FDA's regulatory framework. (Directive to Take Action)

Your Reference Committee heard mixed testimony for Resolution 245. Testimony stated that our AMA remains concerned about the interpretation and use of the biosimilar-interchangeable terminology. Your Reference Committee also heard that, specifically, the FDA's use of the term "interchangeability" must be removed from AMA policy and as an FDA designation overall. Testimony noted that our AMA remains concerned with any regulatory actions that draw unnecessary distinctions between biosimilars and their reference products and interfere with physician and patient choice. Furthermore, testimony encouraged further study on the value of the "interchangeability" designation. Your Reference Committee also heard that removing the term "interchangeable" may

result in increased costs, and furthermore that other countries do not have this designation as their purpose is already understood. Accordingly, your Reference Committee recommends that Resolution 245 be adopted as amended.

(30) RESOLUTION 259 - STRENGTHENING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

RECOMMENDATION A:

The first Resolve of Resolution 259 be deleted.

~~RESOLVED, That our AMA support increases and oppose decreases in funding, eligibility, benefit generosity, and purchasing power incentives in the Supplemental Nutrition Assistance Program (SNAP); and be it further~~

RECOMMENDATION B:

The fourth Resolve of Resolution 259 be deleted.

~~RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.~~

RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.

RECOMMENDATION C:

Resolution 259 be adopted as amended.

RECOMMENDATION D:

AMA Policies 150.937 and 440.927 be reaffirmed.

HOD ACTION: Resolution 259 adopted as amended with an additional Resolve and AMA Policies 150.937 and 440.927 reaffirmed.

RESOLVED, That our AMA advocate for increased federal funding for the Supplemental Nutrition Assistance Program (SNAP) that improves and expands benefits and broadens eligibility.

RESOLVED, That our AMA support increases and oppose decreases in funding, eligibility, benefit generosity, and purchasing power incentives in the Supplemental Nutrition Assistance Program (SNAP); and be it further
RESOLVED, That our AMA support allowing the use of SNAP benefits to purchase hot, heated, and prepared foods at SNAP-eligible vendors; and be it further

RESOLVED, That our AMA support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance; and be it further

RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.

Your Reference Committee heard testimony mostly in support of Resolution 259. Your Reference Committee heard that the temporary COVID-era expansions of the Supplemental Nutrition Assistance Program (SNAP) expired earlier this year, resulting in widespread benefit disruption in the face of persistent inflation. Your Reference Committee further heard that SNAP benefits have historically been insufficient and that SNAP's benefit formula was updated in 2021 for the first time in 15 years to better reflect accurate costs of healthy diets. Your Reference Committee also heard testimony that increased SNAP purchasing power at farm direct outlets is associated with increased spending on fruits and vegetables and higher fruit and vegetable consumption, and that permanently codifying COVID-era expansions that expanded SNAP for purchase of hot, heated, and prepared items at SNAP-eligible vendors would increase healthy options for participants. Your Reference Committee further heard that documented adult immigrants are subject to a five-year SNAP eligibility waiting period, contributing to a lower SNAP participation rate among households with mixed immigration status compared to households with all citizens. Your Reference Committee also heard that the first and fourth resolve clauses are already supported by existing AMA policies H-150.937 and D-440.927 and heard a recommendation that these policies be reaffirmed in lieu of these two resolves. Therefore, your Reference Committee recommends that Resolution 259 be adopted as amended and that existing AMA policies H-150.937 and D-440.927 be reaffirmed.

Improvements to Supplemental Nutrition Programs H-150.937

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

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

RECOMMENDED FOR ADOPTION IN LIEU OF

(31) RESOLUTION 214 - ADVOCACY AND ACTION FOR A SUSTAINABLE MEDICAL CARE SYSTEM
RESOLUTION 234 - MEDICARE PHYSICIAN FEE SCHEDULE UPDATES AND GRASSROOTS CAMPAIGN
RESOLUTION 257 - AMA EFFORTS ON MEDICARE PAYMENT REFORM

RECOMMENDATION: Alternate Resolution 214 be adopted in lieu of Resolutions 214, 234, and 257.

AMA EFFORTS ON MEDICARE PAYMENT REFORM

RESOLVED, That our American Medical Association declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA; and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index; and be it further

RESOLVED, That our AMA Board of Trustees report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

RESOLVED, That AMA Policy D-390.922 be amended by addition and deletion to read as follows:

Physician Payment Reform and Equity, D-390.922
Our AMA will ~~develop~~ implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

RESOLVED, That our AMA reaffirm AMA Policy H-390-849, "Physician Payment Reform," which states, among other things, that our AMA will advocate for the development and adoption of physician payment reforms that are designed with input from the physician community, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practice.

RESOLVED, That our AMA reaffirm AMA Policy D-390.946, "Sequestration," which states, among other things, that our AMA will continue to seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, ensure Medicare physician payments are sufficient to safeguard beneficiary access to care, and work towards the elimination of budget neutrality requirements within Medicare Part B; as well as our AMA advocate strongly to the Administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

HOD ACTION: Alternate Resolution 214 adopted in lieu of Resolutions 214, 234, and 257.

