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REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-24

Subject:	Council on Legislation Sunset Review of 2014 House Policies
Presented by:	Willie Underwood, III, MD, MSc, MPH, Chair
Referred to:	Reference Committee B

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the HOD identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the HOD should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

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.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-105.996	Impact of Pharmaceutical Advertising on Women's Health	1. Our AMA urges the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes. 2. Our AMA urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex. (Res. 509, A-14)	Retain – this policy remains relevant.
D-115.988	Medication Non-Adherence and Errors	Our AMA will recommend the Centers for Medicare & Medicaid Services conduct a cost/benefit analysis and an analysis of the ability of seniors and people with disabilities to use blister packs in order to determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities. (BOT Rep. 11, A-14)	Sunset this policy. The recommendation was communicated to the Centers for Medicare & Medicaid Services.
D-120.944	Improvement of Electronic Prescription Software	Our AMA will~~: (1) advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner; and (2)~~ work with pharmacies, vendors, and other appropriate entities to encourage the use of standards that would allow the transmission of short messages regarding	Retain this policy in part. Delete clause (1). Drug Enforcement Administration regulations allow the option of writing prescriptions for controlled substances electronically. The regulations also permit

Policy Number	Title	Text	Recommendation
		prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using. (Res. 209, A-14)	pharmacies to receive, dispense, and archive these electronic prescriptions.
D-120.980	Regulation of Media-Based Drug Sales Without Good Faith Medical Examination	Our AMA will develop and promote model federal legislation to eliminate the sale, without a legitimate prescription, of prescription drugs over the Internet, if such bills to establish national standards in this area are not forthcoming. (Sub. Res. 520, A-04; Reaffirmed: BOT Rep. 19, A-14)	Sunset this policy. This policy has been superseded by more recent AMA policy (H-120.956, Internet Prescribing).
D-130.971	The Future of Emergency and Trauma Care	Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort. (BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08; BOT action in response to referred for decision Res. 204, A-11; Appended: Res. 221, I-11; Modified: CCB/CLRPD Rep. 2, A-14)	
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. (CME Rep. 3, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 605, I-08; Modified: CCB/CLRPD Rep. 2, A-14)	
D-160.991	Licensure and Liability for Senior Physician Volunteers	Our AMA (1) and its Senior Physician Group will inform physicians about federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues; and (2) will work with organizations representing free clinics to promote opportunities for physicians who wish to volunteer. (BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)	Retain – this policy remains relevant.
D-175.985	The CMS Electronic Medical Records Initiative Should Not Be Used To Detect Alleged Fraud by Physicians	~~1. Our AMA will (A) communicate its concerns about the plan recently announced by the Centers for Medicare and Medicaid Services (CMS), in which CMS is to use data from the electronic medical record incentive program in the pursuit of fraud, waste and abuse; and (B) seek active involvement in the drafting of all program directives for CMS's electronic medical record~~	Retain this policy in part. Delete clauses (1) - (4) and modify clause (7). Our AMA communicated these concerns to the Centers for Medicare & Medicaid Services.

Policy Number	Title	Text	Recommendation
		~~initiative, including all directives about potential data capture and subsequent audit processes.~~ ~~2. Our AMA will lead an effort in concert with the Centers for Medicare and Medicaid Services to establish specific guidance to be utilized by entities that audit documentation generated by an electronic health record.~~ ~~3. Such guidance will provide specific protocols used by Medicare and Medicaid auditors to allege a service is not reasonable and necessary based on the generation of an electronic health record.~~ ~~4. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with audits of electronic health records and prominently feature on their website information about methods, resources, and technologies related to appeals of electronic health record audits and Medicare and Medicaid overpayment recoveries as a members-only benefit.~~ ~~5~~1. Our AMA believes that the use of time-saving features, such as cloning, templates, macros, "pull forward technology", auto-population and identical language in EMRs, by itself is not an indication of inaccurate documentation or incorrect coding. ~~6~~2. Our AMA believes that audit results that imply incorrect coding must specifically indicate which portion of the chart language either does not accurately reflect the office visit or reflects unnecessary care. ~~7~~3. Our AMA will: ~~(1) develop guidelines in conjunction with the Centers for Medicare & Medicaid Services to provide clear and direct guidance to physicians concerning the permissible use for coding and billing of electronic health record (EHR) clinical documentation tools, such as templates, macros, cutting and pasting, and cloning, and (2)~~ study the impact of EHR clinical documentation tools and shortcuts on	

Policy Number	Title	Text	Recommendation
		patient safety, quality of care and safe harbor laws. (Res. 212, A-10; Appended: Res. 206, I-11; Appended: Res. 715, A-13; Reaffirmed: BOT Rep. 20, A-14)	
D-215.995	Specialty Hospitals and Impact on Health Care	Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; and (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities. (BOT Rep. 15, I-04; Reaffirmation A-09; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-255.985	Conrad 30 - J-1 Visa Waivers	1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program. 2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program. 3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs. 4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses. 5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA	

Policy Number	Title	Text	Recommendation
		Litigation Center, if it meets the Litigation Center's established case selection criteria. (Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11; Modified: BOT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation A-14)	
D-255.993	J-1 Visas and Waivers	1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. ~~2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.~~ ~~3~~2. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians~~?~~' service requirements through the J-1 waiver and Conrad-30 programs ~~with a report back at A-03~~. ~~4~~3. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B waiver visas ~~for their J-1 visa waiver~~, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area. ~~5~~4. Our AMA ~~will work with state medical societies to study and report back on the feasibility of having~~ support a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program. (BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14)	Retain this policy in part. Delete clause (2) and modify clauses (3) – (5). In 2002 the USDA decided to discontinue its role as an IGA on behalf of foreign research scientists or physicians desiring a recommendation of a J-1Visa waiver. Moreover, HHS has already expanded its J-1 visa waiver program.

Policy Number	Title	Text	Recommendation
D-260.994	Point of Care Availability for Blood Glucose Testing	Our AMA will work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing. (Res. 727, A-14)	Sunset this policy. Our AMA communicated support to the U.S. Food and Drug Administration and the Centers for Medicare & Medicaid services for Clinical Laboratory Improvement Amendments exempt status of point of care blood glucose testing.
D-315.984	Ownership of Claims Data	Our AMA will: (1) encourage physicians to include language designed to buttress rights associated with claims data ownership and access when contracting with health plan payers and other third parties; (2) continue to educate physicians on providing public and private health plan payers the "minimum necessary," as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations thereunder, protected health information necessary to achieve the purpose of a disclosure; (3) assist physicians wishing to register a complaint against health plan payers that have used claims data to form a database, or that have permitted access to or sale of the database or its contents without explicit patient and/or physician authorization, beyond the scope permitted by HIPAA with the Department of Health and Human Services Office of Civil Rights; (4) advocate to the Department of Health and Human Services, Office of the National Coordinator of Health Information Technology and/or other appropriate agencies for rules and regulations ensuring appropriate physician ownership and access rights to claims data, and appropriate protection of claims data held by various parties; and (5) continue to monitor federal and state activities impacting the exchange of physician-generated health information, including claims data.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. 19, I-06; Modified: CCB/CLRPD Rep. 2, A-14)	
D-35.994	Scope of Practice Participants in Health Plans	Our AMA Advocacy Resource Center will work at the invitation of AMA component societies to oppose legislative mandates on health care plans that may lead to inappropriate scope of practice expansion of non-physician providers. (Res. 923, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
D-375.997	Peer Reviewer Immunity	Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law. (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-40.995	The Implications of Health Care Personnel Delivery System	Our AMA will continue to monitor the Health Care Personnel Delivery System (HCPDS) and initiate communication with the Selective Service System and other relevant governmental bodies to address questions and concerns related to the implementation of the HCPDS.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)	
D-400.984	Transparency, Participation, and Accountability in CMS' Payment Determination Process	1. Our AMA will urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect. 2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect. (Res. 220, A-14)	Retain – this policy remains relevant.
D-406.998	National Provider Identification	Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians' privacy, integrity, autonomy, and ability to care for patients. (Res. 717, I-04; Reaffirmed: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-435.978	Loss of Medical Staff Privileges for Lack of "Tail Coverage"	Our AMA will: (1) Advocate for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent; and (2) Support model medical staff bylaw language stating: "Where continuous professional liability	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." (BOT Action in response to referred for decision Res. 537, A-04; Modified: CMS Rep. 1, A-14)	
D-435.985	Use of Countersuits to Discourage Frivolous Lawsuits	Our AMA will advise members of the option for countersuits against plaintiffs and attorneys who have filed frivolous lawsuits against physicians. (Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
D-440.933	VA ACES Travel Policy	Our AMA will send a letter to the Secretary of the Department of Veterans Affairs (VA) and any other appropriate entities noting that the Attendance and Cost Estimation System (ACES) system has become a barrier to VA physician attendance at medical and scientific meetings, and encourage the Secretary to adopt ACES system reforms that will allow VA employed physicians to attend medical and scientific conferences. (Res. 614, A-14)	Sunset this policy. Our AMA submitted a letter to the Department of Veterans Affairs advocating for ACES reforms to lower the barriers and make it easier for VA-employed physicians and researchers to attend medical and scientific conferences.
D-440.934	Onerous Restrictions on Travel of Government Scientists	Our AMA ~~will pursue legislative or regulatory action to achieve~~ supports easing ~~of~~ travel restrictions for federally-employed scientists who are attending academic or scientific conferences that are consistent with current HHS policies and procedures, to include a simplified approval process. (Res. 608, A-14)	Retain this policy in part. Our AMA has communicated to the federal government about easing and simplifying restrictions related to federally employed scientists attending academic and scientific conferences.
D-450.959	Improvements to the Value-Based Modifier	Our AMA will: (1) seek a delay in the Value-Based Modifier (VBM) penalty for smaller practices; and (2) continue to encourage selection of VBM quality	Sunset this policy. The Value-Based Modifier program was replaced by

Policy Number	Title	Text	Recommendation
		measures that are physician-defined, clinically meaningful, specialty-appropriate, realistic, and within reasonable control of the physician. (Sub. Res. 218, A-14)	the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program.
D-450.981	Protecting Patients Rights	Our AMA will: (1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA's principles for pay-for-performance; and (2) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines. (Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. The sustainable growth rate was repealed by the Medicare Access and CHIP Reauthorization Act.
D-450.987	Support of Patient Safety Aspects of The Joint Commission	Our AMA will continue to work with The Joint Commission on the development of standards which improve patient safety; and our AMA and The Joint Commission will then present these changes to the Centers for Medicare & Medicaid Services to effect an update of good health care policy and to delete outdated wasteful health care policy. (Res. 530, A-04; Modified: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-480.973	President's Council on Science and Technology Report	Our AMA will analyze the President's Council on Science and Technology Report entitled "Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering" and respond as appropriate. (Res. 523, A-14)	Sunset this policy. Our AMA thoroughly analyzed the May 2014 President’s Council on Science and Technology Report (PCAST) and has taken steps to implement the recommendations through testimony to an Office the National Coordinator Federal Advisory Committee, public comment on ONC’s proposed 10-year health IT roadmap, and comment letters to the

Policy Number	Title	Text	Recommendation
			Administration in support of the health IT framework outlined in the November 2014 Report to the President: Better Health Care and Lower Costs: Accelerating Improvement Through Systems Engineering.
D-60.968	Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth	Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (Res. 8, I-14)	Retain – this policy remains relevant.
D-80.997	Identify Theft	~~1.~~ Our AMA will request that the Internal Revenue Service (IRS) adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers. ~~2. Our AMA will request that the IRS and the Centers for Medicare & Medical Services promulgate regulations to prohibit the use of Social Security numbers (SSN) by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses.~~ (Res. 613, A-14)	Retain this policy in part. Delete clause 2. In 2023, the Centers for Medicare & Medicaid Services removed SSN-based health insurance claim numbers from Medicare cards and is now using Medicare Beneficiary Identifiers (MBIs) for Medicare transactions like billing, eligibility status, and claim status.
H-110.998	Cost of New Prescription Drugs	Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)	Sunset this policy. This policy has been superseded by more recent AMA policy (H-110.987, Pharmaceutical Costs; H-110.988, Controlling the Skyrocketing Costs of Generic Prescription Drugs;

Policy Number	Title	Text	Recommendation
			H-110.997, Cost of Prescription Drugs; H-285.965, Managed Care Cost Containment Involving Prescription Drugs; H-110.997, Cost of Prescription Drugs).
H-120.937	Methadone Should Not Be Designated as the Sole Preferred Analgesic	Our AMA recommends that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private. (Res. 117, A-14)	Sunset this policy. This policy has been superseded by more recent policy (H-185.931, Workforce and Coverage for Pain Management; D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids).
H-120.948	Positive Verification of Contact Lens Prescriptions	Our AMA will support positive prescription verification for contact lenses and recommend that the federal government monitor the effects of the Fairness to Contact Lens Consumers Act (FCLCA) on the accuracy of prescriptions. (Res. 225, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-160.907	Hospital Inpatient Admission Order and Certification	Our AMA: (1) supports the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services; and (2) believes that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should have access to appropriate information--for example the Geometric Mean Length of Stay (GMLOS)--to help the physician plan appropriately for the services that will be required to care for that particular patient~~; and (3) will inform the Centers for Medicare & Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy~~.	Retain this policy in part. Delete clause (3). Our AMA communicated to the Centers for Medicare & Medicaid Services the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital.

Policy Number	Title	Text	Recommendation
		(Res. 227, I-13; BOT action in response to referred for decision Res. 227, I-13; Reaffirmation A-14)	
H-175.984	Health Care Fraud and Abuse Update	AMA policy is that: (1) our AMA leadership intensify efforts to urge federal policy makers to apply traditional definitions of fraud and abuse which focus on intentional acts of misconduct and activities inconsistent with accepted medical practice; (2) our AMA continue to work with federal law enforcement officials to improve the ability to root out intentional schemes to defraud public programs; (3) our AMA work with federal policymakers to balance payment integrity objectives with reasonable documentation and other administrative requirements; (4) our AMA develop model compliance plans and educational materials to assist physicians in conforming to the latest laws and regulations; and (5) our AMA continue to work in a coalition of other health care organizations to lobby for restrictions on the use of the False Claims Act. (BOT Rep. 25, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 223, A-14)	Retain – this policy remains relevant.
H-185.949	Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions - Present on Admission	1. Our AMA will: (a) continue its strong opposition to non-payment for conditions outlined in the Hospital Acquired Condition -- Present on Admission (HAC-POA) policy that are not reasonably preventable through the application of evidence-based guidelines developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies; (b) ask CMS or other appropriate bodies to monitor and evaluate practice changes made as a result of HAC-POA law, and associated outcomes, and report back on best practices; (c) educate physicians about	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		the HAC-POA law and its implications for patient care, coding requirements and payment; (d) continue its education and advocacy of CMS, Members of Congress and the public about the unintended consequences of non-payment for hospital acquired conditions that may not in fact be preventable, and that adversely affect access to and quality of care; (e) oppose the use of payment and coverage decisions of governmental and commercial health insurance entities as determinative of the standard of care for medical practice and advocate that payment decisions by any third party payer not be considered in determining standards of care for medical practice; and (f) continue to study the effect of HAC-POA penalty programs on professional liability; potential institutional demands to control or micro-manage doctors' professional decision-making; and efforts to develop evidence-based information about which events may be truly preventable as opposed to those whose frequency can be reduced by appropriate intervention. 2. Our AMA will: (a) continue its efforts to advocate against expansion of the Hospital Acquired Conditions - Present on Admission policy to physicians; (b) communicate to the Administration how burdensome the HAC-POA policy is for physicians and the Medicare program; (c) work with federal agencies to further monitor the HAC-POA program evaluation, and offer constructive input on its content and design; and (d) maintain efforts with our hospital association colleagues, such as the American Hospital Association, to monitor HAC-POA policy and its impact. (BOT Rep. 17, A-08; Appended: BOT Rep. 2, I-10; Modified: CCB/CLRPD Rep. 2, A-14)	