Resolution 214:

RESOLVED, That our American Medical Association continue to strongly advocate for fair reimbursement of all segments of health care, particularly physicians, to undo inadequate payment relative to inflation (Directive to Take Action); and be it further

RESOLVED, That our AMA seek ongoing reimbursement adjustments for fair physician payment at least on an annual basis in order to match that given to hospitals, extended and ambulatory care facilities, medical device and pharmaceutical companies for rising practice costs and inflation. (Directive to Take Action)

Resolution 234:

RESOLVED, That our American Medical Association's top priority be to advocate for positive annual updates to the Medicare Physician Fee Schedule (PFS) to accurately account for annual inflation, cost of living, and practice expense increases (Directive to Take Action); and be it further

RESOLVED, That our AMA actively engage in an AMA-organized and sponsored national grassroots campaign that educates patients about how lack of sufficient positive updates to the physician fee schedule places physician practice survivability and access to quality health care at risk (Directive to Take Action); and be it further

RESOLVED, That this newly-created AMA grassroots campaign actively engage America's patients, as constituents, to use their influence to lobby Congress in favor of positive Medicare PFS updates to help ensure the survivability of physician practices and access to quality health care for all. (Directive to Take Action)

Resolution 257:

RESOLVED, That our American Medical Association House of Delegates declare Medicare physician payment reform as both an urgent and a top advocacy and legislative priority for our AMA; and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically to ensure Medicare physician payment reforms are achieved and updated annually according to the Medicare Economic Index; and be it further

RESOLVED, That our AMA use the increased federal and state advocacy funding to:

1. Create and sustain a national media strategy and campaign promoting Medicare physician payment reform;

2. Fund Washington, D.C., fly-ins, with a white coat march promoting Medicare physician payment reform; and

3. Develop and implement any additional new strategies to accomplish this goal;

And be it further;

RESOLVED, That our AMA consider this policy the top advocacy priority until this goal is accomplished; and be it further

RESOLVED, That the next National Advocacy Conference be sharply focused upon reforming the Medicare payment system to create a more sustainable payment formula for physician practices with annual updates according to the Medicare Economic Index; and be it further

RESOLVED, That our AMA Board of Trustees report back to the house at each annual and interim session on the progress of our AMA staff and physicians until this goal is accomplished.

Your Reference Committee heard unanimous support for the goals of Resolutions, 214, 234, and 257. Your Reference Committee heard testimony expressing intense frustration with the current Medicare physician payment system and its lack of positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs. Testimony stated that the current physician payment system is in crisis and driving private practices out of business. Your Reference Committee heard passionate testimony arguing that achieving permanent physician payment reform should be our AMA’s highest advocacy priority and supporting the types of additional actions called for in Resolution 234 and 237, including a significant increase in funding to advocate for physician payment reform, creating a sustained media strategy, and enhancing our AMA’s grassroots efforts

by engaging patients in our AMA's advocacy efforts. Your Reference Committee also heard testimony that our AMA has already initiated a comprehensive advocacy campaign to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members. Your Reference Committee heard testimony that our AMA, in collaboration with Federation members, has successfully advocated for the introduction of H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," a bipartisan bill that provides for a payment update that is equal to the annual percentage increase in the Medicare Economic Index (Federation sign-on support letter), and that our AMA is collaborating with Federation members to secure additional bipartisan cosponsors for this legislation and to educate Congress on why it is needed, as well as strongly advocating for this bipartisan legislation to be introduced in the Senate. (Federation sign-on letter). Testimony also highlighted a number of other recently enhanced AMA advocacy activities, including: the relaunching of the FixMedicareNow.org campaign to build awareness and support through a highly visible paid and earned media tactic, as well as a grassroots and grasstops strategy to position our AMA as a go-to source for information about Medicare payment reform and to establish a strong grassroots base of patients and physicians ready to call on Congress to take action; a patient message testing initiative with patient focus groups and polling that will begin this month; collaboration with Federation members in drafting legislation to reform the budget neutrality policies that have been producing across-the-board payment cuts; and developing several impactful advocacy resources, which can be found here. Your Reference Committee also heard testimony that these AMA advocacy efforts and our AMA's collaboration with Federation members is not being effectively communicated to AMA members in general, or to the media and patients, despite AMA advocacy updates, press releases, and other communication efforts. Your Reference Committee heard testimony in strong agreement that our AMA should improve its communication and outreach, but that the specific strategy and tactics to implement these advocacy efforts have been and should continue to be decided by the Board and senior management. Your Reference Committee acknowledges the intense frustration of those who testified in support of Resolutions, 214, 234, and 257. At the same time, your Reference Committee acknowledges the significant advocacy efforts our AMA has initiated based on recently adopted policy. Your Reference Committee considered an alternate resolution offered during the hearing that captures the essence of these resolutions while leaving the specific strategy and tactics to the Board. Your Reference Committee agrees with this approach and believes the Alternate Resolution should be further strengthened to capture some of the provisions in Resolution 237. In addition, your Reference Committee alternate resolves reflect comments on the importance of enhancing our AMA's visible advocacy on this crucial issue. Therefore, your Reference Committee recommends that Alternate Resolution 214 be adopted in lieu of Resolutions 214, 234, and 257.

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

a) promote improved patient access to high-quality, cost-effective care;
b) be designed with input from the physician community;
c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;

e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Sequestration D-390.946
Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

(32) RESOLUTION 219 - REPEALING THE BAN ON PHYSICIAN-OWNED HOSPITALS
RESOLUTION 222 - PHYSICIAN OWNERSHIP OF HOSPITAL BLOCKED BY THE ACA
RESOLUTION 261 - PHYSICIAN OWNED HOSPITALS

RECOMMENDATION A:

The first Resolve of Resolution 219 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate for policies that remove ~~alleviate any~~ restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type ~~- in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment of physicians dedication to patient care~~ (Directive to Take Action); and be it further-

RECOMMENDATION B:

The second Resolve of Resolution 219 be deleted.

~~RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to ensure that physician-owned hospitals are operating in the best interests of patients (Directive to Take Action); and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~encourage further~~ study and research ~~into~~ the ~~benefits and drawbacks~~ impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, ~~of physician-owned hospitals~~ and thei~~r~~ impact on ~~patient care~~ competition in highly concentrated hospital markets;~~, as well as the potential impact of regulatory safeguards to ensure transparency and accountability in physician-owned hospitals~~ (New HOD Policy); and be it further

RECOMMENDATION D:

The fourth Resolve of Resolution 219 be deleted.

~~RESOLVED, That our AMA work with policymakers to develop regulations that promote transparency and accountability in physician-owned hospitals, and protect against any potential conflicts of interest, while also fostering competition and innovation in the healthcare market (Directive to Take Action); and be it further~~

RECOMMENDATION E:

The seventh Resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA collaborate with other stakeholders~~, including hospital associations, patient advocacy groups, and government agencies,~~ to develop and promote policies that support physician ownership of hospitals (Directive to Take Action).~~; and be it further.~~

RECOMMENDATION F:

The eighth Resolve of Resolution 219 be deleted.

~~RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the progress made in implementing these resolutions, with recommendations for future action as appropriate. (Directive to Take Action)~~

RECOMMENDATION G:

Resolution 219 be adopted as amended in lieu of Resolutions 222 and 261.

RECOMMENDATION H:

The title of Resolution 219 be changed to read as follows:

PHYSICIAN-OWNED HOSPITALS

HOD ACTION: Resolution 219 adopted as amended in lieu of Resolutions 222 and 261 with a change of title.

PHYSICIAN-OWNED HOSPITALS

Resolution 219:

RESOLVED, That our American Medical Association advocate for policies that alleviate any restriction upon physicians from owning, constructing, and/or expanding any hospital facility type - in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment of physicians dedication to patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to ensure that physician-owned hospitals are operating in the best interests of patients (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage further study and research into the benefits and drawbacks of physician-owned hospitals and their impact on patient care, as well as the potential impact of regulatory safeguards to ensure transparency and accountability in physician-owned hospitals (New HOD Policy); and be it further

RESOLVED, That our AMA work with policymakers to develop regulations that promote transparency and accountability in physician-owned hospitals, and protect against any potential conflicts of interest, while also fostering competition and innovation in the healthcare market (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to support physician leadership in healthcare and advocate for policies that enable physicians to provide the highest quality care to their patients, including policies that remove unnecessary barriers to physician ownership of hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA work to educate its members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other stakeholders, including hospital associations, patient advocacy groups, and government agencies, to develop and promote policies that support physician ownership of hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the progress made in implementing these resolutions, with recommendations for future action as appropriate. (Directive to Take Action)

Resolution 222:

RESOLVED, That our American Medical Association explore and report back to the House of Delegates at the 2024 Annual Meeting, the feasibility of filing judicial or legislative challenges to the ban on physician ownership of new hospitals under the relevant provisions of the Affordable Care Act. (Directive to Take Action)

Resolution 261:

RESOLVED, That our American Medical Association study the patient selection practices of both physician-owned and non-physician-owned hospitals to better understand the impact of hospital ownership status on access to care through:

1. A thorough review of the existing literature;
2. Analyzing patient characteristics across both physician-owned and non-physician-owned hospitals to elucidate whether there are any meaningful differences between these 2 populations. This study should take into account that half of physician-owned hospitals are community hospitals and half are specialty hospitals focused on cardiac, orthopedic, or surgical care;
3. Proposing solutions if there are meaningful differences in these patient populations to ensure equitable access to care (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association conduct a comprehensive study into the impact of Section 1877 of the Social Security Act, the Physician Self-Referral Law (also called the Stark Law), on physician-owned hospitals and market-wide consolidation, including the following:

1. Analyzing the impact that restrictions on physician-owned hospitals enacted by the Stark Law have had on patient access to care, in terms of both cost and quality;
2. Examining the impact of the Stark Law on physician practices, especially those that are integrated or affiliated with physician-owned hospitals;
3. Understanding the extent to which the Stark Law has driven market consolidation and, in doing so, impacted healthcare costs, quality, and patient access to care;
4. Proposing alternative approaches to the Stark Law, including consideration of repeal of relevant provisions, that would promote competition and improve patient access to high-quality care (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study the impact of Section 6001 of the Patient Protection and Affordable Care Act on physician hospital ownership metrics, physician fiscal health and retirement, physician burnout, patient continuity of care, physician turnover within hospitals, and most importantly physicians' empowerment to advocate for the health and wellbeing of their patients (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association report the initial findings of studies into Section 1877 of the Social Security Act and/or Section 6001 of the Patient Protection and Affordable Care Act to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of the repeal of the ban on physician-owned hospitals on patients, physicians, and hospital prices. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolutions 219, 222, and 261. Testimony urged that our AMA provide additional advocacy support for physician-owned hospitals. Your Reference Committee heard that advocacy surrounding physician-

owned hospitals is ultimately in the best interest of patients. Your Reference Committee heard that our AMA should continue to educate AMA members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership. Your Reference Committee also heard that Resolutions 219, 222, and 261 were very similar. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended in lieu of Resolutions 222 and 261.

(33) RESOLUTION 237 - PROHIBITING COVENANTS NOT-TO-COMPETE IN PHYSICIAN CONTRACTS
RESOLUTION 263 - ELIMINATION OF NON-COMPETE CLAUSES IN EMPLOYMENT CONTRACTS

RECOMMENDATION:

Resolution 237 be adopted in lieu of Resolution 263.

HOD ACTION: Resolution 237 adopted in lieu of Resolution 263.

Resolution 237:

RESOLVED, That our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program (New HOD Policy), and be it further

RESOLVED, That our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of 1) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and 2) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination. (Directive to Take Action)

Resolution 263:

RESOLVED, That our AMA support the elimination of restrictive not-to-compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit or not-for-profit status of the employer; and be it further

RESOLVED, That our AMA strongly advocate for policies that enable all physicians, including residents and fellows currently in training, to have greater professional mobility and the ability to serve multiple hospitals, thereby increasing specialist coverage in communities and improving overall patient care; and be it further