Policy Number	Title	Text	Recommendation
H-185.951	Home Anti-Coagulation Monitoring	1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions. 2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy. 3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)	Retain – this policy remains relevant.
H-225.995	Duplication in Hospital Liability and Physicians' Professional Liability Insurance	Our AMA believes that (1) Each physician should be free to determine whether to carry liability coverage as well as the amount of such coverage. Likewise, it is the responsibility of the hospital governing board to determine the extent to which the hospital should protect its assets by purchasing liability insurance; and (2) Regardless of the type of insurance coverage or protection plan hospitals and physicians on the organized staff have, the AMA encourages medical staffs and hospitals to work toward the establishment of effective risk management programs. (Res. 60, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Modified: Res. 813, I-02; Reaffirmation A-04; Modified: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
H-245.979	Opposition to Proposed Budget	The AMA opposes reductions in funding for WIC and Head Start and other	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Cuts in WIC and Head Start	programs that significantly impact child and infant health and education. (Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	
H-250.987	Duty-Free Medical Equipment and Supplies Donated to Foreign Countries	Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries. (Res. 229, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-275.918	Pediatric Medical Orders Between States	1. Our AMA supports legislation or regulation that allows physicians currently licensed and registered to practice medicine in any of the United States to duly execute conventional medical orders for their patients who are moving out of their state and into another state for use in any of the United States, for a transitional period of no more than sixty days. This would allow a child with special health care needs to attend early child care, daycare, nursery, preschool, and school safely in their new location while the family secures a new medical home, health insurance, and, when indicated, subspecialty care. 2. Our AMA will work with interested states and specialties on legislation or regulations to allow temporary honoring of medical orders by an out-of-state physician, as long as the physician is registered and licensed to practice medicine in the United States. (BOT Rep. 16, A-14)	Retain – this policy remains relevant.
H-330.974	Modification or Repeal of the Federal False Claims Act and Other Similar Statutes	It is the policy of the AMA to expend those resources necessary to monitor situations where physicians are under investigation, to provide financial and legal assistance where it is determined these are necessary, and to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Res. 152, A-90; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed in lieu of Res. 223, A-14)	
H-335.980	Payment For Copying Medical Records	It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08; Reaffirmed in lieu of Res. 710, A-14)	Sunset this policy. This matter is covered under Code of Medical Ethics 3.3.1, Management of Medical Records, which allows for physicians to charge a reasonable fee for the cost of transferring a record.
H-35.968	Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws	~~1. Our AMA will: (A) work to repeal new Public Health Service Act Section 2706, so-called provider "Non-Discrimination in Health Care," as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees; and (B) promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine. 2.~~ Our AMA ~~will: (A) create and actively pursue legislative and regulatory opportunities to~~ advocates for the repeal of the ~~so-called~~ "Non-discrimination in Health Care" clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act~~; and (B) lead a specific lobbying effort and grassroots campaign in cooperation with members~~	Retain this policy in part. Delete part 1 and modify part 2. Our AMA has advocated for repeal of section 2706 of the Affordable Care Act and has successfully advocated to the Centers for Medicare & Medicaid Services to clarify, consistent with the statutory language in the ACA and with Medicare Advantage and Medicaid policies, that section 2706 does not go beyond existing Medicare or Medicaid rules regarding the scope of practice of particular types of non-physician practitioners, nor does it require health plans and issuers to contract with particular types of non-physician practitioners or cover all types of services.

Policy Number	Title	Text	Recommendation
		~~of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA's "Non-Discrimination in Health Care" language~~. (Res. 220, A-10; Appended: Res. 241, A-12; Appended: BOT Rep. 8, I-12; Modified: CCB/CLRPD Rep. 2, A-14)	
H-350.962	Reauthorization of the Indian Health Care Improvement Act	Our AMA supports reauthorization of the Indian Health Care Improvement Act. (Res. 221, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. The Indian Health Care Improvement Act (IHCIA) was made permanent in 2010 as part of the Patient Protection and Affordable Care Act.
H-355.975	Opposition to the National Practitioner Data Bank	1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank. 2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank. 3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office. 4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank. 5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report; 6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement. 7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.	

Policy Number	Title	Text	Recommendation
		8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates. (CCB/CLRPD Rep. 3, A-14)	
H-365.980	OSHA Regulations Pertaining to Physicians' Offices and Hospitals	The AMA continues to review the data and rationale used to substantiate OSHA regulations pertaining to medical practice in physician offices and health care facilities. Where OSHA rules and regulations are found to be unnecessary or inappropriate, the AMA will work for their modification or repeal. (Sub. Res. 218, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-375.972	Lack of Federal Peer Review Confidentiality Protection	Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. Our AMA will immediately work with the Administration and Congress to enact legislation that is consistent with Policy H-375.972. (Res. 221, I-96; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02; Appended: Res. 925, I-03; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11; Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. This policy is superseded by more recent AMA policy (D-375.999, Confidentiality of Physician Peer Review; H-375.962, Legal Protections for Peer Review).
H-40.967	Physician Participation in Department of Defense Reserve Components	1. Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice his/her profession without interruption in peace time. 2. Our AMA supports the U.S. Department of Defense by publicizing its needs for physicians in active duty military service and in the reserve components and guard, and encourages the active support and participation of	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		physicians in active duty military service and in the reserves. 3. Our AMA will (a) continue to work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and "weekend drill." 4. Our AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or "points" to prioritize options available to individual reservists as to call-up, retention, rotation and recall. (CCB/CLRPD Rep. 3, A-14)	
H-406.989	Work of the Task Force on the Release of Physician Data	1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation. 2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data. 3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. 4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. 5. Our AMA will continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. 6. Our AMA: A) opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; and B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician. (BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11; Modified: CCB/CLRPD Rep. 2, A-14)	
H-415.998	Preferred Provider Organizations	The AMA: (1) opposes federal legislation that would preempt state regulation of PPOs; and (2) encourages state medical associations to support legislation that: (a) insures proper state regulation of PPOs, with particular attention to such practices as arbitrary determinations of medical necessity by carriers, "hold harmless" clauses, and predatory pricing concepts; and (b) requires independent, physician-directed peer review of the services provided by PPOs. (Sub. Res. 16, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-435.957	Uniform and Consistent Tort Reform	Our AMA will not pursue federal medical liability reform legislation that would divide or diminish the voice of the House of Medicine. (Sub. Res. 910, I-03; Reaffirmed in lieu of Res. 216, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.963	Professional Liability Claims Reporting	The AMA opposes the need for reporting on medical staff and other non-licensing board applications, including insurance company credentialing applications, (excepting professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician. (Sub. Res. 818, A-95; Modified: BOT Rep. 18, A-03; Reaffirmed: Res. 806, I-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.968	Enterprise Liability	The AMA: (1) affirms its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services. (BOT Rep. III, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)	
H-435.991	Professional Liability Countersuits	Our AMA supports the principle that the "special injury" element required to win a malicious prosecution countersuit in some jurisdictions should be eliminated. (Res. 44, I-84; Reaffirmed: Sunset Report, I-98; Reaffirmed: Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-440.876	Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients	1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA ~~will work with local and state medical societies to immediately, actively and publicly~~ oppose<u>s</u> any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Retain this policy in part. Modify Part 2 by broadening the language and making it more consistent with Part 1.
H-45.975	Proposed Change in Medical Requirements for 3rd Class Pilots' Licenses	Our AMA will: (1) oppose efforts to substitute the third class medical certificate with a driver's license; and (2) write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process. (Res. 228, A-14)	Sunset this policy. Legislation was enacted in 2016 (Public Law 114-190, the FAA Extension, Safety, and Security Act of 2016) that statutorily allows pilots of small, non-commercial planes to forgo the medical

Policy Number	Title	Text	Recommendation
			certification process if the pilot and aircraft meet certain prescribed conditions under an FAA program called "BasicMed." A 2020 FAA study found no difference in accident risk between flights conducted by pilots operating under BasicMed and flights conducted by pilots holding third-class medical certificates.
H-478.987	Compliance with Meaningful Use Requirements as a Condition of Medical Licensure	1. Our AMA stands on record as opposing any requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements. 2. Our AMA, working with state and specialty medical societies, will make efforts at all appropriate levels of government to secure the reversal of any requirements that medical licensure be conditioned upon compliance with meaningful use requirements. (Res. 232, A-14)	Sunset this policy. The Centers for Medicare & Medicaid Services renamed this EHR Incentive Program to the Medicare and Medicaid Promoting Interoperability Programs in April 2018. This policy has been superseded by more recent AMA policy (H-478.993, Implementing Electronic Medical Records).
H-478.991	Federal EMR and Electronic Prescribing Incentive Program	Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)	
H-55.991	Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain	Our AMA remains opposed to legislation or any other action that would reschedule heroin from Schedule 1 to Schedule 2 of the Controlled Substances Act. (BOT Rep. TT, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Retain - this policy remains relevant.
H-60.940	Partner Co-Adoption	Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. (Res. 204, A-04) (Res. 204, A-04; Modified: CSAPH Rep. 1, A-14)	Retain – this policy remains relevant.
H-75.998	Opposition to HHS Regulations on Contraceptive Services for Minors	(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible. (Sub. Res. 65, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28,	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		A-03; Reaffirmed: Res. 825, I-04; Reaffirmed: CMS Rep. 1, A-14)	
H-95.941	Restricting Prescriptions to Medicare Beneficiaries	1. Our AMA will work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. 2. Our AMA supports federal legislation to eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. (BOT Rep. 22, A-14)	Retain – this policy remains relevant.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-24

Subject: Safe and Effective Overdose Reversal Medications in Educational Settings

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 217 entitled, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings," was adopted. This resolution called on the AMA to:

- Encourage states, communities, and educational settings, to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications naloxone readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings;
- Encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications; and
- Study and report back on issues regarding student access to safe and effective overdose reversal medications.

The HOD adopted the resolution, which has been codified at Policy H-95.908, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings." In response to the third resolve of the HOD action, this report provides background information, a discussion on naloxone access in schools and other educational settings, relevant AMA advocacy initiatives, and other updates.

BACKGROUND

More than 2,200 adolescents (ages 10-19) died of a drug-related overdose between July 2019-December 2021, with nearly 84 percent of these deaths involving illicitly manufactured fentanyl. An opioid of any type was involved in more than 91 percent of deaths, according to the Centers for Disease Control and Prevention (CDC).[1] Naloxone was administered only 30 percent of the time, according to the CDC.[2] Unintentional drug overdose deaths among young people (ages 15-19) continued to remain high in 2022, according to the National Institute on Drug Abuse (NIDA).[3] Two-thirds of those who died did not have any history of prior opioid use.[4]

Naloxone was created in the 1960s and subsequently began being used in emergency departments and other hospital settings.[5] Naloxone distribution in the community became more prevalent in the 1990s through harm reduction organizations.[6] Naloxone is most commonly administered via intramuscular injection or intranasal spray, and user preference may vary depending on familiarity with a product and how to use it.[7] With respect to availability in schools and other educational settings, the nasal spray formulation is most commonly cited in school educational resources and

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guidelines. It is important to emphasize, however, that the AMA does not endorse any specific brand or generic formulation of naloxone or other U.S. Food and Drug Administration (FDA)-approved opioid overdose reversal agents. While it is beyond the scope of this report to review the several decades of life-saving benefits of naloxone, it is notable that AMA policy supports continued development of and access to additional medications to reverse opioid-related overdoses.

Access to naloxone in the community has increased considerably in the past decade. From 2012-2017, naloxone prescriptions dispensed in the United States grew from 1,061 prescriptions to nearly 270,000 prescriptions.[8] Naloxone prescriptions dispensed increased to nearly 1.7 million prescriptions in 2022. Based on our strong policy, the AMA continues to urge all physicians to prescribe naloxone or other overdose reversal medications to patients at risk of overdose—and to friends and family of those who might be in a position to save a life from overdose. The AMA also continues to encourage physicians and physician offices to educate patients about the availability of naloxone and other overdose reversal agents available over the counter, from pharmacists via a standing order, or reversal agents that may be available through public health agencies. The National Association of Counties details multiple strategies and examples to increase state- and community-level distribution of naloxone.[9]

In addition to physicians' increasing efforts in prescribing naloxone, the AMA also recognizes the longstanding role that harm reduction organizations have played in saving lives from overdose. Harm reduction and other community-based organizations distributed more than 3.7 million doses of naloxone between 2017–2020.[10] From August 2021 to July 2023, national harm reduction organization, Remedy Alliance For The People, sent 1,639,542 doses of generic injectable naloxone to 196 harm reduction projects in 44 US states, DC, and Puerto Rico, of which 206,371 doses were provided at no-cost to 138 under-resourced harm reduction projects.[11] Naloxone has saved hundreds of thousands of lives in the United States, and the Board of Trustees continues to strongly support all efforts to increase access to naloxone and other opioid overdose reversal agents.

DISCUSSION

Increasing access to naloxone was one of the first recommendations of the AMA Substance Use and Pain Care Task Force (Task Force),[12] which was first convened in 2014 and remains a vital part of ensuring that organized medicine communicates emerging issues and policies to improve outcomes and save lives. The Task Force's work, including providing input on and development of AMA model state legislation[13] to increase access to naloxone, has been part of every state now having broad naloxone access laws.[14]

AMA model legislation also includes broad authority and immunities for high schools, universities, and other educational settings to possess, distribute and administer naloxone to teachers, staff, and students. As a result of AMA and other organizations' advocacy, approximately 30 states authorize educational settings to administer naloxone, and it varies by state regarding whether that includes elementary schools, high schools, or schools of higher education.[15]

Multiple school districts and universities already provide naloxone and overdose prevention and education opportunities. While the total number continues to grow, representative examples can be found in Southwest Virginia, where nearly all schools carry naloxone,[16] and the state itself has amended its laws to authorize the ability for schools and school employees to carry, administer, and distribute naloxone.[17] All schools in the Miami-Dade public school system carry naloxone, although it is most commonly held by school public safety officials.[18] One student remarked that she carries naloxone in her purse because, "Our friends do not know that those pills are more than

likely to be fake [or] have enough fentanyl in it to kill you. And that is scary. I carry Narcan in my school bag. If I am going to a party, I will put it in my purse. It is just a layer of protection. You wear your seatbelt not because you are going get in a car accident. It is to keep yourself safe."

Additional examples of schools, universities and other educational settings carrying naloxone:

- University of Pennsylvania Perelman School of Medicine—medical students are taught how to recognize signs of overdose and administer naloxone on their first day of medical school.[19]
- University of Southern California—a group of pharmacy students found that once they started a naloxone education and distribution program, demand outpaced expectations.[20]
- Vanderbilt University—makes naloxone and other harm reduction supplies available for individuals as well as at public locations throughout campus.[21]
- Akron (Ohio) School District—voted to approve naloxone availability in schools in 2017.[22]
- Columbia (NY) University—students who carry naloxone have saved lives from overdose in the community[23] and in schools. Naloxone education events have occurred since 2018 and resulted in "more than 2,500 students, faculty, staff and community members on how to recognize an overdose and administer treatment."[24]
- University of South Carolina—naloxone is accessible at the university fitness center, school pharmacy and other locations.[25]
- Montana—authorizing naloxone distribution and use in schools has been one part of the state's naloxone efforts, which distributed more than 26,000 naloxone kits to first responders, law enforcement, schools, and others.[26]
- Texas—schools now are required to carry naloxone, which has been administered multiple times to save the life of a young person, according to news reports.[27]

This short list above of high schools, universities, and other settings is a very brief snapshot showcasing the fact that school districts recognize the value of having naloxone in educational settings. Given the rapid adoption of efforts to increase access to naloxone in school-based settings, data on the total number of educational settings with naloxone is not currently available. The Board of Trustees strongly encourages these trends to continue.

The Board of Trustees also wants to continue to dispel myths about naloxone. The Board is aware of ongoing myths that naloxone may increase risky drug use behaviors. Much like debunked and dangerous myths of how use of seatbelts encourages risky driving; that the presence of fire hydrants encourages arson; or "that HPV vaccination increases promiscuity or increases risky sexual behavior,"[28] the presence and availability of naloxone has consistently been found to not increase use of drugs or increase risk of overdose. For example, a 2023 study found that "Naloxone access laws and pharmacy naloxone distribution were more consistently associated with decreases rather than increases in lifetime heroin and [injection drug use] among adolescents."[29] The study authors make clear that "Our findings therefore do not support concerns that naloxone access promotes high-risk adolescent substance use behaviors." A smaller study of heroin users found "no evidence of compensatory drug use following naloxone/overdose training."[30] And a report from 2010 looking at multiple myths cited multiple studies disproving the link between naloxone availability and increased drug use.[31] The Board of Trustees further emphasizes that while the Board does not support illicit drug use, it unequivocally supports efforts to save lives from unintentional drug-related overdose, including dispelling myths and supporting widespread availability of naloxone and other opioid overdose reversal agents. The limitations of naloxone, however, should be recognized. NIDA advises that "People with physical dependence on opioids may have withdrawal symptoms within minutes after they are given naloxone. Withdrawal

symptoms might include headaches, changes in blood pressure, rapid heart rate, sweating, nausea, vomiting, and tremors."[32] NIDA aptly points out, however, that "The risk of death for someone overdosing on opioids is worse than the risk of having a bad reaction to naloxone." The Board of Trustees agrees that death is a greater harm than withdrawal symptoms.