1 RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to evaluate
2 amending the AMA Code of Medical Ethics in order to oppose non-compete clauses.
3
4 Your Reference Committee received diverse testimony concerning Resolutions 237 and
5 263. The testimony heavily favored Resolution 237 as opposed to Resolution 263. Your
6 Reference Committee heard that Resolution 237, which in its first Resolved calls on
7 our AMA to oppose the use of noncompetes in physician employment contracts with for-
8 profit or non-profit hospital, hospital system, or staffing company employers, received
9 wide-spread support. However, testimony did not support Resolution 263. Your Reference
10 Committee heard that Resolution 263 was opposed because the first resolve clause of
11 Resolution 263 calls on our AMA to oppose the use of physician noncompetes with any
12 employer, which would include independent physician practices. Testimony expressed
13 concern that prohibiting independent physician practices from using noncompetes would
14 harm competition and weaken independent practices' because they would not be able to
15 use reasonable noncompetes to protect the investments they make in their
16 physicians. Your Reference Committee did not receive any testimony opposing the
17 adoption of the second resolve clause of Resolution 237, although your Reference
18 Committee notes that the second resolve clause of Resolution 237 is already covered by
19 AMA Code of Ethics Opinion 11.2.3.1 Restrictive Covenants. Finally, your Reference
20 Committee received broad support for the study called for by the third resolve clause of
21 Resolution 237 and no opposition was expressed. Therefore, your Reference Committee
22 recommends that Resolution 237 be adopted in lieu of 263.

(34) RESOLUTION 239 - CREATING AN AMA TASKFORCE DEDICATED TO THE ALIGNMENT OF SPECIALTY
RESOLUTION 262 - ALIGNMENT OF SPECIALTY DESIGNATIONS FOR ADVANCED PRACTICE PROVIDERS WITH THEIR SUPERVISING PHYSICIANS

RECOMMENDATION A:

The first Resolve of Resolution 239 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~Board of Trustees~~ study ~~and report back at the 2023 Interim meeting on~~ the movement of nonphysician health care professionals, such as physician assistants and nurse practitioners, ~~economic impact to~~ between ~~and other lower tier income medical specialties of~~ specialties ~~switching by Advanced Practice Providers~~ (Directive to Take Action). ~~; and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 239 be deleted.

~~RESOLVED, That our AMA Board of Trustees study and report back at the 2023 Interim meeting about possible options on how APP's can best be obligated to stay in a specialty tract that is tied to the specialty area of their supervising physician in much the same way their supervisory physicians are tied to their own specialty, with an intent for the study to look at how the house of medicine can create functional barriers that begin to make specialty switching by Advanced Practice Providers appropriately demanding. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 239 be adopted as amended in lieu of Resolution 262.

RECOMMENDATION D:

The title of Resolution 239 be changed to read as follows:

PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

HOD ACTION: Resolution 239 adopted as amended in lieu of Resolution 262 with a change of title.

PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

Resolution 239:

RESOLVED, That our American Medical Association create a national task force that will make recommendations for the best process for advanced practice providers (APPs) to develop specialty designations or an associated apprenticeship process that is parallel to the specialties of the physicians that supervise them (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study and report back at Interim 2023 on the economic impact to medical practices of specialty switching by advanced practice providers (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study and report back at the 2023 Interim Meeting about possible options on how advanced practice providers can best be obligated to stay in a specialty tract (Directive to Take Action).

Resolution 262:

RESOLVED, That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the economic impact to primary care and other lower tier income medical specialties of specialty switching by Advanced Practice Providers (Directive to Take Action); and be it further

RESOLVED, That our AMA Board of Trustees study and report back at the 2023 Interim meeting about possible options on how APP's can best be obligated to stay in a specialty tract that is tied to the specialty area of their supervising physician in much the same way their supervisory physicians are tied to their own specialty, with an intent for the study to look at how the house of medicine can create functional barriers that begin to make specialty switching by Advanced Practice Providers appropriately demanding. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 239 and Resolution 262. Your Reference Committee heard that the first resolve clause of Resolution 262 is being addressed by CME Report 9 (A-23) and notes that our AMA does not have the authority or purview over post-graduate clinical training requirements of nonphysicians. Your Reference Committee heard that our AMA has extensive resources on the education and training of nonphysicians, including information confirming, for example, that the majority of nurse practitioners are educated, trained, and certified in primary care. Yet, research suggests that a growing number of non-physician practitioners are moving between specialties. Your Reference Committee heard personal observations that this rings true. Your Reference Committee heard concern regarding the tone and specificity of Resolutions 239 and 262, particularly on the limited focus of primary care, as well as the inappropriate role of our AMA setting up "functional barriers" as described in Resolution 239. Your Reference Committee also heard that there is a need to act on this issue. Your

Reference Committee received an amendment which sought to meet the underlying concern raised in Resolutions 239 and 262 while also directing our AMA to act by studying the root cause of the issue. Therefore, your Reference Committee recommends that Resolution 239 be adopted as amended in lieu of Resolution 262.

(35) RESOLUTION 247 - ASSESSING THE POTENTIALLY DANGEROUS INTERSECTION BETWEEN AI AND MISINFORMATION
RESOLUTION 251 - FEDERAL GOVERNMENT OVERSIGHT OF AUGMENTED INTELLIGENCE
RESOLUTION 256 - REGULATING MISLEADING AI GENERATED ADVICE TO PATIENTS

RECOMMENDATION:

Alternate Resolution 247 be adopted in lieu of Resolutions 247, 251, and 256.

Assessing the Intersection Between Augmented Intelligence (AI) and Healthcare

RESOLVED, That our American Medical Association study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24 (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs. (New HOD Policy)

RESOLVED, Our AMA support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

HOD ACTION: Alternate Resolution 247 adopted as amended in lieu of Resolutions 247, 251, and 256.

Resolution 247:

RESOLVED, That our American Medical Association study the potential for AI to augment medical and public health misinformation, as well as the potential to augment cyber-libel, cyber-slander, cyber-bullying, and dissemination of internet misinformation about physicians; and that our AMA propose appropriate state and federal regulations and legislative remedies, with report back at the 2023 Annual meeting. (Directive to Take Action)

Resolution 251:

RESOLVED, That our American Medical Association study and develop recommendations on how to best protect public health by regulation and oversight of the development and implementation of augmented intelligence and its applications in the healthcare arena. (Directive to Take Action)

Resolution 256:

RESOLVED, That our American Medical Association commence a study of the benefits and unforeseen consequences to the medical profession of GPTs, with report back to the HOD at the 2023 interim meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA consider working with the Federal Trade Commission and other appropriate organizations to protect patients from false or misleading AI-generated medical advice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to educate our patients about the benefits and risks of consumers facing generative pretrained transformers. (New HOD Policy)

Your Reference Committee heard sparse but supportive testimony for the spirit of Resolutions 247, 251, and 256. Testimony noted the similarity of the requests contained in Resolutions 247, 251, and 256 and accordingly offered an alternative resolution that covers the spirit of all of the Resolutions. Your Reference Committee heard testimony in support of Alternate Resolution 247. Your Reference Committee heard testimony that our AMA remains concerned about the ability and the abundance of generated medical advice that is being produced via platforms such as ChatGPT and other large language models. Your Reference Committee also heard that, while existing AMA policy on this topic is vast, recommendations proffered by the combined resolution supports the need for the creation of updated policy that is sensitive to the need for educational support for physicians on the impacts of newer generative augmented intelligence (AI) tools that may influence clinical decision making. Your Reference Committee also heard testimony that encouraged advocacy on the creation of guardrails and the threat that AI may have that could resemble the spread of misinformation that social media has evidenced. Your Reference Committee heard testimony that if the potential threats are not addressed, the risk of misinformation spread by AI may make physicians' jobs harder or potentially impossible. Your Reference Committee heard testimony that no current policy exists on this topic. Accordingly, your Reference Committee recommends adopting Alternate Resolution 247 in lieu of Resolutions 247, 251, and 256.

RECOMMENDED FOR REFERRAL

(36) RESOLUTION 202 - SUPPORT FOR MENTAL HEALTH COURTS

RECOMMENDATION:

Resolution 202 be referred.

HOD ACTION: Resolution 202 referred.

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

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

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

Your Reference Committee heard mixed testimony on Resolution 202. Testimony expressed support for evidence-based treatment for those with a mental illness, substance use disorder, or other medical disease. Testimony noted support for our current AMA policy concerning “drug courts.” However, your Reference Committee heard considerable testimony raising substantive concerns about “mental health courts,” including uncertainty about whether Resolution 202 would lead to unintentional, adverse consequences for those with a mental illness. Your Reference Committee also heard testimony stating concern that increased support for “mental health courts” could lead to increased use of involuntary commitment or increased disparities in care. Testimony noted that some states and local jurisdictions might use different terminology to describe mental health courts or drug courts. Your Reference Committee did not hear testimony, however, about best practices of mental health courts, drug courts, sobriety courts or other similarly named entities. Based upon the diversity of testimony your Reference Committee acknowledges that more information concerning the background and criteria of mental health courts and the difference between drug courts and mental health courts and the uses of each is needed. Your Reference Committee, therefore, recommends that Resolution 202 be referred.

(37) RESOLUTION 203 – DRUG POLICY REFORM

RECOMMENDATION:

Resolution 203 be referred.

HOD ACTION: Resolution 203 referred.

RESOLVED, That our American Medical Association advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual (New HOD Policy); and be it further

RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession. (New HOD Policy)

Your Reference Committee heard conflicting testimony on Resolution 203. Testimony noted that the issue of decriminalization of the possession of illicit substances for personal use/possession is one that our AMA has no policy on and as such, it is one of first impression for our AMA. Your Reference Committee heard testimony that noted concerns that this Resolution seeks to wholesale replace the current regulatory structure governing possession of illicit substances without making any suggestions for replacing it. Your Reference Committee also heard testimony that the so-called “War on Drugs” has not led to reductions in drug-related mortality or meaningful increases in treatment for those with a substance use disorder. Your Reference Committee also heard testimony about how the current regulatory structure governing drug possession is inequitable for Brown and Black Americans. Your Reference Committee is concerned, however, that the testimony provided insufficient evidence to argue in favor of removing the current regulatory structure and decriminalizing illicit drug possession offenses, have them expunged, or remove certain penalties. Your Reference Committee heard overwhelming testimony concerning the need for additional information so that the unintended consequences of the potential adoption of Resolution 203 can be understood. Your Reference Committee, therefore, recommends that Resolution 203 be referred.

(38) RESOLUTION 204 - SUPPORTING HARM REDUCTION

RECOMMENDATION:

Resolution 204 be referred.

HOD ACTION: Resolution 204 referred.

RESOLVED, That our American Medical Association advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic (Directive to Take Action); and be it further

RESOLVED, That our AMA support any efforts to decriminalize the possession of non prescribed buprenorphine (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy D-95.987 by addition and deletion to read as follows:

Prevention of Drug-Related Overdose, D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing, safer smoking, and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA will advocate for ~~supports efforts to~~ increased access to and decriminalization of fentanyl test strips, ~~and~~ other drug checking supplies, and safer smoking kits for purposes of harm reduction. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 204. Testimony stated that more must be done to increase access to buprenorphine to treat opioid use disorders (OUD). Compelling testimony stated that buprenorphine is not a “harm reduction” tool so much as it is part of treatment for OUD. Your Reference Committee heard testimony that the use of non-prescribed buprenorphine presents a low risk, but there is a difference between anecdotal evidence and deliberative review of available research. Your Reference Committee notes that it heard strong and consistent testimony in opposition to our AMA supporting “safer smoking.” Your Reference Committee also heard conflicting testimony concerning the use of non-prescribed buprenorphine, including that there is an

absence of current AMA policy to guide our AMA with respect to decriminalization of a Schedule III Controlled Substance. Your Reference Committee, therefore, recommends that Resolution 204 be referred.

(39) RESOLUTION 240 - ATTORNEYS' RETENTION OF CONFIDENTIAL MEDICAL RECORDS AND CONTROLLED MEDICAL EXPERT'S TAX RETURNS AFTER CASE ADJUDICATION

RECOMMENDATION:

Resolution 240 be referred.

HOD ACTION: Resolution 240 referred.