As noted in the 2023 AMA Overdose Epidemic Report, overdose and death related to illicitly manufactured fentanyl, methamphetamine and cocaine increase; and xylazine and other toxic synthetic adulterants present new challenges. Naloxone does not reverse an overdose related to methamphetamine, cocaine or other toxic substances. Naloxone also does not work to counteract overdose related to alcohol, benzodiazepines or xylazine, which may increase the sedative effects of opioids, making the antagonist effects of naloxone appear not as rapid or sustaining.[33] Polysubstance use, moreover, may be intentional or unintentional as illicit substances may contain multiple toxic adulterants, including illicitly manufactured fentanyl.[34] The CDC, SAMHSA, NIDA and many other leading public health organizations, including the AMA, continue to counsel that in addition to immediately calling 911, it is still advised to administer naloxone because it is likely an opioid is present, and naloxone will not harm an individual. The Board of Trustees agrees and further points out that if an individual's overdose is related to multiple substances, administering naloxone could help reduce respiratory depression. Again, the benefits of naloxone outweigh the limitations.

The presence of fentanyl in the nation's illicit drug supply also has raised the question of whether additional doses of naloxone are necessary, greater dose strengths, or different opioid overdose reversal medication (OORM) work more effectively than another. According to SAMHSA, the evidence shows that:

- Giving more than one dose of naloxone and using higher dose products may not be necessary when responding to a known fentanyl overdose.
- An overdose may appear to need additional doses if other sedating drugs are present in the person's body, such as alcohol, benzodiazepines, or xylazine; however, rapidly giving more naloxone or using a stronger, more concentrated OORM will not necessarily speed up the reversal process.

In fact, SAMHSA reports that "Multiple studies have found that despite the presence of fentanyl, more doses were not associated with improved outcomes."[35] The Board of Trustees further emphasizes that there are multiple OORM that have been approved by the FDA. The AMA does not take a position on which OORM is more effective than another and—for the purposes of this report—encourages states, communities, and educational settings, to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications such as naloxone readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings. The Board of Trustees further encourages states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications. The Board of Trustees wants to make clear that even when naloxone or other OORM saves a life from overdose, it is essential to seek immediate medical attention.

AMA POLICY

The two most relevant AMA policies covering the areas of this report are (1) "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932); and (2) "Prevention of Drug-Related Overdose" (Policy D-95.987). Adoption of H-95.932 has helped the AMA to support a broad array of naloxone access initiatives for nearly a decade. As identified in H-95.932, these initiatives include:

> …legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.

Moreover, in accordance with AMA policy, specifically "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), AMA advocacy has helped states enact broad liability protections "for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law." As part of our advocacy to support broad access, in accordance with AMA policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), AMA continues "to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively."

As noted briefly above, existing AMA policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), also allows for broad support for "the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations," as well as "access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription." This includes public schools and other educational settings.

Given the broad nature of our existing AMA policy, which is amply reflected in the positive developments to implement these policies throughout the United States, the Board of Trustees concludes that AMA policy is sufficient and that additional new policy is not necessary. This report also accomplishes the task set to the Board of Trustees to study and report back on issues regarding student access to safe and effective overdose reversal medications.

RECOMMENDATIONS

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

1. Existing American Medical Association (AMA) policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H-95.932), be reaffirmed, and (Reaffirm HOD Policy)

2. The third resolve of Policy H-95.908, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings" be rescinded and that the policy be updated as noted. (Modify Current HOD Policy)

   1. Our AMA will encourage states, communities, and educational settings to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings.

2. Our AMA will encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.

~~3. Our AMA will study and report back on issues regarding student access to safe and effective overdose reversal medications.~~

Fiscal Note: Less than $500.

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REPORT 13 OF THE BOARD OF TRUSTEES (A-24)
Prohibiting Covenants Not-to-Compete (Resolution 237-A-23, Resolve 3)
Reference Committee B

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 237 entitled, "Prohibiting Covenants Not-to-Compete in Physician Contracts." Resolution 237 was introduced by California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, and The Society of Thoracic Surgeons.

Resolve 3 of Resolution 237 (Resolve 3) directs 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.

The term "non-compete" in the report refers to an agreement between an employer and an employed physician that prohibits the physician from working within a certain geographic area and for a period of time after the physician's employment ends.

This report discusses physicians' recurring concerns about the effect that non-competes have on both physicians and patients. The report also highlights the reasons why an independent physician group may think it necessary to use a reasonable non-compete to protect legitimate business interests (LBIs).

As directed by Resolve 3, this report describes many ways that non-competes can be regulated, restricted, or modified to achieve the purposes of Resolve 3. The report ends with a recommendation that would be new HOD policy. The recommendation calls on the AMA to continue assisting interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA's state restrictive covenant legislative template.

Following the instructions of the HOD, this report addresses only Resolve 3. As such, this report does not consider non-competes generally, nor does it adjust any AMA policy positions regarding the pros and cons of non-competes as they may exist between physician practices and physician employees.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-24

Subject: Prohibiting Covenants Not-to-Compete (Resolution 237-A-23, Resolve 3)

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 237 entitled, "Prohibiting Covenants Not-to-Compete in Physician Contracts." Resolution 237 was introduced by California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, and The Society of Thoracic Surgeons. Resolution 237 stated the following:

> 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)

As directed by the HOD, this report addresses only Resolve 3 of Resolution 237 (Resolve 3). As such, this report does not consider non-competes generally, nor does it adjust any AMA policy positions regarding the pros and cons of non-competes as they may exist between physician practices and physician employees.

In this report, "non-compete" is defined as "a contractual term between a physician employer, e.g., a hospital, and a physician employee that prohibits the employee from working within a certain

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geographic area and period of time after the physician's employment ends." For example, a restrictive covenant may prohibit the physician from practicing medicine within 10 miles of the location where he or she treated patients for two years after employment has ended.

BACKGROUND

Adoption of Resolution 237 made a significant change to the AMA's policy on non-compete clauses (a/k/a covenants not-to-compete or non-competes). Prior to Resolution 237, the AMA was primarily guided by *Ethical Opinion 11.2.3.1, Restrictive Covenants (Ethical Opinion 11.2.3.1),* which states that physicians should not enter into unreasonable non-competes.[1]

Pursuant to Resolution 237, AMA policy now requires the AMA to "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." Resolution 237 does not supplant *Ethical Opinion 11.2.3.1*, which opposes the use of unreasonable physician non-competes. Thus, while Resolution 237 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, *Ethical Opinion 11.2.3.1* applies in other contexts, and thus opposes the use of unreasonable non-competes between physician employers and physician employees.

Resolve 3 appears to recognize the negative impact that non-competes – even those used by physician employers – may have on physicians and patients. Specifically, Resolve 3 asks the AMA to make recommendations concerning the appropriate regulation or restriction of non-competes in physician contracts with independent physician groups that include time, scope, and geographic restrictions. What follows is a brief discussion regarding how non-competes may harm patients and physicians.

Non-competes Harm Patients

Enforcement of non-competes often harms patients by ending patient-physician relationships, e.g., if a non-compete forces a physician out of a community or otherwise makes the physician geographically inaccessible to patients. Patients may be particularly at risk when the non-compete severs long-standing patient-physician relationships where the physician has been taking care of patients with chronic illnesses. Similarly, a non-compete can thwart a patient's choice of physician.

Non-competes may hinder patients' ability to timely access care. For example, depending on the geographic area, there may be a few physicians, general practitioners, or specialists available to serve the patient population. Even if several physicians practice in the community, forcing a physician to leave the area may reduce the number of available physicians. Although a replacement physician may ultimately be recruited to the area, recruitment can be a lengthy process. In the meantime, the absence of the physician subject to the non-compete may frustrate timely patient access to physician services – assuming the community's remaining physicians have the capacity to take on new patients.

Non-competes may also harm patients by compromising physician autonomy. For example, most physician employment agreements allow the employer (and the physician) to end the agreement at any time, so long as the other party is given advance notice. (This is typically referred to as "without cause" termination). A physician who knows that an employer can end their employment at any time, which will in turn trigger a non-compete, may be very reluctant to engage in patient advocacy, and speak up about matters negatively affecting patient care, clinical decision-making,

etc.

Non-competes Harm Physicians

Non-competes can also harm employed physicians by locking them into untenable working conditions or responsibilities that are detrimental to physicians' mental and/or physical health, thereby contributing to the physician burnout epidemic. A physician who is practicing medicine in demoralizing working conditions may feel an urgent need to find a job with a better working environment and where the employer listens to its physicians' concerns and fosters a workplace that is more conducive to the practice of medicine. If a competing employer in the community offers the physician such an opportunity, a non-compete would bar the physician from accepting the new position. The physician might solve this issue if he or she were willing to work for an employer outside the non-compete's geographic restrictions. Doing so, however, could not only force the physician to leave the area, but require the physician to uproot his or her family from a community where the family has established significant roots. As a practical matter, working outside of the non-compete's geographic restriction may then be completely out of the question. Thus, the physician will simply have no option but to stay in a demoralizing employment situation that continues to put the physician's mental and physical health at risk and increasingly subjects the physician to burnout.

Based on all of the above, we understand that employed physicians have a strong case for wanting the AMA to adopt policy calling for a complete ban on non-competes. However, while Resolve 3 requires the AMA to support a ban on non-competes in employment contracts with for-profit or non-profit hospitals, hospital systems, or staffing company employers, Resolve 3 does not call on the AMA to do the same with respect to non-competes between independent physician groups and their physicians. Rather, Resolve 3 asks the AMA to study and report back with recommendations to address balancing legitimate business interests (LBIs) of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care. Thus Resolve 3 appears to recognize that physician employers may feel the need to use reasonable non-competes to protect LBIs. The next paragraph discusses those interests.

Employer's Reasons for Requiring Restrictive Covenants

Physician employers may feel that reasonable non-competes are essential to protect LBIs, which may take several forms. For example, an independent physician group may train the physician, make referral sources and contacts available to the physician, give the physician access to patients and patient lists, market the physician in the community, and provide the physician with proprietary practice information to help the physician build up his or her practice. Physician employers may want to use non-competes to prohibit a physician from leaving and then opening up their own practice "down the hall," in the same building, or even across the street – after receiving the benefit of information, training, patient contacts, and other resources provided by the independent physician group. Non-competes may give the physician employer the freedom and security to invest significant resources in the employed physician's success, without the employer having to worry that the physician will later leave after the physician has developed a significant patient base, taking those patients with him or her.

DISCUSSION

There are two recent, major developments or trends relating to physician employment contract terms relating to the potential balancing of the physician employer and their employed physicians and patient access. These developments are: (1) the Federal Trade Commission's (FTC) proposed

rule on non-competes and (2) the ongoing enactment of state legislation dealing with non-competes. Because the FTC's proposed rule bans physician non-competes, except with respect to 501(c)(3) organizations under the U.S. Internal Revenue Code (which includes at least some hospitals and health systems), the proposed rule is not a source of recommendations about how physician contracting, regulation, or restrictions to non-competes might modify non-competes themselves to achieve the balance described in Resolve 3. The proposed rule does not prohibit the use of reasonable confidentiality provisions to protect trade secrets and other confidential information or repayment agreements. These types of provisions might, if taken together, be a possible means of achieving the kind of balance described by Resolve 3.

Recommendations Concerning Possible Modifications to Traditional Non-competes

State legislatures continue to consider bills that address non-competes, and most states have enacted statutes that are applicable to non-competes between physician employers and physician employees. These laws, as well as court decisions, provide the basis of how non-competes between physician employers and physician employees might be regulated. In states where one or more of these laws do not apply, the following recommendations could also be considered in contract negotiations between physician employers and their employees as a means of trying to achieve the balance described in Resolve 3.

- **Bases of termination.** Rather than having the non-compete apply regardless of the reason for employment termination, the non-compete might be modified so that it is enforceable only if: (1) the physician terminated his or her employment without cause; (2) the physician's license to practice medicine, or prescribe or dispense controlled substances, is currently revoked; or (3) the physician is currently excluded from participating in Medicare, Medicaid, or any other governmental program providing compensation for services rendered to patients.

- **Duration.** A non-compete could be drafted so that it has a short duration. It is not unusual for physician non-competes to last two years. But, following the direction of several state laws, the duration could be reduced to one year, or even six months. For example, Connecticut limits the duration of a physician non-compete to no more than one year.[2] In a frequently cited Arizona Supreme Court case, the court affirmed a lower court's ruling that six months, rather than three years, was sufficient to protect the legitimate business interests of a physician practice with respect to competition from a formerly employed pulmonologist.[3]

- **Scope of services.** A non-compete should apply only to services that the employed physician provided to the physician employer, and not, for example, broadly restrict the physician from "practicing medicine." For example, a Louisiana court ruled that a non-compete was too broad because it prohibited the physician employee from engaging in the practice of medicine, rather than being limited to the pain management services that he provided.[4] On the other hand, the Illinois Supreme Court upheld a ruling holding that a non-compete prohibiting a physician from practicing medicine was not too broad.[5]

- **Working for competitors.** A non-compete could be structured so that it prohibits the departing physician from working for a competitor, rather than prohibiting the physician from working for any employer in the relevant geographic area.[6]

- **Tying the geographic scope of the non-compete to a single location**. A non-compete should be written so that it is tied to the specific location where the physician provided the majority of his or her services, sometimes referred to in state law as the "primary practice site." A non-

compete should not include any geographic area where the physician employer has offices—since the employer may have several offices in a state or states.[7]

- **Reasonable buy-out provision.** A non-compete could be drafted so that the departing physician could buy his or her way out of the non-compete.[8] The amount of the buyout should be reasonable based on a predetermined formula to eliminate ambiguity concerning how the buyout amount will be calculated. However, in some cases, even if there is no dispute concerning the buyout's reasonableness, a departing physician may not be able to buy his or her way out of a non-compete because the amount of the buyout is more than the physician can pay.

- **Carve out for specific types of patients.** Some state statutes that do permit the use of non-competes allow the departing physician to continue to see patients with specific types of conditions. For example, the Texas statute permits the physician to still treat patients with an acute illness.[9] The Colorado statute may also serve as an example here. Although the Colorado law prohibits non-competes in physician employment agreements, it does permit punitive damages related to competition. However, punitive damages are not recoverable if the formerly employed physician is treating a patient with a rare disorder.[10]

Use of Contractual Provisions that are not Non-competes

There are other kinds of post-employment restrictions that may represent other ways of attempting to achieve the balance described in Resolve 3. A physician employer may, however, be concerned that these alternatives do not sufficiently protect its LBI. This section describes some of these other options, which may be used in combination with one another.

Trade Secrets

A contract clause obligating the departing physician not to disclose the employer's trade secrets is one way that the physician employer could protect its LBI. All states have laws protecting trade secrets and most states have adopted the Uniform Trade Secrets Act[11] (UTSA) in various forms. The UTSA defines "trade secret" as information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (1) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use and (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

The UTSA includes a civil cause of action for trade secret misappropriation, which refers to disclosure or use of a trade secret by a former employee without express or implied consent. Moreover, the courts have held that trade secrets include patient lists, medical records, and superbills containing patient addresses, medical diagnoses and treatment codes, and patient insurance information.[12] AMA policy states, however, that billing records and associated medical records should not be treated as proprietary or as trade secrets.[13]

Confidentiality Clauses

Physician employers may also use confidentiality agreements to protect legitimate business interests. Confidential information includes, but is not limited to, trade secrets. Some state laws define "confidential information." For example, the Georgia non-compete statute defines "confidential information" in part to mean data and information:

> Relating to the business of the employer, regardless of whether the data or information constitutes a trade secret…disclosed to the employee, that has value to the employer; is not generally known to the employer's competitors; competitors of the employer; and includes trade secrets, methods of operation, names of customers, price lists, financial information and projections, route books, personnel data, and similar information…[14]

The employer should require that, upon termination of the physician's employment, that the departing physician promptly return any confidential information in the physician's possession or control to the physician employer, including but not limited to, information on electronic devices. Further, the physician employer should consider requiring the employee to agree to a provision prohibiting a physician from taking any property, patient lists, or records of the employer with him or her upon the termination or expiration of the employment agreement.[15]

Protecting Trade Secrets and Confidential Information Through Non-disclosure Agreements

A physician employer can take steps to protect both confidential and trade secrets information by requiring the employee to sign a non-disclosure agreement (NDA) that applies after the physician leaves the employer. An NDA needs to be (1) clear about the information that is protected and (2) specifically tailored to protect that information. Courts may refuse to enforce NDAs that are too broad, e.g., they apply to information that is not considered to be confidential.