RESOLVED, That our American Medical Association advocate that attorney requests for controlled medical expert personal tax returns should be limited to 1099-MISC forms (miscellaneous income) and that entire personal tax returns (including spouse's) should not be forced by the court to be disclosed (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate through legislative or other relevant means the proper destruction by attorneys of medical records (as suggested by Haage v. Zavala, 2021 IL 125918) and medical expert's personal tax returns within sixty days of the close of the case. (Directive to Take Action)

Your Reference Committee received little testimony regarding Resolution 240. No opposition to Resolution 240 was expressed. However, testimony indicated that Resolution 240 raises complex issues that need to be studied further and a greater understanding needs to be obtained about the potential consequences of adopting Resolution 240. Accordingly, your Reference Committee recommends that Resolution 240 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(40) RESOLUTION 258 - ADJUSTMENTS TO HOSPICE DEMENTIA ENROLLMENT CRITERIA

RECOMMENDATION:

Resolution 258 by referred for decision.

HOD ACTION: Resolution 258 referred for decision.

RESOLVED, That the American Medical Association actively lobby the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses.

Your Reference Committee heard limited testimony on Resolution 258. Your Reference Committee heard that the existing admission criteria for hospice enrollment for dementia patients relies on the Functional Assessment Staging Test (FAST) scoring mechanism, which measures activities of daily living and rates appetite, nourishment, and mobility, based on the presumption of a linear progression (ordinal) of decline. Your Reference Committee further heard that the FAST scoring criteria do not accurately predict survival rates for dementia patients (or their families on their behalf) who have chosen not to receive medications or interventions for acute illnesses, and that the scoring criteria for secondary hospice enrollment needs to be changed. Your Reference Committee heard testimony in support of an amendment to clarify the requests in the Resolution. However, your Reference Committee also heard that there was not enough background or evidence provided by the authors to support adoption: while statistics are provided in the whereas clauses of the Resolution, there are no citations or sources for such statistics, and therefore it is difficult to ascertain whether this ask is something our AMA should “actively lobby” the Centers for Medicare and Medicaid Services to adopt. Your Reference Committee heard testimony that given the lack of information and understanding surrounding this Resolution that it should be referred to the Board for decision. The author of the Resolution said that they would accept referral for decision. Therefore, your Reference Committee recommends that Resolution 258 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(41) RESOLUTION 205 - AMENDING H-160.903, ERADICATING HOMELESSNESS, TO REDUCE EVICTIONS AND PREVENT HOMELESSNESS

RECOMMENDATION:

AMA Policy H-160.903 be reaffirmed in lieu of Resolution 205.

HOD ACTION: AMA Policy H-160.903 reaffirmed in lieu of Resolution 205.

RESOLVED, That our American Medical Association recognize and support the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as follows:

Eradicating Homelessness, H-160.903

Our AMA: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to

develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;
(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals~~.~~;
(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement~~.~~; and
(14) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony about Resolution 205. Your Reference Committee heard passionate testimony expressing concerns about homelessness, and that affordable housing is important and social needs such as housing, or the lack of housing, have a profound impact on health outcomes. Your Reference Committee also heard that after hospitals for patients experiencing mental illness closed, community/group home alternatives did not materialize to meet housing needs. Testimony also noted that creative solutions to the homelessness crisis include rent-control laws, just eviction statutes, right to counsel policies, and the creation of local, state, and/or national rental registries to monitor tenant and landlord contracts and prevent unlawful evictions. However, your Reference Committee further heard that this Resolution calls for our AMA to support specific mechanisms and policies to achieve affordable housing, and our AMA does not have expertise in housing policy or landlord/tenant law. Your Reference Committee heard that as a result, our AMA does not know whether these are the right policies or what their unintended consequences may be. Your Reference Committee also heard concerns expressed about the unintended consequences of rent control laws with regard to price controls. Your Reference Committee further heard that existing AMA policy H-160.903, on eradicating homelessness, already recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. Moreover, your Reference Committee heard that this policy also recognizes more broadly that adaptive strategies based on regional variations, community characteristics, and state and local resources are necessary to address this societal problem on a long-term basis. Your Reference Committee heard that this policy should be reaffirmed in lieu of adoption. Accordingly, your Reference Committee recommends that existing AMA policy H-160.903 be reaffirmed in lieu of Resolution 205.

Eradicating Homelessness H-160.903

Our AMA:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;

(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;

(8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;

(9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;

(10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and

(11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;

(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

(42) RESOLUTION 210 - THE HEALTH CARE RELATED EFFECTS OF RECENT CHANGES TO THE US MEXICO BORDER

RECOMMENDATION:

That AMA Policies D-350.975, D-160.988, D-65.992, and D-255.980 be <u>reaffirmed in lieu</u> of Resolution 210.

HOD ACTION: AMA Policies D-350.975, D-160.988, D-65.992, and D-255.980 <u>reaffirmed in lieu</u> of Resolution 210.

RESOLVED, That our American Medical Association recognize the health-related effects and humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant populations and the resulting effects on the U.S. healthcare system (New HOD Policy); and be it further

RESOLVED, That our AMA oppose efforts to increase the height or length of border walls and fences at the US-Mexico border, and other policies that deter people from crossing the border by increasing or creating risks to their health and safety. (New HOD Policy)

Your Reference Committee heard mixed that was passionate on both sides of this issue for Resolution 210. In general, your Reference Committee heard that our AMA has a strong immigration policy platform that includes policies on health care at the border, immigrant privacy, immigrant access to public services, and physician payment for care of immigrants regardless of immigration status. Testimony noted that our AMA has been able to advocate to the Administration and Congress via detailed comment letters on immigrant health at the border and in detention centers. In addition, our AMA has advocated on the changes to the legal process for asylum seekers, the legal review standard for immigrants attempting to immigrate by crossing the border and more. As such, testimony stated that reaffirmation of current AMA policy would be more appropriate. Furthermore, testimony highlighted that Resolution 210 would not help to build upon existing AMA policy. Instead, Resolution 210 would make our AMA appear out of touch since the physical size of the border wall is not an important immigration issue under this Administration. Moreover, testimony highlighted that our AMA already has policy that supports harm reduction for immigrants. Your Reference Committee also heard that our AMA's advocacy resources have been directed to providing timely comments, advice, opposition, and support for issues regarding immigrant health at the border and within the nation as a whole under current AMA policy. Therefore, your Reference Committee recommends that existing AMA policies D-350.975, D-160.988, D-65.992, and D-255.980 be reaffirmed in lieu of Resolution 210.

Immigration Status is a Public Health Issue D-350.975

1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.

4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Financial Impact of Immigration on American Health System D-160.988
Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(43) RESOLUTION 212 - MARIJUANA PRODUCT SAFETY

RECOMMENDATION:

That AMA Policies D-95.969, H-95.952, H-95.924, and H-95.936 be reaffirmed in lieu of Resolution 212.

HOD ACTION: AMA Policies D-95.969, H-95.952, H-95.924, and H-95.936 reaffirmed in lieu of Resolution 212.

RESOLVED, That our American Medical Association support the policy against marijuana use, either medical or recreational, until such time scientifically valid and well-controlled clinical trials are done to assess the safety and effectiveness as any new drug for medical use, prescription or nonprescription (New HOD Policy); and be it further

RESOLVED, That our AMA Council on Legislation draft state model legislation for states that have legalized “medical” or “recreational” marijuana that (1) prohibit dispensaries from selling marijuana products if they make any misleading health information and/or therapeutic claims, (2) to require dispensaries to include a hazardous warning on all marijuana product labels similar to tobacco and alcohol warnings and (3) ban the advertising of marijuana dispensaries and marijuana products in places that children frequent. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 212. Testimony stated that cannabis use presents challenging issues for physicians and patients. Testimony noted that cannabis for medical use as well as adult (also referred to as “recreational”) use is legal in many states. Your Reference Committee heard that state regulation of cannabis for medical and/or adult use is viewed differently by different states. Your Reference Committee heard that States would like to receive advocacy assistance on this issue. Your Reference Committee encourages our medical society colleagues to work with our AMA Advocacy Resource Center which has resources available for states to advocate for legislative or regulatory changes. Testimony also noted that our AMA has extensive and robust policy on marijuana. Testimony noted policy H-95.924 which testimony stated goes beyond the intent of the second resolve in calling on states “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." Your Reference Committee heard that our AMA has consistently promoted these policies to our state and specialty medical society partners and that more policy is not needed when existing policy already guides our AMA in a clear manner. Your Reference Committee, therefore, recommends that D-95.969, H-95.952, H-95.924, and H-95.936 be reaffirmed in lieu of Resolution 212.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical

research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.

4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.

5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.

6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.

7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding

cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.

(44) RESOLUTION 215 - SUPPORTING LEGISLATIVE AND REGULATORY EFFORTS AGAINST FERTILITY FRAUD

RECOMMENDATION:

That AMA Policies H-140.900 and B-1.1.1 be reaffirmed in lieu of Resolution 215.

HOD ACTION: AMA Policies H-140.900 and B-1.1.1 reaffirmed in lieu of Resolution 215.

RESOLVED, That our American Medical Association oppose physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or fertility fraud (New HOD Policy); and be it further

RESOLVED, That our AMA support legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent. (New HOD Policy)

Your Reference Committee heard strong testimony in favor of the intent behind Resolution 215 but somewhat mixed testimony in terms of adoption. Your Reference Committee heard that over the past several years, more than 50 fertility doctors in the United States have been accused of illicit insemination by a patient's physician without informed consent, also referred to as fertility fraud. Your Reference Committee also heard strong agreement about the egregious nature of fertility fraud, that it is a violation of our AMA's Code of Medical Ethics, that informed consent does not exist in situations where fertility fraud occurs, as it is illegal. Moreover, testimony stated that this is an issue that should not be legislated since it is illegal and against medical ethics. Your Reference Committee further heard that existing AMA policy could be reaffirmed in lieu of this Resolution since it already covers the intent of this Resolution. Therefore, your Reference Committee recommends that existing AMA policies H-140.900 and B-1.1.1 be reaffirmed in lieu of Resolution 215.

A Declaration of Professional Responsibility H-140.900
Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:
(1) Respect human life and the dignity of every individual.
(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
(3) Treat the sick and injured with competence and compassion and without prejudice.
(4) Apply our knowledge and skills when needed, though doing so may put us at risk.
(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
(7) Educate the public and polity about present and future threats to the health of humanity.
(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
(9) Teach and mentor those who follow us for they are the future of our caring profession.
We make these promises solemnly, freely, and upon our personal and professional honor.

Active Membership. B-1.1.1
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 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.

1.1.1.1.1 Admission. Active constituent members are admitted to membership upon certification by the constituent association to the AMA, provided there is no disapproval by the Council on Ethical and Judicial Affairs.

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 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.

1.1.1.2.1 Admission. Active direct members are admitted to membership upon application to the AMA, provided that there is no disapproval by the Council on Ethical and Judicial Affairs.

1.1.1.2.1.1 Notice. The AMA shall notify each constituent association of the name and address of those applicants for active direct membership residing within its jurisdiction.

1.1.1.2.1.2 Objections. Objections to applicants for active direct membership must be received by the Executive Vice President of the AMA within 45 days of receipt

by the constituent association of the notice of the application for such membership. All objections will immediately be referred to the Council on Ethical and Judicial Affairs for prompt disposition pursuant to the rules of the Council on Ethical and Judicial Affairs.

1.1.1.3 Council on Ethical and Judicial Affairs Review. The Council on Ethical and Judicial Affairs may consider information pertaining to the character, ethics, professional status and professional activities of the applicant for membership. The Council shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

1.1.1.4 Rights and Privileges. Active members are entitled to receive the Journal of the American Medical Association and such other publications as the Board of Trustees may authorize.