In some circumstances an NDA may be so broad that it can function as a de facto non-compete. One example of an NDA functioning as a de facto non-compete is found in *Brown v. TGS Mgmt. Co., LLC*. In this case, "confidential information" included any information that was "usable in" or "relates to" the securities industry. A California court refused to enforce the NDA because it defined confidential information "so broadly as to prevent [the employee] from ever working again in securities trading" and thus, operated as a de facto non-compete. As a result, the court concluded that it could not be enforced under California law.[16]

While NDAs do not restrict the mobility of physician employees as much as non-competes, physician employers may be concerned that an NDA is not sufficient to protect its trade secrets and other confidential information. It may be challenging for the physician employer to detect a breach of an NDA in comparison with a non-compete. Further, there can be significant litigation concerning just what damage the breach has caused the employer. Issues with detection and establishing damage amounts are likely to make enforcement of NDAs more expensive than enforcement of non-competes. However, in lieu of having to prove damage amounts, the physician employer might, to the extent permitted by state law, be able to include in the employment contract a clause entitling the employer to liquidated damages if the physician breaches an NDA, although the amount of liquidated damages could itself be subject to litigation.

Non-solicitation Agreements

Most states that prohibit non-competes do not disallow the use of non-solicitation agreements (NSA). For example, the Minnesota non-compete statute does not prohibit an NDA, an agreement designed to protect trade secrets or confidential information, an NSA, or an agreement restricting the ability to use client or contact lists or solicit customers of the employer.[17] NSAs can apply to the physician employer's patients, employees, or both. An NSA should, however, entitle the physician to notify patients whom they have seen and who wish to continue care with them of their new location and be advised they may sign a records release to have their records transferred to their physician of choice.

As in the case of NDA, it is likely that an employer will find it more difficult, and thus more expensive, to detect the breach of an NSA and prove damages, as opposed to a non-compete. Proving a breach of an NSA may be particularly challenging because employees may want to work for, and patients may decide to continue their relationship with, the departing physician on their own initiative without any solicitation from the physician. Again, as in the case of breach of an NDA, the physician employer might, to the extent permitted by state law, include a liquidated damages provision in its employment agreement with the physician to remedy a breach of an NSA, which, as noted above, may also be the subject of litigation.

Repayment Agreements

Using a repayment agreement can be another way to attempt to achieve the balance described in Resolve 3. The main concern here most likely has to do with what costs are covered by the agreement. Fortunately, some state non-compete statutes address this issue. For example, the New Mexico non-compete law, which bans non-competes in physician employee contracts, states that during an initial employment period of less than three years, the physician employer can require the departing physician to repay all or a portion of: (1) a loan; (2) relocation expenses; (3) a signing bonus or other remuneration to induce the health care practitioner to relocate or establish a health care practice in a specified geographic area; or (4) recruiting, education, and training expenses.[18] The West Virginia non-compete statute, on the other hand, states that a physician employer may require an employed physician to repay all or a portion of: (1) a loan; (2) location expenses; (3) a signing bonus; (4) remuneration to induce the physician to relocate or establish a physician practice in a specific geographic area; or (5) recruiting, education, and training expenses. (The West Virginia statute does permit the use of physician non-competes lasting no more than one year). Unlike the New Mexico statute, the repayment obligation appears to have no time limit.[19]

A physician employer must take care that the repayment agreement is fair and is not inflated by costs that do not reflect actual financial benefits conferred on the employed physician. Notably, the FTC's proposed non-compete rule states that a repayment agreement may function as a de facto non-compete if the repayment obligation is not reasonably related to the costs the employer incurred for training the worker.[20] The abuse of repayment agreements has come under fire from other quarters as a means of preventing employees from leaving their jobs through debt, and are being used as a work-around in states where non-competes are banned.[21] If a physician employer is considering how to structure a repayment agreement and what types of costs ought to be covered, the cost categories listed in the New Mexico and the West Virginia laws may be useful guides, keeping in mind that the cost amounts must also be reasonable.

AMA Educational and Advocacy Resources

The AMA has many educational and advocacy resources concerning non-competes. For example, the Advocacy Resource Center (ARC) has, pursuant to prior AMA policy, developed a comprehensive analysis of all state non-compete laws that apply to physicians entitled "Legislative Template: Covenants not-to-Compete in Physician Contracts." Those interested in this advocacy resource may obtain it by contacting the ARC at https://www.ama-assn.org/system/files/rc-legislative-template.pdf. The AMA Career Planning Resource webpage also has a wealth of information discussing physician employment issues, which includes information and tips regarding restrictive covenants. The AMA Career Planning Resource webpage may be accessed at https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts.

RELEVANT AMA POLICY

The following AMA policy is relevant to this Board Report:

- **Code of Medical Ethics 11.2.3.1 Restrictive Covenants**

  Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

  Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

  Physicians should not enter into covenants that:

  (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and

  (b) Do not make reasonable accommodation for patients' choice of physician.

  Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

  AMA Principles of Medical Ethics: III, IV, VI, VII

- **Restrictive Covenants of Large Health Care Systems D-383.978**

  Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.

- **Restrictive Covenants in Physician Contracts H-383.987**

  Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

- **Prohibiting Covenants Not-To-Compete in Physician Contracts H-265.988**

  (1) 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.

  (2) Our AMA will 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.

  (3) Our AMA will 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 a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

- **Covenants Not to Compete D-265.988**

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

RECOMMENDATIONS

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

1. That the American Medical Association (AMA) continue to assist interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA's state restrictive covenant legislative template. (New HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] *See* https://policysearch.ama-assn.org/policyfinder/detail/%2211.2.3.1%20Restrictive%20Covenants%22?uri=%2FAMADoc%2FEthics.xml-E-11.2.3.1.xml
[2] Conn. Gen. Stat. § 20-14p
[3] *Valley Medical Specialists v. Farber*, 982 P.2d 1277, 1281 (Ariz. 1999)
[4] *Paradigm Health Sys., L.L.C. v. Faust*, 218 So. 3d 1068, 1071 (La.App. 1 Cir. 2017)
[5] *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 77 (2006)
[6] *See e.g.,* NV Rev Stat § 613.195(6)(a) and (b)
[7] *See e.g.,* Conn. Gen. Stat. section 20-14p and W. Va. Code § 47-11E-2
[8] For statutory examples, see IN Code § 25-22.5-5.5 and TX Bus & Com Code § 15.50
[9] Tex. Bus. & Com. Code § 15.50
[10] C.R.S. 8-2-113
[11] *See* https://www.uniformlaws.org/committees/community-home/librarydocuments?communitykey=3a2538fb-e030-4e2d-a9e2-90373dc05792&LibraryFolderKey=&DefaultView=&5a583082-7c67-452b-9777-e4bdf7e1c729=eyJsaWJyYXJ5ZW50cnkiOiI3NDkwMWU4OS0zZmFkLTRjOGItODk3Yi1jYWE2ZjA4N2U4ZWMifQ%3D%3D
[12] *See e.g., Total Care Physicians, P.A. v. O'Hara*, 798 A.2d 1043, 1054 (Del. Super. Ct. 2001)
[13] Physician Access to Their Medical and Billing Records D-315.971
[14] O.C.G.A. § 13-8-51
[15] *See e.g.,* W.Va. Code § 47-11E-3
[16] *Brown v. TGS Mgmt. Co., LLC*, 57 Cal. App. 5th 303, 306, 319 (Cal. Ct. App. 2020); FTC Proposed Non-compete Rule, 88 F.R. 3482, 3509 (January 19, 2023) https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf
[17] Minn. Stat. § 181.988
[18] N.M. Stat. Ann. § 24-1I-3
[19] W.Va. Code § 47-11E-3
[20] FTC Proposed Non-compete Rule, 88 F.R. 3482, 3535 (January 19, 2023) https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf
[21] See e.g., Harris, Jonathan, The New Non-compete: The Training Repayment Agreement Provision (TRAP) as a Scheme to Retain Workers through Debt (November 9, 2022). Northwestern University Law Review Of Note, Nov. 9, 2022, Loyola Law School, Los Angeles Legal Studies Research Paper No. 2022-15, Available at SSRN: https://ssrn.com/abstract=4273728

REPORT 14 OF THE BOARD OF TRUSTEES (A-24)
Physician Assistant and Nurse Practitioner Movement Between Specialties (Resolution 239)
Reference Committee B

EXECUTIVE SUMMARY

While physicians receive extensive training in a chosen specialty during their medical residency, nurse practitioners and physician assistants do not specialize in a comparable way. Both nurse practitioners and physician assistants must graduate from an accredited program and pass a certification examination for licensure in most states. While didactic education and clinical training differs between the two professions, the education of both nurse practitioners and physician assistants is broadly focused, especially compared to that of a physician. Any focus on a specific specialty in formal training is limited. While some nurse practitioners and physician assistants may "specialize" by gaining certifications in a certain area, these additional certifications are earned by acquiring experience "on-the-job," are optional upon completion of their formal training, and are separate from the initial certifications typically attained upon graduation.

Nurse practitioner programs do prepare students to provide care to a particular population as determined by the population focus selected by the students. Students choose one of six population foci—for example, family/individual, pediatrics, or psychiatric/mental health—to emphasize in their training. The chosen population focus typically determines the certification a nurse practitioner attains following graduation. As such, nurse practitioner programs vary based on the nurse practitioner's chosen population foci and the primary certification they plan to attain. Importantly, however, the education around the population focus does not rise to the level of specialty training. Specialty training represents a "much more focused area of preparation and practice than does the APRN role/population focus level."[i]

On the other hand, physician assistant programs intentionally train physician assistants as "generalists," not specialists. The physician assistant curriculum is largely the same for all physician assistant students. However, physician assistants can obtain Certificates of Added Qualifications (CAQs) post-graduation in certain specialties such as cardiovascular and thoracic surgery or emergency medicine. These CAQs are optional and require physician assistants to acquire work hours in the relevant specialty. Of note, CAQs are separate from the PA-C certification, which is the single certification offered to physician assistants who have graduated from an accredited program and passed the Physician Assistant National Certifying Examination.

A nurse practitioner or physician assistant's certification is not always aligned with the specialty or setting in which they practice during their career. In fact, both can move between specialties throughout their career often with little to no additional education or training. Available data shows that an increasing number of nurse practitioners and physician assistants are practicing in specialties outside of primary care. However, there is no publicly available data on how often nurse practitioners change specialties and very little such data on physician assistants. Nevertheless, the flexibility to move between specialties is often touted as a "selling point" for prospective students.

This Board Report provides a summary of the underlying education and training of nurse practitioners and physician assistants, as well as an overview of initial certifications and optional specialty certifications available to each profession. The report also examines existing workforce studies and data on specialties and practice settings of nurse practitioners and physician assistants and the alignment of such to the certification of the respective nurse practitioner or physician assistant.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-24

Subject: Physician Assistant and Nurse Practitioner Movement Between Specialties

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 239 entitled, "Physician Assistant and Nurse Practitioner Movement Between Specialties." This resolution asked the AMA to study the movement of nonphysician health care professionals between specialties.

Procedural History

Resolution 239 was introduced by the Arizona delegation and asked:

> 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
>
> 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)

Similar in intent, Resolution 262 was introduced by the Private Practice Physicians Section and asked:

> 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);
>
> 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

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> 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).

Testimony on both of these Resolutions was limited. The Reference Committee heard that the AMA does not have the authority or purview over post-graduate clinical training requirements of nonphysicians and that the AMA has extensive resources detailing the education and training of nurse practitioners and physician assistants. However, the Reference Committee also heard testimony indicating that a growing number of nonphysicians are moving between specialties, and that this is a concern for physicians.

Seeking to meet the underlying concerns raised in Resolutions 239 and 262, the Reference Committee recommended that Resolution 239 be adopted with an amendment, and that the amended Resolution 239 be adopted in lieu of Resolution 262. The HOD agreed and ultimately adopted amended Resolution 239, which reads as follows:

> That our American Medical Association study the movement of nonphysician health care professionals such as physician assistants and nurse practitioners between specialties.

This Board of Trustees Report aims to address this directive. It examines the educational preparation of nurse practitioners and physician assistants and evaluates their ability to move between specialties.

BACKGROUND

The implications of specialty switching by nurse practitioners and physician assistants are best understood when one considers the underlying education, training, and certification of each profession.

Nurse Practitioner Education and Training

Nurse practitioners are one type of Advanced Practice Registered Nurse (APRN). While the focus of this board report is on nurse practitioner and physician assistant certification, the foundational documents for nurse practitioner education include APRNs in four types of "roles:" nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists (CRNAs). Each type of APRN has its own accreditation and certifying bodies. For example, CRNA programs are accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA) and CRNAs can obtain certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). By contrast, the Commission on Collegiate Nursing Education (CCNE) and the Accreditation Commission for Education in Nursing (ACEN) both accredit nurse practitioner programs, and nurse practitioners may be certified by one of several different certifying bodies.

APRN education and training is based on foundational documents that were drafted and agreed to by leaders in the nursing profession:

- Two American Association of Colleges of Nursing (AACN) "Essentials" documents: *The Essentials of Master's Education in Nursing (2011)* and *The Essentials of Doctoral Education for Advanced Nursing Practice (2006)* (together, the *AACN Essentials*).

- The National Task Force on Quality Nurse Practitioner Education's *2016 Criteria for Evaluation of Nurse Practitioner Programs* (*NTF Standards*).
- The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (APRN Consensus Model).

Taken together, these documents provide the framework for the curriculum and accreditation of nurse practitioner graduate education programs.

What is referred to as the "APRN Consensus Model" also provides a model for APRN regulation and certification. The APRN Consensus Model is the basis for the four distinct roles of APRNs and the six-population foci that are foundational to APRN education and training:

- Family/individual across the lifespan;
- Adult-gerontology;
- Pediatrics;
- Neonatal;
- Women's health/gender-related; and
- Psychiatric/mental health.

A nurse practitioner's specific educational experience will depend on their chosen population focus, and so will their certification. The APRN Consensus Model states that, "[e]ducation, certification, and licensure of an individual must be congruent in terms of role and population foci."[ii] As such, distinct certifications—which are generally required for licensure—were created for each population focus, and in some cases for primary care as distinct from acute care. Each certification is aligned with a different educational track. In short, it is expected that a nurse practitioner's education and training will be based on the certification they plan to attain after graduation. Consequentially, nurse practitioner programs vary slightly based on the nurse practitioner's chosen population foci and the certification they plan to attain. Each certification has a somewhat different educational pathway, but all nurse practitioners must meet the same core academic requirements. The APRN Consensus Model provides the required "APRN core" courses included in the curriculum for all nurse practitioners (and all APRNs):

- Physiology/pathophysiology;
- Health assessment; and
- Pharmacology.[iii]

Specialty training, by contrast, represents a "much more focused area of preparation and practice than does the APRN role/population focus level."[iv]

Across all population foci, nurse practitioner clinical training requirements are largely not standardized, in sharp contrast to physician clerkships and residencies. Nurse practitioners only undergo 500-750 hours of clinical training. This results in evident experience gaps. For example, even though some of the nurse practitioner certifications broadly span patient populations, including across the lifespan from children to geriatric patients, studies on nurse practitioner education have documented that family nurse practitioners (FNPs) often receive minimal training across patient populations.

Notably, a study in the *Journal of Nursing Regulation* surveyed recent FNP graduates on how often they performed basic tasks like prescribing medications, obtaining a health history, ordering

diagnostic tests, and developing differential diagnoses during their entire training.[v] The survey also examined these tasks across patient populations, providing a window into how the FNP education and training prepares students for practice. The results were shocking. For example, only 61.5 percent of FNPs reported they prescribed medications to an adult patient more than 10 times, 15 percent said they only prescribed medications to an adult patient one to two times.[vi] The numbers were even lower for pediatric and geriatric patients. Only 44.6 percent and 56.3 percent of FNP students surveyed said they prescribed medications more than 10 times to a pediatric patient and geriatric patient respectively, with 5.5 percent and 4.0 percent of FNP students indicating they *never* prescribed medications to pediatric or geriatric patients respectively during their clinical training.[vii] This study demonstrates the lack of standardization in nurse practitioner training programs. Yet, FNPs often practice across patient populations and increasingly in specialties outside primary care.

Nurse Practitioner Certification

For initial certification of nurse practitioners, two major certifying bodies exist: the American Academy of Nurse Practitioners Certification Board (AANPCB) and the American Nurses Credentialing Center (ANCC).[viii] Each certifying body administers their own examination and offers their own certifications. Both AANPCB and ANCC require nurse practitioners to renew their certification every five years. Most states require certification for licensure as a nurse practitioner, and certification exams are generally aligned with population foci.