1.1.1.5 Dues and Assessments. Active members are liable for such dues and assessments as are determined and fixed by the House of Delegates.

1.1.1.5.1 Active Constituent Members. Active constituent members shall pay their annual dues to the constituent associations for transmittal to the AMA, except as may be otherwise arranged by the Board of Trustees.

1.1.1.5.2 Active Direct Members. Active direct members shall pay their annual dues directly to the AMA.

1.1.1.5.3 Exemptions. On request, active members may be exempt from the payment of dues on January 1 following their sixty-fifth birthday, provided they are fully retired from the practice of medicine. Additionally, the Board of Trustees may exempt members from payment of dues to alleviate financial hardship or because of retirement from medical practice due to medical disability. The Board of Trustees shall establish appropriate standards and procedures for granting all dues exemptions. Members who were exempt from payment of dues based on age and retirement under Bylaw provisions applicable in prior years shall be entitled to maintain their dues-exempt status in all subsequent years. Dues exemptions for financial hardship or medical disability shall be reviewed annually.

1.1.1.5.4 Delinquency. Active members are delinquent if their dues and assessments are not received by the date determined by the House of Delegates, and shall forfeit their membership in the AMA if such delinquent dues and assessments are not received by the AMA within 30 days after a notification to the delinquent member has been made on or following the delinquency date.

(45) RESOLUTION 231 - EQUITABLE INTERPRETER SERVICES AND FAIR REIMBURSEMENT

RECOMMENDATION:

That AMA Policies D-385.957, D-385.946, H-160.924, H-385.928, and H-385.917 be reaffirmed in lieu of Resolution 231.

HOD ACTION: AMA Policies D-385.957, D-385.946, H-160.924, H-385.928, and H-385.917 reaffirmed in lieu of Resolution 231.

RESOLVED, That our American Medical Association support the standardization of physician reimbursement in regard to interpreter services, whether it be through the usage of a Current Procedural Terminology (CPT) code or direct reimbursement by payers including Medicaid programs and Medicaid managed care plans (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy D-385.957, “Certified Translation and Interpreter Services,” which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services and relieve the burden of the costs associated with translation services. (Reaffirm HOD Policy)

Your Reference Committee heard mostly supportive testimony for the spirit of Resolution 231. Your Reference Committee heard that the Resolution aligns with our AMA's ongoing efforts to ensure that physicians and healthcare providers are adequately supported in providing high-quality care to all patients, regardless of language barriers. Testimony strongly highlighted that our AMA already has longstanding and substantial policies in place that directly address the concerns raised in the Resolution. Your Reference Committee heard that these existing policies demonstrate our AMA's commitment to advocating for equitable access to healthcare for individuals with limited English proficiency, hearing impairments, and vision impaired as well as fair payment for interpreter services. Your Refence Committee heard that our AMA has written multiple advocacy letters to the Administration on this topic in the past year and is actively engaging to ensure that access is available while at the same time ensuring that physicians are either paid or that physicians do not have to pay for interpreter services. Your Reference Committee heard that while our AMA would not advocate for a new CPT code due to budget neutrality concerns, it strongly supports fair and adequate payment for interpreter services to ensure equitable access to healthcare. Moreover, your Reference Committee acknowledges that American Sign Language is included within the purview of language interpreter services and heard that our AMA already has policy that directly covers payment for sign language interpreters, namely D-385.946. Therefore, your Reference Committee recommends that existing AMA policies D-385.957, D-385.946, H-160.924, H-385.928, and H-385.917 be reaffirmed in lieu of Resolution 231.

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Physician Reimbursement for Interpreter Services D-385.946
1. Our AMA will prioritize physician reimbursement for interpreter services, including American Sign Language, and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services.
2. Our AMA will continue to work with interested state and specialty societies to advocate for physician reimbursement for interpreter services, including American Sign Language, for commercial health plans, workers' compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services.

Interpreters in the Context of the Patient-Physician Relationship H-160.924
1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.

(46) RESOLUTION 260 - ADVOCATE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND THE JOINT COMMISSION TO REDEFINE THE TERM “PROVIDER” AND NOT DELETE THE TERM “LICENSED INDEPENDENT PRACTITIONER”

RECOMMENDATION:

That AMA Policies H-405.968 and H-405.951 be reaffirmed in lieu of Resolution 260.

HOD ACTION: AMA Policies H-405.968 and H-405.951 reaffirmed in lieu of Resolution 260.

RESOLVED, That our American Medical Association request a meeting with the Center for Medicare and Medicaid services (CMS), and The Joint Commission to discuss the definition of terms used in CMS Conditions of Participation, and in TJC Standards (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate that in state and federal rules and regulations and legislation that the use the term “providers” not be used to refer to “physicians” as consistent with AMA policy H-405.968 (Directive to Take Action); and be it further,

RESOLVED, that our American Medical Association encourage the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission not to delete the term and definition of “licensed independent practitioner” (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 260. Testimony was given about the importance of maintaining the term physician and ensuring it is only used to refer to those who are Doctors of Medicine, Doctors of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. Additional testimony agreed with this position but noted that our AMA already has policy on point and that our AMA already does advocacy in this space. Significant testimony was provided that noted the extensive work that our AMA already does in this space to ensure that physicians are differentiated from providers. Therefore, your Reference Committee recommends that existing AMA policies H-405.968 and H-405.951 be reaffirmed in lieu of Resolution 260.

Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968

1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.

2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health

professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs.

Definition and Use of the Term Physician H-405.951

Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.

2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:

a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;

b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and

c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.

3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.

4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.

5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.

6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.

7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

1 Mister Speaker, this concludes the report of Reference Committee B. I would like
2 to thank Renato Guerrieri, Deepak Kumar, MD, Christopher Bush, MD, Joanna
3 Loethen, MD, Laurel Reis, MD, Elizabeth Torres, MD, and all those who testified
4 before the Committee.
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