The AANPCB offers three initial certifications: Family Nurse Practitioner (FNP), Adult-Gerontology Primary Care Nurse Practitioner (A-GNP), and Psychiatric Mental Health Nurse Practitioner (PMHNP).[ix] AANPCB's FNP examination is an online examination with 150 multiple choice questions, which must be completed in three-hours. In 2021 the pass rate was 84 percent. AANPCB has retired a couple of certifications, including the Adult Nurse Practitioner (retired in 2017) and Gerontology Nurse Practitioner (retired in 2012). Nurse practitioners who obtained these retired certifications can maintain the credential as long as they continue to renew their certification by completing the required clinical practice hours and continuing education.

ANCC offers four certifications for nurse practitioners: Family Nurse Practitioner (FNP-BC), Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC), Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC), and Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). ANCC's FNP-BC certifying examination includes 150-200 questions that vary in format from multiple choice, drop and drag, and multiple response. The average pass rate in 2021 was 87 percent. ANCC also offers certifications for registered nurses, as well as micro-credentials in certain sub-specialties. ANCC has also retired several certifications, including Acute Care Nurse Practitioner, Adult Nurse Practitioner, Adult-Psychiatric Mental Health Nurse Practitioner, Emergency Nurse Practitioner, Gerontological Nurse Practitioner, Pediatric Primary Care Nurse Practitioner, and School Nurse Practitioner. Like the retired certifications offered by AANPCB, nurse practitioners may renew these ANCC retired certifications to maintain their credential.[x]

	American Academy of Nurse Practitioners Certification Board (AANPCB)	American Nurses Credentialing Center (ANCC)
Current certifications	Family Nurse Practitioner (FNP) Adult-Gerontology Primary Care Nurse Practitioner (A-GNP) Psychiatric Mental Health Nurse Practitioner (PMHNP)	Family Nurse Practitioner (FNP-BC) Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC) Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC) Psychiatric Mental Health Nurse Practitioner (PMHNP-BC)
Retired certifications	Adult NP (retired) Gerontology NP (retired)	Acute Care NP (retired) Adult NP (retired) Adult-Psychiatric Mental Health NP (retired) Emergency NP (retired) Gerontological NP (retired) Pediatric Primary Care NP (retired) School NP (retired)

While AANPCB and ANCC are the largest certifying bodies for nurse practitioners, other smaller certification bodies exist, including the American Association of Critical-Care Nurses (AACN), National Certification Corporation (NCC), Pediatric Certification Board (PNCB), Certification Board for Urological Nurses & Associates (CBUNA), and Hospice & Palliative Credentialing Center (HPCC).

Nurse Practitioner Specialties

Under the APRN Consensus Model, advanced practice registered nurses are licensed at the level of the population focus—not at the specialty level.[xi] Advanced practice registered nurses cannot be licensed solely within a specialty area.[xii] Regarding specialties, the APRN Consensus Model notes that specialties are optional but must be congruent with and build on the individual's established role and population foci.

Nurse practitioners may pursue optional certification in various specialties/subspecialties after initial certification in their role and population focus. An array of certifying boards issue "specialty" certifications for nurse practitioners—typically these certifications are based on hours of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are specific to nursing and specific to a single specialty. For example, the Orthopaedic Nurses Certification Board certifies nurse practitioners in the orthopaedic specialty (ONP-C) and the Dermatology Nurses Association certifies dermatology nurse practitioners (DCNPs). However, AANPCB offers an Emergency Nurse Practitioner (ENP) certification for certified FNPs with specialty education and practice in emergency care.

Note that specialty certification is generally not required for practice within a given specialty—indeed, work within a specific specialty is required to earn specialty certification.

Nurse Practitioner Workforce

Nurse practitioners are not required to practice within the specialty in which they are certified, and so there is great misalignment between nurse practitioner certification and the setting or specialty in which they practice. The APRN Consensus Model attempts to align the nurse practitioner curriculum with the certification a nurse practitioner can attain after graduation, however, a nurse

practitioner's certification is not always congruent with the specialty or setting in which the nurse practitioner practices during their career. Myriad data sources confirm this misalignment. For example, the American Association of Nurse Practitioners (AANP) claims that 88 percent of nurse practitioners are certified in primary care, but also reports that only 70.3 percent of nurse practitioners deliver primary care. The most recent Health Resources and Services Administration (HRSA) workforce data suggests a greater disparity, reflecting that only 24 percent of nurse practitioners deliver primary care.[xiii]

HRSA's findings are consistent with several state-level workforce studies, including the following:

- A study from the Oregon Center for Nursing examined the number of nurse practitioners practicing in primary compared to specialty care in Oregon. Looking at practice setting and area of practice, data from the survey revealed that only one-third of nurse practitioners practice in primary care and about 22 percent provided a combination of primary and specialty care. Of those nurse practitioners providing both primary and specialty care, about 62 percent spent less than half of their time focusing on primary care.[xiv] The study found that the gap between nurse practitioners providing primary care versus specialty care is widening over time, with a greater number of nurse practitioners providing specialty care and fewer nurse practitioners providing primary care. It concluded that certification alone is not enough to determine one's area of practice.
- Adding to this body of evidence is *A Profile of New York State Nurse Practitioners, 2017*, a workforce report in which only about *one-third* of actively practicing nurse practitioners were considered primary care nurse practitioners based on their specialty certification and practice setting, even though a vast majority of nurse practitioners in the state report a primary care specialty certification. To indicate, 87 percent of nurse practitioners reported a certification in primary care (36.8 percent in family health, 23.2 percent in adult health, 8.1 percent in pediatrics). [xv]
- A *2023 South Dakota Workforce Study* had similar findings.[xvi] Based on data gathered from nurse license renewal applications, including nurses who renewed their license, reactivated an inactive license, or reinstated a lapsed license, 80.9 percent indicated they were licensed and certified as family nurse practitioners yet only 24.9 percent identified "family health" as their primary area of specialty, 5.1 percent chose "primary care", and 6 percent chose adult health.[xvii] Other notable specialties selected include "other" (11.6 percent), psychiatric/mental health/substance abuse (8.2 percent), acute/critical care (7.3 percent), cardiology (4.2 percent), and emergency/trauma (3.5 percent).[xviii]

Studies also elucidate lack of congruence between nurse practitioners' certification and their practice in acute care settings.[xix] As noted earlier, some certifications distinguish between primary and acute care—and this distinction is ostensibly reflected in the nurse practitioner's educational track. Yet, many nurse practitioners are certified in primary care work in an acute care practice specialty or setting.

A study published in *Nursing Outlook* using data from HRSA's 2018 National Sample Survey of Registered Nurses found that among nurse practitioners working in acute care settings, only 44.5 percent held a certification in acute care, while 55.5 percent held only a primary care certification (13.7 percent held both acute care and primary care certifications). Notably, only about half of nurse practitioners working in acute care reported that they feel prepared to be an independent practitioner.[xx]

Below are findings by clinical specialty area in which the respondents worked:

	Acute Care Certified (N = 8,256)	Primary Care Certified (N = 10,297)
Total	44.5%	55.5%
Clinical Specialty		
General medical surgical	27.5%	37.6%
Critical care	23.5%	25.3%
Chronic Care	30.0%	10.6%
Neurological	6.4%	7.0%
Oncology	5.0%	9.2%
Other	7.6%	10.3%

*from Nursing Outlook $p < .01$

These findings were consistent with other studies examining the misalignment between nurse practitioners' credentials and their practice setting. For example, using data from the AANP National Nurse Practitioner Sample Survey, researchers found that of the 366 nurse practitioners who responded they were a hospitalist caring for adult patients (i.e., in an acute care setting), 74.7 percent were certified in primary care—with a full 75 percent indicating "on-the-job training" as their qualification to be a nurse practitioner hospitalist.[xxi]

Similarly, while emergency departments are for acute-life or limb threatening emergencies and providing care to critically ill patients, most nurse practitioners working in emergency departments are certified as an FNP. In fact, while there is a separate specialty certification for emergency nurse practitioners (ENPs), only FNPs are eligible for such certification—not acute care nurse practitioners, even though emergency departments are acute care settings. Moreover, 90 percent of nurse practitioners practicing in emergency departments do not have the ENP additional specialty certification.[xxii]

Altogether, education and certification are not determinative of where a nurse practitioner will practice—workforce studies show that nurse practitioners commonly practice in clinical settings or specialties that are misaligned with, their education, training, and credentials.

Specialty Switching by Nurse Practitioners

Nurse practitioners may switch specialties throughout their career with few limitations, with the primary limitation being that, per the APRN Consensus Model, a nurse practitioner's specialty must align with the population focus of the nurse practitioner's training, as well as their certification. For some nurse practitioners this provides broad latitude in mid-career changes. For example, FNPs are trained to provide primary care across the lifespan and so would qualify for a broad range of specialties. By contrast, an adult-gerontology primary care nurse practitioner (AG-PCNP) might be more limited. For example, an AG-PCNP would likely have to complete additional training to care for children, or to care for adult or geriatric patients outside primary care.[xxiii]

Physician Assistant Education and Training

Physician assistant programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and are two-to-three years in length. Physician

assistant programs provide a generalist education rather than focus on a particular specialty.[xxiv] Per the standards, program curriculum must include, "applied medical, behavioral and social sciences; patient assessment and clinical medicine; *supervised clinical practice*; and health policy and professional practice issues."[xxv] Upon completion of the program graduates are awarded a master's degree and become eligible to sit for the physician assistant certification examination.

Physician Assistant Certification

A single body certifies physician assistants: the National Commission on Certification of Physician Assistants (NCCPA). Certification is available to physician assistants who graduate from an ARC-PA accredited program and pass the Physician Assistant National Certifying Examination. Physician assistants are eligible to take the examination up to six-years after graduation and those who pass are awarded the PA-C credential. To maintain certification, physician assistants must complete a minimum number of hours of continuing medical education (CME) and pass the Physician Assistant National Recertifying Examination (PANRE) every 10 years. Most states require completion of a minimum number of hours of CME, current certification by NCCPA, or both as a condition of licensure or for licensure renewal.

The single certification for physician assistants is consistent with the approach for physician assistant education and training—to provide a generalist education without a focus on specialty. This is evident in both the didactic curriculum and clinical training of physician assistants. For example, the 2,000 hours of clinical practice required of physician assistants includes rotations in various specialties, including emergency medicine, obstetrics and gynecology, psychiatry, family medicine, and internal medicine. Standards also include requirements that these clinical rotations must include specific types of encounters. For example, physician assistant students must treat patients requiring chronic, acute, emergent, and preventive care and must also provide care in a variety of settings, including the emergency department, outpatient, and inpatient facilities. There is no path for specialized focus in the physician assistant educational program.

In addition to the PA-C certification, NCCPA also offers optional specialty Certificates of Added Qualification (CAQs) to physician assistants in 10 specialties, including:

- Cardiovascular & Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Hospital Medicine;
- Nephrology;
- Obstetrics and Gynecology;
- Orthopaedic Surgery;
- Palliative Medicine and Hospice Care;
- Pediatrics; and
- Psychiatry.[xxvi]

A physician assistant who has acquired a CAQ is considered "board certified." The specific requirements vary by specialty but generally require the following: (1) completion of specialty-specific CME, (2) attestation that the physician assistant has completed a certain number of hours of experience in the specialty, (3) attestation that the physician assistant has the knowledge and skills relevant to practice in the specialty, including the knowledge and skills to perform the procedures relevant to the specialty, and/or that the physician assistant understands how and when

the knowledge and skills should be applied for appropriate patient management or how and when the procedures should be performed, and (4) achieve a passing score on a specialty examination (online or in person).

CAQs often rely heavily on attestations and may not actually require the physician assistant to complete relevant procedures. Consider as an example the requirements to attain a CAQ in emergency medicine:

- Self-attest to completing 75 credits of Category 1 CME focused on emergency medicine; 25 of which must be earned within two-years of the date of the application for the specialty examination and the remaining earned within six years before this date.
- Complete a comprehensive emergency medicine course that reflects the guidelines set forth in the most current version of Model of the Clinical Practice of Emergency Medicine, and complete the following courses:
    - Pediatric Advanced Life Support or Advanced Pediatric Life Support
    - Advanced Trauma Life Support
    - Airway course
- Self-attest to completing 3,000 hours of experience working as a physician assistant in emergency medicine within at least six-years.
- Obtain attestation from a physician, lead/senior physician assistant, or physician/physician assistant post graduate program director who works in emergency medicine and is familiar with the physician assistant's practice and experience. The attestation must affirm that the physician assistant, "*has performed* the procedures and patient management relevant to the practice setting and/or *understands* how and when the procedures *should* be performed…the PA may not have experience with each procedure, but he or she must be knowledgeable of the basics of the procedures, in what situation the procedures should be done, and the associated management of patients."[xxvii]
- Pass an examination which consists of 120 multiple choice questions, which can be taken at a test center or online.

CAQs are wholly optional for physician assistants and are generally not required for physician assistants to practice. Indeed, before earning and in order to earn a CAQ in the first instance, a physician assistant must practice in a chosen specialty.

Physician Assistant Workforce

According to the NCCPA 2022 statistical profile of board-certified physician assistants, only 23.1 percent of physician assistants work in primary care, which includes "family medicine/general practice, internal medicine general, and pediatrics general." When asked to identify their primary area of practice, the most physician assistants reported working in the five specialties:

- Surgical subspecialties (18.6 percent);
- Family medicine/general practice (17.1 percent);
- Emergency medicine (11.2 percent);
- Other (10.6 percent; *note that the most frequent responses include: urgent care, interventional radiology, sleep medicine, aesthetics, trauma surgery, wound care, and transplant surgery); and
- Internal medicine subspecialties (9.9 percent).

Most physician assistants practice in hospital settings (41.7 percent) with office-based private practice a close second (37.1 percent). Urgent care (5.6 percent) and federal government facility/hospital/unit (4.7 percent) are a distant fourth and fifth.

While most physician assistants hold one clinical position (84.9 percent), 11.3 percent of physician assistants hold two or more clinical positions, with emergency medicine (25.6 percent) being the most common secondary specialty area of these physician assistants.

Specialty Switching by Physician Assistants

Since physician assistants are trained as "generalists," they face very few barriers to specialty switching. Indeed, more than half have changed specialties at least once during their career with over 20 percent indicating they have changed specialties two to three times.[xxviii] This can be done without any additional education, formal training, or certification.

AMA POLICY

The AMA has extensive policy supporting physician-led team-based care, including policy on appropriate physician supervision of nurse practitioners and physician assistants:

- Policy H-160.949, "Practicing Medicine by Non-Physicians;"
- Policy H-160-906, "Models /Guidelines for Medical Health Care Teams;"
- Policy H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner;"
- Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice;"
- Policy H-35.989, "Physician Assistants;" and
- Policy D-35.985 "Support for Physician Led, Team Based Care."

The AMA also has policy directing our AMA to educate the public on the difference in the education and training of physicians and non-physicians. Specifically:

- Policy H-160.949, "Practicing Medicine by Non-Physicians;"
- Policy H-450.955, "Education of the General Public on the Role of Physician and Non-Physician Health Care Providers;" and
- Policy H-275.943, "Public Education about Physician Qualifications."

DISCUSSION

The nurse practitioner and physician assistant professions both began with an emphasis on providing primary care to patients to help address the primary care workforce shortages. Over time, however, both nurse practitioners and physician assistants are increasingly choosing to practice in specialties instead of primary care and may switch specialties multiple times during their career. The idea of specialty switching by nurse practitioners and physician assistants is not a new phenomenon and such flexibility in specialization is often touted by both professions as a positive attribute to prospective students.

The underlying education and clinical training of both nurse practitioners and physician assistants is founded upon a generalist approach. With limited exceptions, there is no focus on specialty care.

While state licensure requires graduation from an accredited program and certification by a designated body, physician assistant certification and most nurse practitioner certifications are extremely broad, allowing wide latitude in the patient population, specialty or setting in which they can practice.

Moreover, there are little-to-no guardrails limiting the specialties in which nurse practitioners and physician assistants may work. In fact, many studies show a misalignment between nurse practitioner education, training, and certification and the specialty or setting in which they practice, such that some nurse practitioners find themselves in the position of caring for a patient population or level of acuity in which they have received no formal education or training. For both professions, on-the-job training post-graduation is a common means to gain the requisite knowledge in the specialty and practice setting in which they practice. This reinforces the importance of physician-led team-based care.

While studies demonstrate the increased number of nurse practitioners and physician assistants practicing in specialties as opposed to primary care, there is no publicly available data on specialty switching by nurse practitioners. There are also no studies on the impact of specialty switching on the cost and quality of care provided by nurse practitioners and physician assistants. Moreover, there are no studies on the additional workload placed on physicians and other health care professionals who must provide on-the-job training to nurse practitioners or physician assistants who have switched specialties and/or are practicing in a specialty in which they have no formal education, training, or certification. Moreover, there are no studies looking at the impact of specialty switching in these professions on physician burnout, nor are there studies that look at the impact on physician's time away from providing direct patient care. These gaps in literature are ripe for analysis, particularly by those conducting research on the health care workforce. State nursing and medical boards could also capture this information as part of a survey conducted at the time of licensure renewals by nurse practitioners and physician assistants.

RECOMMENDATIONS

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

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)
3. That the AMA encourage hospitals and other health care entities employing nurse practitioners to ensure that the nurse practitioner's certification aligns with the specialty in which they will practice. (New HOD Policy)
4. That the AMA continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT 15 OF THE BOARD OF TRUSTEES (A-24)
Augmented Intelligence Development, Deployment, and Use in Health Care
(Resolution 247-A-23) (Resolution 206-I-23)
(Reference Committee B)

EXECUTIVE SUMMARY

At the June 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "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." This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI's ChatGPT and other LLMs/generative AI.

Additionally, at the November 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers."

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. There has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. Generative AI tools are also being developed to assist with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care.

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the AMA and the physician community engage in the development of policies to help inform patient and physician education, help guide development of these tools in a way that best meets both patient and physician needs, and advocate for governance policies to help ensure that risks arising from AI are mitigated to the greatest extent possible.

This report highlights the AMA's recognition of the issues raised at both the A-23 and I-23 HOD meetings, introduces and explains major themes of the report's recommendations, and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-24

Subject: Augmented Intelligence Development, Deployment, and Use in Health Care
(Res. 247-A-23) Assessing the Potentially Dangerous Intersection Between AI and Misinformation
(Res. 206-I-23) The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "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." This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI's ChatGPT and other LLMs/generative AI.

Additionally, at the 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers."

Testimony on Resolution 206-I-23 highlighted the importance of physician understanding of LLMs and the ability to weigh the benefits and risks of these tools as the excitement and eagerness to implement them in everyday practice increases. Testimony emphasized that our AMA is currently in the process of fulfilling the directive in Policy H-480-935 (adopted at A-23) that directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs, such as GPTs, and other augmented intelligence-generated medical advice or content. The HOD referred Resolution 206 so that the issues raised in this resolution could be considered along with the issues in Policy H-480.935.

BACKGROUND

The issue of AI first presented itself as an area of potential interest to AMA physicians and medical students that necessitated creation of AMA policy in 2018. At that time, physicians and medical students primarily considered AI-enabled technologies within the context of medical

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device and clinical decision support (CDS), although administrative applications of AI began to grow exponentially and started to gain traction in the hospital, health system, and insurer space. Since the development of the AMA's foundational AI policy in 2018 and subsequent policy on coverage and payment for AI in 2019, the number of AI-enabled medical devices approved by the U.S. Food and Drug Administration (FDA) has grown to nearly 700. In 2022, the concept of "generative AI" and what it can do became better understood to the public. Generative AI is a broad term used to describe any type of artificial intelligence that can be used to create new text, images, video, audio, code, or synthetic data. Generative AI and LLMs have rapidly transformed the use cases and policy considerations for AI within health care, necessitating updated AMA policy that reflects the rapidly evolving state of the technologies.

AMA policy adopted in 2018 and 2019 enabled the AMA to be a strong advocate on behalf of patients and physicians and has been the bedrock of AMA's advocacy on AI in the form of lobbying key congressional committees, participating in expert panel discussions, creating educational resources, and working with our Federation colleagues at the federal and state levels. However, as AI has rapidly developed beyond AI-enabled medical devices and into LLMs/generative AI, new policy and guidance are needed to ensure that they are designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent.

As an initial step, in November 2023, the AMA Board of Trustees approved a set of advocacy principles developed by the Council on Legislation (COL) that serve as the framework of this Board report. The main topics addressed in the principles include AI oversight, disclosure requirements, liability, data privacy and security, and payor use of AI. In addition to the COL, these principles have been vetted among multiple AMA business units, and AMA staff has worked with several medical specialty societies that have an expertise in AI and has received additional guidance and input from outside experts that have further refined these principles. These principles build upon and are supplemental to the AMA's existing AI policy, especially Policy H-480.940, "Augmented Intelligence in Health Care," Policy H-480.939, "Augmented Intelligence in Health Care," and Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," as well as the AMA's Privacy Principles. The Board recommends adoption of these principles as AMA policy to guide our AMA's advocacy and educational efforts on LLM/generative AI issues.

This report highlights the AMA's recognition of the issues raised at both the A-23 and I-23 HOD meetings, introduces and explains major themes of the report's recommendations, and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

CURRENT STATUS OF OVERSIGHT OF AUGMENTED INTELLIGENCE-ENABLED TECHNOLOGIES

There is currently no whole-of-government strategy for oversight and regulation of AI. The U.S. Department of Health and Human Services (HHS) did establish an AI Office in March 2021 and developed a general strategy to promote the use of trustworthy AI, but has not produced a department-wide plan for the oversight of AI. While many other federal departments and agencies also have some authority to regulate health care AI, many regulatory gaps exist. To address the lack of a national strategy and national governance policies directing the development and deployment of AI, the federal government has largely defaulted to public "agreements" representing promises by large AI developers and technology companies to be good actors in their development of AI-enabled technologies.

In December 2023, the Biden Administration released a reasonably comprehensive executive order on the "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence." While the executive order does not create new statutory or regulatory requirements, it does serve to direct federal departments and agencies to take action to provide guidance, complete studies, identify opportunities, etc. on AI across several sectors, including HHS. The AMA was pleased to see close alignment between the executive order's direction and AMA principles. However, executive orders do not represent binding policy, so the regulatory status quo remains unchanged at present.

The Biden Administration had also previously released a "Blueprint for an AI Bill of Rights" setting forth five principles that should guide the design, use, and deployment of AI. Those include recommendations for creating safe and effective systems; algorithmic discrimination protections; data privacy; notice and explanation; and human alternatives, considerations, and fallback. Like executive orders, this blueprint does not create new or binding policy and it does not appear there have been new efforts by federal departments and agencies to take action to ensure that AI aligns with these principles.

There have been few, but notable, additional actions by federal agencies that may serve to impact patient and physician interaction with AI-enabled technologies. In 2022, the Centers for Medicare & Medicaid Services (CMS) and HHS Office for Civil Rights (OCR) introduced a sweeping liability proposal within its Section 1557 Non-Discrimination in Health Programs and Activities proposed rule. The proposal, if finalized, would create liability for physicians if they "rely" on a clinical algorithm that results in discriminatory harm to a patient. In the proposal, "clinical algorithm" is defined to include AI. The AMA submitted detailed comments opposing this section of the proposed rule. CMS and OCR have yet to finalize the rule.

In addition, the Office of the National Coordinator for Health Information Technology (ONC) proposed and finalized, with some modifications, polices that will require electronic health record (EHR) technology developers to make certain information about AI used in EHRs available to physicians and other users. ONC refers to these AI tools as Predictive Decision Support Interventions (Predictive DSI). Starting in 2025, EHR developers that supply Predictive DSIs as part of the developer's EHR offering must disclose specific attributes and inform users if patient demographic, social determinants of health, or health assessment data are used in the Predictive DSI. EHRs will be subject to regulatory requirements regarding the design, development, training, and evaluation of Predictive DSIs along with mandated risk management practices. ONC's stated goal is to ensure that physicians understand how these tools work, how data are used, the potential for bias, and any known limitations.

FDA APPROVED AI-ENABLED MEDICAL DEVICES

The FDA continues to rapidly approve AI-enabled medical devices. While FDA approval and clearance of algorithmic-based devices dates back to 1995, clearance and approval of these devices has rapidly accelerated in the last several years. As of October 2023, 692 devices that FDA classifies as Artificial Intelligence/Machine Learning (AI/ML) devices have been approved for marketing. The overwhelming number of these devices are classified as radiology devices and this category of devices has seen the steadiest increases in the number of applications for FDA approval. However, the number of applications is increasing in several specialties, including cardiology, neurology, hematology, gastroenterology, urology, anesthesiology, otolaryngology, ophthalmology, and pathology. A significant number of cleared or approved devices are considered diagnostic in nature and many currently support screening or triage functions.

In 2017, the FDA announced that they were evaluating a potentially new regulatory approach towards Software as a Medical Device, which would include AI/ML technologies. The so-called Pre-Certification program, or "Pre-Cert," progressed to an initial pilot program involving nine manufacturer applicants. The program proposed to pre-certify manufacturers of software-based medical devices. Devices developed by pre-certified manufacturers would be subject to varying levels of FDA review based on risk to patients, including potentially being exempt from review if the risk is low. However, the Pre-Cert program has been tabled and the pilot dismantled for the time being, leaving FDA to utilize traditional review pathways for AI-enabled medical devices. In the absence of new regulatory strategies tailored to SaMD and AI/ML, FDA has issued some proposed guidance for developers of these devices but has not yet moved forward with additional guidance for important, physician-facing topics, such as transparency and labeling requirements. While transparency was listed as one of five major FDA priorities in this area, the Agency does not have current plans to move forward on additional guidance at this time. This leaves a critical gap in the oversight of AI-enabled medical devices.

Data Privacy and Cybersecurity Considerations in Health Care AI

The integration of AI into health care signifies a transformative era, greatly enhancing patient care and operational efficiency. However, this advancement also introduces considerable challenges, particularly in data privacy and cybersecurity. As health care facilities, technology vendors, clinicians, and users increasingly adopt AI, it is vital to focus on protecting patient and user data and securing AI systems against cyber threats. Handling vast amounts of sensitive data raises critical questions about privacy and security. Survey data has shown that 9 out of 10 patients believe privacy is a right and nearly 75 percent of people are concerned about protecting the privacy of their health data.[i] Addressing these concerns necessitates a multifaceted approach that includes advanced data privacy techniques, data use transparency, robust cybersecurity strategies, and compliance with regulatory standards.

Ensuring the protection of patient data in the context of AI requires sophisticated privacy techniques. Key methods such as anonymization and pseudonymization can remove or replace personal identifiers in data sets and significantly reduce the risk of re-identification. Additionally, implementing a robust data management system empowers patients by providing clear ways to grant, deny, or revoke consent for the use of their data, enhancing patient trust and ensuring compliance with global data protection regulations such as the General Data Protection Regulation and the Health Insurance Portability and Accountability Act (HIPAA). Moreover, the collection of data should be kept to a minimum. By collecting only the data necessary for the intended purpose, AI systems can mitigate the risks associated with data breaches and misuse.

Cybersecurity plays a crucial role in health care, especially in the context of the increasing digitalization of medical records, patient data, and health care services. The health care sector is a prime target for cyber-attacks due to the sensitivity and value of the data it handles, including personal health information (PHI), financial data, and intellectual property related to medical research. The integration of technology in health care has undoubtedly brought significant benefits such as improved patient care, streamlined operations, and enhanced data analytics. However, it also introduces vulnerabilities. These include potential unauthorized access, data breaches, and disruptions to health care services, which can have dire consequences for patient privacy and safety. In 2017, 83 percent of surveyed physicians had already experienced a cyberattack and 85 percent stated that they want to share electronic PHI but were concerned about the data security necessary to protect it.[ii] This risk is amplified by the recent increased use of interconnected devices and systems, such as EHRs, telemedicine platforms, and mobile health applications.

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. The attack was attributed to ransomware. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians and delays in patient care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

The implications of cybersecurity in health care AI are multifaceted. AI in health care, encompassing machine learning algorithms, predictive analytics, and robotic process automation, hold immense potential for diagnostic accuracy, personalized medicine, and operational efficiency. However, the deployment of AI in health care settings creates unique cybersecurity challenges. AI systems require large datasets to train and operate effectively, increasing the risk of large-scale data breaches. Additionally, the complexity of AI algorithms can make them opaque and vulnerable to manipulation, such as adversarial attacks that can lead to misdiagnoses or inappropriate treatment recommendations. AI-driven health care solutions often rely on continuous data exchange across networks, escalating the risk of cyber-attacks that can compromise both the integrity and availability of critical health care services.

Model stealing attack represents a significant cybersecurity threat in the realm of AI, where a malicious actor systematically queries an AI system to understand its behavior and subsequently replicates its functionality. This form of intellectual property theft is particularly alarming due to the substantial resources and time required to develop sophisticated AI models. An example of this issue involves a health care organization that has invested heavily in an AI model designed to predict patient health outcomes based on a wide range of variables. If a malicious entity were to engage in model stealing by extensively querying this predictive model, it could essentially duplicate the original model’s predictive capabilities along with capitalizing on sensitive health care information and physicians, users, or the entity’s intellectual property. Absent strong protections against input manipulation and malicious attacks, AI can become a new conduit for bad actors to compromise health care organizations and harm patients. This not only undermines the original investment but also poses a direct threat to the competitive advantage of the innovating organization.

Moreover, the risk extends beyond intellectual property theft to encompass serious privacy concerns. This is exemplified by incidents where generative AI models, trained on vast datasets, inadvertently reveal sensitive information contained within their training data in response to certain prompts. In the health care sector, where models are often trained on highly sensitive patient data, including personally identifiable information, the unauthorized extraction of this data can lead to significant breaches of patient confidentiality. The dual threat of intellectual property theft and data privacy breaches underscores the critical need for robust cybersecurity measures in safeguarding AI models, particularly those developed and utilized within the health care industry, to maintain the integrity of both their intellectual property and the confidentiality of the sensitive data they handle.

While there are new federal policies to increase data transparency when AI is used in conjunction with health information technology, such as those issued by ONC, these new policies only cover

the certified EHR developer and stop short of holding AI developers accountable for robust data governance or data security and privacy practices.[iii]

GENERATIVE AI

The broad introduction of generative AI into the public sphere in 2022 saw a paradigm shift in how physicians contemplated AI. Open-source LLM Chat GPT presented a new, easily accessible AI-enabled technology with significant capabilities to generate new content and provide readily available access to information from a huge number of sources. Generative AI tools have significant potential to relieve physician administrative burdens by helping to address actions such as in-box management, patient messages and prior authorization requests. They also show promise in providing clinical decision support. These generative AI tools, however, can also pose significant risk, particularly for clinical applications. They are largely unregulated, as there is no current regulatory structure for generative AI clinical decision support tools unless they meet the definition of a medical device regulated by the FDA. The U.S. Federal Trade Commission (FTC) has limited authority to regulate data privacy issues that may be associated with generative AI tools. The FTC can also regulate activities considered to be an unfair, deceptive, or abusive business practice and can enforce laws for consumer protection. CMS has some authority to regulate use of AI by entities receiving funds from Medicare and Medicaid, including use by Medicare Advantage plans. OCR has some additional authorities to regulate data privacy and nondiscrimination. CMS and OCR have already put forth a very concerning proposal regarding physician liability for clinical algorithms, which the AMA has vigorously opposed.

While some federal agencies may have oversight and authorities to regulate some aspects of AI, there are many regulatory gaps. These regulatory gaps are particularly significant when considering generative AI, as tools like ChatGPT and others currently fall well outside the definition of a regulated medical device. While generative AI use for clinical applications is relatively limited right now, it is expected to grow and patients and physicians will need assurances that it is providing safe, correct, non-discriminatory answers to the full extent possible, whether through regulation or generally accepted standards for design, development, and deployment.

USE OF AI BY PAYORS

There have been numerous reports recently regarding the use of what has been termed "automated decision-making tools" by payors to process claims. However, numerous reports regarding the use of these tools show a growing tendency toward inappropriate denials of care or other limitations on coverage. Reporting by ProPublica claims that tools used by Cigna denied 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.[iv] Two class action lawsuits were filed during 2023, charging both United Health Care and Humana with inappropriate claims denials resulting from use of the nHPredict AI model, a product of United Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied care to elderly and disabled patients enrolled in Medicare Advantage (MA) plans with both companies. Plaintiffs also claim that payors used the model despite knowing that 90 percent of the tool's denials were faulty.

There is growing concern among patients and physicians about what they perceive as increasing and inappropriate denials of care resulting from the use of these automated decision-making tools. In his recent Executive Order on AI, President Biden addressed this issue as an area of concern, directing the HHS to identify guidance and resources for the use of predictive and generative AI

in many areas, including benefits administration, stating that it must take into account considerations such as appropriate human oversight of the application of the output from AI.

There are currently no statutory and only limited regulatory requirements addressing the use of AI and other automated decision-making tools by payors. States are beginning to look more closely at this issue given the significant negative reporting in recent months and are a likely place for near-term action on this issue. Congress has also shown increasing concern and has convened hearings for testimony on the issue; however, there has been no further Congressional action or legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not taken broad regulatory action to limit the use of these algorithms by entities administering Medicare and Medicaid benefits.

AMA POLICY

The AMA has existing policies, H-480.940 and H-480.939 both titled "Augmented Intelligence in Health Care," which stem from a 2018 and 2019 Board report and cover an array of areas related to the consequences and benefits of AI use in the physician's practice. In pertinent part to this discussion, AMA Policy H-480.940 seeks to "promote development of thoughtfully designed, high-quality, clinically validated health care AI, encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, and explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI." This policy reflects not only the significance of attribution on the part of the developer, but furthermore emphasizes that physicians and other end users also play a role in understanding the technology and the risks involved with its use.

AMA Policy H.480.939 also addresses key aspects of accountability and liability by stating that "oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment." Furthermore, this policy asserts that "liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Specifically, developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users."

AMA Policy D-480.956 supports "greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires such reviews include human examination of patient records prior to a care denial."

DISCUSSION

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the physician community engage in development of policies to help drive advocacy, inform patient and physician education, and guide engagement with these new technologies. It is also important that the physician community help guide development of these tools in a way that best meets both patient and physician needs, and help define their own organization's risk tolerance, particularly where AI impacts direct patient care. AI has significant potential to advance clinical care, reduce administrative burdens, and improve clinician well-being. This may only be accomplished by ensuring that physicians engage only with AI that satisfies rigorous, clearly defined standards to meet the goals of the quadruple aim:[v] advance health equity, prioritize patient safety, and limit risks to both patients and physicians.

Oversight of Health Care Augmented Intelligence

There is currently no national policy or governance structure in place to guide the development and adoption of non-device AI. As discussed above, the FDA regulates AI-enabled medical devices, but many types of AI-enabled technologies fall outside the scope of FDA oversight[vi]. This potentially includes AI that may have clinical applications, such as some generative AI technologies serving clinical decision support functions. While the FTC and OCR have oversight over some aspects of AI, their authorities are limited and not adequate to ensure appropriate development and deployment of AI generally, and specifically in the health care space. Likewise, ONC's enforcement is limited and focused on EHR developers' use and integration of AI within their federally certified EHRs. While this is a major first step in requiring AI transparency, it is still the EHR developer that is regulated with few requirements on the AI developer itself. Encouragement of a whole-of-government approach to implement governance policies will help to ensure that risks to consumers and patients arising from AI are mitigated to the greatest extent possible.

In addition to the government, health care institutions, practices, and professional societies share some responsibility for appropriate oversight and governance of AI-enabled systems and technologies. Beyond government oversight or regulation, purchasers and users of these technologies should have appropriate and sufficient policies in place to ensure they are acting in accordance with the current standard of care. Similarly, clinical experts are best positioned to determine whether AI applications are high quality, appropriate, and whether the AI tools are valid from a clinical perspective. Clinical experts can best validate the clinical knowledge, clinical pathways, and standards of care used in the design of AI-enabled tools and can monitor the technology for clinical validity as it evolves over time.

Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

As implementation of AI-enabled tools and systems increases, it is essential that use of AI in health care be transparent to both patients and physicians. Transparency requirements should be tailored in a way that best suits the needs of the end users. Care must be taken to preserve the integrity of data sets used in health care such that individual choice and data privacy are balanced with preserving algorithms that remain as pristine as possible to avoid exacerbating health care inequities. Disclosure should contribute to patient and physician knowledge without increasing administrative burden. When AI is utilized in health care decision-making, that use should be disclosed and documented to limit risks to, and mitigate inequities for, both patients and

physicians, and to allow each to understand how decisions impacting patient care or access to care are made. While transparency does not necessarily ensure AI-enabled tools are accurate, secure, or fair, it is difficult to establish trust if certain characteristics are hidden.

Heightened attention to transparency and additional transparency requirements serve several purposes. They help to both ensure that the best possible decisions are made about a patient's health care and help patients and physicians identify critical decision points and possible points of error. They can also serve as mechanisms to help shield physicians from liability so that potential issues related to use of AI-enabled technologies can be isolated and accountability apportioned appropriately.

There are currently few federal requirements for transparency regarding AI. The FDA requires product labeling to provide certain information to physicians and other users, but requirements for device labeling are generally considered to be less stringent and have more leeway than drug product labeling. While FDA has stated that transparency is a key priority for the agency to address, they have not taken any additional action to update the labeling requirements for AI-enabled medical devices or put into place additional transparency requirements for AI-enabled devices. As discussed above, ONC also has new transparency requirements applicable to the use of AI within EHRs; however, again, those requirements are limited to AI within an EHR or other applications integrated and made available through the EHR. They will not apply to AI-enabled tools accessible through the Internet, cellular phones, etc. It is clear that there is an urgent need for additional federal action to ensure AI transparency.

Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

Along with significant opportunity to improve patient care, all new technologies in health care will likely present certain risks and limitations that physicians must carefully navigate during the early stages of clinical implementation of these new systems and tools. AI-enabled tools are no different and are perhaps more challenging than other advances as they present novel and complex questions and risks. To best mitigate these risks, it is critical that physicians understand AI-driven technologies and have access to certain information about the AI tool or system being considered, including how it was trained and validated, so that they can assess the quality, performance, equity, and utility of the tool to the best of their ability. This information may also establish a set of baseline metrics for comparing AI tools. Transparency and explainability regarding the design, development, and deployment processes should be mandated by law where feasible, including potential sources of inequity in problem formulation, inputs, and implementation. Additionally, sufficient detail should be disclosed to allow physicians to determine whether a given AI-enabled tool would reasonably apply to the individual patient they are treating.

Physicians should be aware and understand that, where they utilize AI-enabled tools and systems without transparency provided by the AI developer, their risks of liability for reliance on that AI will likely increase. The need for full transparency is greatest where AI-enabled systems have greater impact on direct patient care, such as by AI-enabled medical devices, clinical decision support, and interaction with AI-driven chatbots. Transparency needs may be somewhat lower where AI is utilized for primarily administrative, practice-management functions.
While some of this information may be provided in labeling for FDA cleared and approved medical devices, the labeling requirements for such devices have not been specifically tailored to clearly convey information about these new types of devices. Updated guidance for FDA-regulated medical devices is needed to provide this critical information. Congress should consider actions to ensure appropriate authorities exist to require appropriate information to be provided to

users of AI so that they can best evaluate the technology to determine reported performance, intended use, intended population, and appropriateness for the task. Developers and vendors should consider voluntarily providing this information about their products, and physicians and other purchasers should consider this information when selecting the AI tools they use.

Generative AI

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. Generative AI tools are finding an increasing number of uses in health care, including assistance with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. Additionally, there has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care. These risks are especially important to consider for clinical applications that may impact clinical decision-making and treatment planning where risks to patients are higher.

Given that there are no regulations or generally accepted standards or frameworks to govern the design, development, and deployment of generative AI, consideration and mitigation of the significant risks is paramount. To manage risk, health care organizations should develop and adopt appropriate polices that anticipate and minimize negative impacts. Physicians who consider utilizing a generative AI-based tool in their practice should ensure that all practice staff are educated on the risks and limitations, including patient privacy concerns, and should have appropriate governance policies in place for its use prior to adoption. Also, as raised in Resolution 206-I-23, physicians should be encouraged to educate their patients about the benefits and risks of using AI-based tools, such as LLMs, for information about health care conditions, treatment options, or the type of health care professionals who have the education, training, and qualifications to treat a particular condition. Patients and physicians should be aware that chatbots powered by LLMs/generative AI could provide inaccurate, misleading, or unreliable information and recommendations. This principle is incorporated in the recommendations in this report and current AMA Policy H-480.940, "Augmented Intelligence in Health Care."

Liability

The question of physician liability for use of AI-enabled technologies presents novel and complex legal questions and poses risks to the successful clinical integration of AI-enabled technologies. It is also one of the most serious concerns for physicians when considering integration of AI into their practice. Concerns also arise for employed physicians who feel they may have no choice but to utilize the AI, should hospitals or health systems mandate its use or utilize an EHR system that incorporates AI-based applications as standard.

The challenge for physicians regarding questions of liability for use of AI is that there is not yet any clear legal standard for determining liability. While there are clear standards for general medical malpractice and for medical device liability, AI presents novel and potentially complex legal questions. When AI has suggested a diagnosis, the question of how appropriate it is for a physician to rely on that result is yet to be determined and will likely continue to evolve as AI improves. Ultimately the "standard of care" will help guide physician liability. It is expected that, as it improves over time, AI will be incorporated into what is likely to be specialty-specific standards of care. However, until that occurs, AI-transparency is of critical importance and

physicians will need to be diligent in ensuring that they engage with AI tools where performance has been validated in their practice setting.

As AI continues to evolve, there may ultimately be questions regarding liability when physicians fail to use AI and rely only on their professional judgment. Again, this question may ultimately turn on what evolves to be considered the standard of care.

It should be noted that, when using AI, physicians will still be subject to general legal theories regarding medical liability. Negligent selection of an AI tool, including using tools outside their intended use or intended population, or choosing a tool where there is no evidence of clinical validation, could be decisions that expose a physician to a liability claim.

Data Privacy and Augmented Intelligence

Data privacy is highly relevant to AI development, implementation, and use. The AMA is deeply invested in ensuring individual patient rights and protections from discrimination remain intact, that these assurances are guaranteed, and that the responsibility rests with the data holders. AI development, training, and use requires assembling large collections of health data. AI machine learning is data hungry; it requires massive amounts of data to function properly. Increasingly, more electronic health records are interoperable across the health care system and, therefore, are accessible by AI trained or deployed in medical settings. AI developers may enter into legal arrangements (e.g., business associate agreements) that bring them under the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. While some uses of AI in health care, such as research, are not allowed by HIPAA absent patient authorization, the applicability of other HIPAA privacy protections to AI use is not as clear and HIPAA cannot protect patients from the "black box" nature of AI which makes the use of data opaque. AI system outputs may also include inferences that reveal personal data or previously confidential details about individuals. This can result in a lack of accountability and trust and exacerbate data privacy concerns. Often, AI developers and implementers are themselves unaware of exactly how their products use information to make recommendations.

It is unlikely that physicians or patients will have any clear insight into a generative AI tool's conformance to state or federal data privacy laws. LLMs are trained on data scraped from the web and other digital sources, including one well-documented instance where HIPAA privacy protections were violated.[vii] Few, if any, controls are available to help users protect the data they voluntarily enter in a chatbot query. For instance, there are often no mechanisms in place for users to request data deletion or ensure that their inputs are not stored or used for future model training. While tools designed for medical use should align with HIPAA, many "HIPAA-compliant" generative tools rely on antiquated notions of deidentification, i.e., stripping data of personal information. With today's advances in computing power, data can easily be reidentified. Rather than aiming to make LLMs compliant with HIPAA, all health care AI-powered generative tools should be designed from the ground up with data privacy in mind.

The AMA's Privacy Principles were designed to provide individuals with rights and protections and shift the responsibility for privacy to third-party data holders. While the Principles are broadly applicable to all AI developers, e.g., entities should only collect the minimum amount of information needed for a particular purpose, the unique nature of LLMs and generative AI warrant special emphasis on entity responsibility and user education.

Augmented Intelligence Cybersecurity

Data privacy relies on strong data security measures. There is growing concern that cyber criminals will use AI to attack health care organizations. AI poses new threats to health IT operations. AI-operated ransomware and AI-operated malware can be targeted to infiltrate health IT systems and automatically exploit vulnerabilities. Attackers using ChatGPT can craft convincing or authentic emails and use phishing techniques that entice people to click on links—giving them access to the entire electronic health record system.

AI is particularly sensitive to the quality of data. Data poisoning is the introduction of "bad" data into an AI training set, affecting the model's output. AI requires large sets of data to build logic and patterns used in clinical decision-making. Protecting this source data is critical. Threat actors could also introduce input data that compromises the overall function of the AI tool. Failure to secure and validate these inputs, and corresponding data, can contaminate AI models—resulting in patient harm.

Because stringent privacy protections and higher data quality standards might slow model development, there could be a tendency to forgo essential data privacy and security precautions. However, strengthening AI systems against cybersecurity threats is crucial to their reliability, resiliency, and safety.

Payor Use of Augmented Intelligence in Automated Decision-Making

Payors and health plans are increasingly using AI and algorithm-based decision-making in an automated fashion to determine coverage limits, make claim determinations, and engage in benefit design. Payors should leverage automated decision-making systems that improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. While the use of these systems can create efficiencies such as speeding up prior authorization and cutting down on paperwork, there is concern these systems are not being designed or supervised effectively—creating access barriers for patients and limiting essential benefits.

Increasingly, evidence indicates that payors are using automated decision-making systems to deny care more rapidly, often with little or no human review. This manifests in the form of increased denials, stricter coverage limitations, and constrained benefit offerings. For example, a payor allowed an automated system to cut off insurance payments for Medicare Advantage patients struggling to recover from severe diseases, forcing them to forgo care or pay out of pocket. In some instances, payors instantly reject claims on medical grounds without opening or reviewing the patient's medical record. There is also a lack of transparency in the development of automated decision-making systems. Rather than payors making determinations based on individualized patient care needs, reports show that decisions are based on algorithms developed using average or "similar patients" pulled from a database. Models that rely on generalized, historical data can also perpetuate biases leading to discriminatory practices or less inclusive coverage.[viii,ix,x,xi]

While AI can be used inappropriately by payors with severe detrimental outcomes to patients, it can also serve to reduce administrative burdens on physicians, providing the ability to more easily submit prior authorization and documentation requests in standardized forms that require less physician and staff time. Given the significant burden placed on physicians and administrative staff by prior authorization requests, AI could provide much needed relief and help to increase professional satisfaction among health care professionals. With clear guidelines, AI-enabled

decision-making systems may also be appropriate for use in some lower-risk, less complex care decisions.

While payor use of AI in well-defined situations with clear guidelines has the potential to reduce burdens and benefit physician practices, new regulatory or legislative action is necessary to ensure that automated decision-making systems do not reduce needed care, nor systematically withhold care from specific groups. Steps should be taken to ensure that these systems do not override clinical judgment. Patients and physicians should be informed and empowered to question a payor's automated decision-making. There should be stronger regulatory oversight, transparency, and audits when payors use these systems for coverage, claim determinations, and benefit design. [See Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization;" Policy H-320.939, "Prior Authorization and Utilization Management Reform"]

CONCLUSION

As the number of AI-enabled health care tools and systems continue to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. In line with AMA Policy H-480-935 and Resolution 206-I-23, this report highlights some of the potential benefits and risks to the medical profession and patients of LLMs (e.g., GPTs) and other AI-generated medical decision-making tools, and recommends adoption of policy to help inform patient and physician education and guide engagement with this new technology, as well as position the AMA to advocate for governance policies that help to ensure that risks arising from AI are mitigated to the greatest extent possible.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

General Governance

- Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent.
- Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
- Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan.

- Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow.
- Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

- When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
- When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
- When health care content is generated by generative AI, including by large language models, it should be clearly disclosed within the content that was generated by an AI-enabled technology.
- When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
- The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology.

What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

- When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
    - Regulatory approval status
    - Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology
    - Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use
    - Intended population and intended practice setting
    - Clear description of any limitations or risks for use, including possible disparate impact
    - Description of how impacted populations were engaged during the AI lifecycle
    - Detailed information regarding data used to train the model:
        - Data provenance

        - Data size and completeness
        - Data timeframes
        - Data diversity
        - Data labeling accuracy
    - Validation Data/Information and evidence of:
        - Clinical expert validation in intended population and practice setting and intended clinical outcomes
        - Constraint to evidence-based outcomes and mitigation of "hallucination" or other output error
        - Algorithmic validation
        - External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation
        - Comprehensiveness of data and steps taken to mitigate biased outcomes
        - Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings
        - Post-market surveillance activities aimed at ensuring continued safety, performance, and equity
    - Data Use Policy
        - Privacy
        - Security
        - Special considerations for protected populations or groups put at increased risk
    - Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training
    - Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review

- Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

Generative Augmented Intelligence

- Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
- Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    - Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response
    - Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations
    - Lack of regulatory or clinical oversight to ensure performance of the tool
    - Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes
    - Data privacy

    - Cybersecurity
    - Physician liability associated with the use of generative AI tools
- Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
- Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
- Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
- Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
- Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

Physician Liability for Use of Augmented Intelligence-Enabled Technologies

- Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
    - Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    - Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    - Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
- When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

Data Privacy and Augmented Intelligence

- Entity Responsibility:
    - Entities should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

- Individuals should have the right to opt-out, update, or forget use of their data in generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
- Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

- User Education:
  - Users should be provided with training specifically on generative AI. Education should address:
    - legal, ethical, and equity considerations;
    - risks such as data breaches and re-identification;
    - potential pitfalls of inputting sensitive and personal data; and
    - the importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

Augmented Intelligence Cybersecurity

- AI systems must have strong protections against input manipulation and malicious attacks.
- Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
- Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
- Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors

should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.

- Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
- Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws. (New HOD Policy)

Fiscal Note: Less than $500.

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[v] AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team.
vi For example, the 21st Century Cures Act includes several exemptions to FDA's oversight, such as software intended for administrative support of a health care facility, maintaining or encouraging a healthy lifestyle (and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition), is intended to be used as electronic patient records, is intended for transferring, storing, converting formats, or displaying data or results, and otherwise does not meet the definition of a medical device under the Federal Food, Drug, and Cosmetic Act.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-24

Subject: Support for Mental Health Courts

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 202 entitled, "Support for Mental Health Courts," was introduced by the Medical Student Section and called on the AMA to amend existing policy – Policy H-100.955 entitled, "Support for Drug Courts" – as follows:

> 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.

There was robust discussion of this resolution, including widespread support for increasing access to evidence-based care for individuals with a mental illness or substance use disorder (SUD) who were involved with the justice system. Multiple questions were raised, however, regarding terms of art that may be in use in legal settings compared to medical settings; the potential of unintended consequences; and the different uses of such courts. Ultimately, the HOD referred this resolution to the Board of Trustees for study. In response, this report provides background information; discusses the different courts; presents AMA policy; and makes recommendations.

BACKGROUND

There are more than 4,000 courts in the United States that provide some measure of alternative to incarceration when there is evidence of a mental illness, SUD, or other health condition impacting an individual and/or family.[1] There are at least 39 states with a diversion program that addresses substance use, and at least 24 that directly address mental health and illness needs.[2] A fact sheet from the Obama Administration noted that, "Since 1989, drug courts have been established or are being planned in all 50 States, the District of Columbia, the Northern Mariana Islands, Puerto Rico, Guam, and in nearly 90 Tribal locations."[3] The AMA has long been a supporter of these programs.[4]

These programs go by many names, including "treatment court," "adult drug court," "DWI court," "family treatment court," "juvenile treatment court," "tribal healing to wellness court," or "veterans treatment court." Other names used to describe programs that seek alternatives to incarceration are "opioid intervention court," "opiate treatment court," "heroin court," "treatment pathway

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program," "overdose avoidance and recovery program," and "heroin overdose prevention and education initiative."[5] The U.S. Department of Justice (DOJ) broadly describes these programs as "pretrial diversion programs" to which the U.S. Attorney has discretion to "divert" if there are "substance abuse or mental health challenges."[6]

Given the many different types of programs that are designed to provide mental health or SUD services as an alternative to incarceration, for the purposes of this report, any program that addresses substance use or mental health in a justice-involved or justice-related setting or program will be denoted as a "diversion program." A recent issue brief from the National Conference of State Legislatures (NCSL)[7] further explains that "Pretrial diversion programs are post-arrest interventions that occur at some point prior to final entry of judgment. Programs can take place before charges are filed, before first appearance or before adjudication."

Public health and public justice and law enforcement officials generally agree on the considerable need to treat mental illness and SUDs. Data reported by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) show much greater prevalence of mental illness and SUDs in jails and prisons compared to the general population. It is estimated that:[8]

- 18 percent of the general population has a mental illness; 44 percent of those in jail and 37 percent of those in prison have a mental illness;
- 11 percent of 18–25-year-olds, and 6 percent of those over 25 years old have a SUD; and
- 63 percent of people in jail and 58 percent in prison have a SUD.

In terms of sheer numbers, "1.2 million individuals living with mental illness sit in jail and prison each year."[9] Making matters more challenging, more than 60 percent of individuals with a history of mental illness do not receive treatment while incarcerated, and more than 50 percent of individuals receiving medication for mental health conditions stop taking them upon being incarcerated.[10] The National Institutes on Drug Abuse says that estimates for SUD prevalence in jails and prisons have been as high as 65 percent.[11]

DISCUSSION

Are Diversion Programs an Effective Method of Intervention for Individuals with Mental Illness or Substance Use Disorder Involved with the Justice System?

The first issue to address is whether diversion programs are an effective method of intervention for individuals with a mental illness or SUD involved with the justice system. If so, what elements of a diversion program demonstrate efficacy? For the purposes of this report, at least two metrics for "efficacy" can be viewed as to whether individuals receive and continue to engage in treatment, as well as whether they become re-incarcerated. While it is beyond the scope of this report to evaluate the 4,000+ programs in existence in the United States, there are innumerable examples of programs reporting that individuals enrolled in diversion programs not only start and continue treatment but are also less likely to return to jail or prison or be re-arrested. Proponents of diversion programs cite multiple economic and other benefits, including that they can connect hundreds of thousands of individuals to medications for opioid use disorder (OUD).

A sample of meta-analyses also show general positivity, but identify challenges that come with evaluating such programs:

- A 2012 meta-analysis found that adult drug courts are effective "in reducing recidivism…[and] The evidence assessing DWI courts' effectiveness is very promising but more experimental evaluations are needed. Juvenile drug courts typically produce small reductions in recidivism."[12]
- A 2013 meta-review broadly found benefits of juvenile justice diversion programs.[13]
- A 2016 review of juvenile justice programs found, "There is no evidence that juvenile drug courts are more or less effective than traditional court processing in terms of reducing juveniles' recidivism and drug use, but there is also no evidence of harm. The quality of the body of evidence is very low, however, so we have little confidence in these null findings."[14]
- A 2016 guide from the National Drug Court Institute cited multiple studies showing that, "Use of all three [MOUD] medications is associated with significantly reduced use of unauthorized opioids among probationers, parolees, and other persons with opioid use disorders involved in the criminal justice system."[15]
- A 2017 review of mental health courts (MHC) found that, "Overall, a small effect of MHC participation on recidivism was noted, compared with traditional criminal processing. Findings suggest the need for research to identify additional sources of variability in the effectiveness of MHCs."[16]
- A 2019 systematic review of drug courts found that, "Treatment accessed via community-based diversion is effective at reducing drug use in Class A drug-using offenders. Evidence of a reduction in offending amongst this group as a result of diversion is uncertain. Poor methodological quality and data largely limited to US methamphetamine users limits available evidence."[17]
- A 2020 literature review of mental health courts found that, while research generally supports MHCs' positive effects to reduce recidivism, there are inconsistencies with overall study designs, data collection, lack of adequate controls and other methodological faults.[18]
- Another 2020 meta-analysis found that, "diversion programs for low-level drug offenders are likely to be cost-effective, generating savings in the criminal justice system while only moderately increasing healthcare costs. Such programs can reduce incarceration and its associated costs and avert overdose deaths and improve quality of life for PWID [people who inject drugs], PWUD [people who use drugs], and the broader population (through reduced HIV and HCV transmission)."[19]

Considering individual programs reporting broad benefits[20] and meta-analyses showing benefits as well as raising questions about how broad those benefits might be, it seems prudent to call for additional research as well as mechanisms to identify best practices. For example, some programs to treat OUD might prohibit use of medications for opioid use disorder (MOUD) or rely on non-evidence-based approaches. The Board of Trustees notes, however, that what works in one jurisdiction may not work in another—and given the evidence that points to the overall benefits and lack of harm, we believe that the AMA should continue to support these programs. To guide programs, we highlight that professional medical organizations have published multiple guidelines and treatment considerations for diversion programs and care for individuals involved with the justice system, including the American Society of Addiction Medicine,[21] American Psychiatric Association,[22] and Providers Clinical Support System.[23]

There are many potential elements of "a comprehensive system of community-based supports and services." This includes benefits provided by "wraparound services," such as community-based interagency cooperation, care coordination, child and/or family teams, unified plans of care, evidence-based systems of care, and other areas.[24] Additional guidance can be found in recent

SAMHSA grants for diversion programs in three jurisdictions.[25] These grants identify multiple types of services that may be useful in a diversion program, including motivational interviewing; crisis intervention training; psychiatric/psychosocial rehabilitation; dialectical behavior therapy; community-based treatment; case management; comprehensive psychiatric services, including psychotherapy and supportive counseling; substance use and detoxification treatment; housing and employment support, including skills training; screening, assessment, referral, and treatment to individuals at risk of entering the criminal justice system; and links between individuals and other community resources. While not all diversion programs will have all these elements, the Board of Trustees believes that the AMA should support development of diversion programs that include broad-based community support that include these types of resources.

Should Diversion Programs be Available to Both Nonviolent and Violent Offenders?

The second issue is whether diversion programs should be available to both nonviolent and violent offenders. It is first important to distinguish that *access to a diversion program* is related to—but different from than *access to evidence-based treatment* for a mental illness or SUD within the justice system. In 2022, the DOJ issued guidance making it clear that the Americans with Disabilities Act (ADA) protects individuals with an OUD to continue treatment for an OUD while incarcerated, including protecting continuity of care with MOUD.[26] The AMA has advocated in multiple legal, legislative, and other forums that individuals involved with the justice system have a medical—and constitutional right—to continue OUD while incarcerated. This advocacy is highlighted in seminal cases: *Smith v. Aroostook County*[27] and *Pesce v. Coppinger.*[28] By extension, an individual also likely has statutory and constitutional rights to MOUD—or other evidence-based care—in a diversion program, but as the DOJ points out, there may be nuances if "the individual is currently engaged in illegal drug use."[29] The National Institute on Drug Abuse (NIDA) explains that:

> The chronic nature of addiction means that for some people relapse, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse.[30]

The Board of Trustees believes that AMA support for individuals being able to stay in treatment even if they engaged in illegal drug use is a natural extension of existing AMA policy to not punish people because they have a SUD.

With respect to whether diversion programs should be available to non-violent and violent offenders, given the evidence showing benefits of these programs—even if limited in some cases—the AMA should continue to support access to evidence-based care, including MOUD, for non-violent offenders. Notably, no change in policy is needed to meet this result. Whether to support and advocate for diversion programs to be available to individuals charged or convicted of violent offenses, however, raises multiple issues.

The first issue is whether those charged or convicted of a violent offense are legally eligible for a diversion program. The U.S. Government Accountability Office (GAO) reports that, "adult drug courts funded by DOJ grants are prohibited by law from using grant funding to include individuals with prior or current violent offenses in their programs."[31] The GAO pointed out, however, that, "a few adult drug courts told us that they admit violent offenders, by ensuring that they do not use federal funding to serve these clients." The GAO, which interviewed representatives from 44 adult drug courts from a mix of rural, suburban, urban, and tribal adult drug courts, highlighted that some

violent offenders and those convicted of drug-related crimes would benefit from drug court services. State law also commonly excludes individuals charged or convicted of a violent offense—or having been convicted within a certain time period in the past.

The National Association of Drug Court Professionals counsels that, "Evidence does not support blanket disqualification from treatment court for persons with a history of violent crimes. Instead, persons charged with offenses involving violence, or who have a history of such offenses, should be evaluated on a case-by-case basis to determine if they can be safely supervised in treatment court."[32] The Board of Trustees agrees. Just as AMA policy does not discriminate against an individual's right to receive treatment based on external factors, the AMA should not discriminate against access to evidence-based care for SUD and mental illness based on carceral status or judicial supervision. As noted above, the provision of evidence-based care for mental illness and SUDs has strong constitutional protections. And as discussed below, current AMA policy strongly supports evidence-based care for individuals with a mental illness or SUD in jails and prisons.

Saying that the AMA should not oppose participation in a diversion program does not mean, however, that there should not be comprehensive considerations about which individuals would benefit most from participation in a diversion program. Such considerations, moreover, should include whether an individual's participation constitutes a threat to public safety. Thankfully, there are robust eligibility criteria to help judicial and health care professionals make those determinations. This guidance can help ensure "equitable access, services, and outcomes for all sociodemographic and sociocultural groups," including "guidance for treatment courts to monitor and rectify unwarranted cultural disparities."[33] The eligibility guidance, moreover, can help diversion programs remove inappropriate restrictions and exclusions, ensure evidence-based care, connect individuals to complementary services, as well as avoid conflicts of interest. And just as important, the Board of Trustees agrees that:

> All persons meeting evidence-based eligibility criteria for treatment court receive the same opportunity to participate and succeed in the program regardless of their sociodemographic characteristics or sociocultural identity, including but not limited to their race, ethnicity, sex, gender identity, sexual orientation, age, socioeconomic status, national origin, native language, religion, cultural practices, and physical, medical, or other conditions.[34]

AMA POLICY

A bedrock of AMA advocacy is found in Policy H-430-987, "Medications for Opioid Use Disorder in Correctional Facilities," which provides, "Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated." This policy also calls for the AMA to advocate for

> . . . legislation, standards, policies, and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

The Board of Trustees recommends that diversion programs be held to the same standards.

The AMA also supports "veterans courts" as "a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder." (Policy H-510-979, "Support for Veterans Courts"). If AMA policy supports broad access to veterans' courts as a matter of policy, the Board of Trustees does not see any reason why such policy should not also apply to other types of diversion programs. Similarly, AMA policy calling to support "justice reinvestment initiatives … and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs," does not distinguish between nonviolent and violent offenses. (Policy H-94-931, "AMA Support for Justice Reinvestment Initiatives").

Finally, AMA Ethics Policy recognizes that, "Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law." (Policy E-9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"). This policy also counsels for physicians to, "Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered." (Policy E-9.7.2, "Court-Initiated Medical Treatment in Criminal Cases"). Thus, while the justice system may have guidance about which individuals are eligible for a diversion program, the physician's role is not to raise barriers to such care.

RECOMMENDATIONS

The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, "Support for Drug Courts" – be amended by addition and deletion in lieu of Resolution 202 as follows:

> Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs
>
> Our AMA:
>
> (1) supports the establishment and use of diversion and treatment programs ~~drug courts~~, including drug courts, mental health courts, veterans courts, sobriety courts, and other types of similar programs, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with a mental illness or substance use disorder involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~;
> (2) encourages legislators and court systems to establish diversion and treatment programs ~~drug courts~~ at the state and local level in the United States; ~~and~~
> (3) encourages diversion and treatment programs ~~drug courts~~ to rely upon evidence-based models of care, including medications for opioid use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and
> (4) supports individuals enrolled in diversion or treatment programs not be removed from a program solely because of evidence showing that an individual used illegal drugs while enrolled. (Modify HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-24

Subject: Drug Policy Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 203 entitled, "Drug Policy Reform," was introduced by the Medical Student Section and called on the AMA to:

- 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;
- 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; and
- Support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession.

Ultimately, Resolution 203 was referred to the Board of Trustees for study. Some of the primary reasons for referral included the need for more background information on criminal penalties for drug possession; the need to review the role of expungement for those convicted of drug-related crimes for drug possession; and the need to identify the AMA's unique role concerning other issues relating to drug possession. This report also provides background information; discusses relevant policy and public health considerations; presents AMA policy; and makes recommendations.

BACKGROUND

The National Center for Drug Abuse Statistics (NCDAS) reports that, "1.16 million Americans are arrested annually for drug related offenses" and that, "227,655 Americans are arrested annually for the possession of heroin, cocaine, and derivative products." At the same time, NCDAS reports that, "40,446 Americans are arrested annually for the possession of synthetic drugs."[1] A 2022 report from the Pew Charitable Trusts found that between 2009-2019, "87 percent [of] drug arrests were for possession; the rest were for sale or manufacturing."[2] In the federal prison system, more than 44 percent of individuals were incarcerated because of a drug-related offense.[3]

Incarceration rates for drug-related offenses, however, are decreasing. While the figures vary by state, between 2009-2019, "The prison population in the 39 states with available data dropped by approximately 117,000 individuals from 2009 to 2019. The decrease in the number of people in prison for drug offenses accounted for 61% of this total decline. Similarly, prison admissions fell by more than 131,000 from 2009 to 2019, with the drop in drug-related admissions accounting for 38 percent of the total."[4]
There are significant racial disparities for those incarcerated for a drug-related offense. While use and dependence rates between groups only vary by 1-2 percent, Black people are far more likely to be arrested

and incarcerated.[5] These disparities have existed for decades,[6] and they unfortunately continue. Research from 2000 showed that Black individuals made up more than 60 percent of those sent to state prisons for a drug-related offense[7]. The same study reported that, "Nationwide, black men are sent to state prison on drug charges at 13 times the rate of white men." More recent data show that, "prison admissions for Black individuals for drug offenses decreased by 59 percent between 2009 and 2019, accounting for a quarter (26 percent) of the total drop in admissions over that span."[8] Despite these decreases, disparities remain. According to the Pew Charitable Trusts, "Black people made up 28 percent of admissions and 36 percent of the population in prison for drug convictions in 2019, which are two and three times, respectively, their share of the general population."

The data also show differences in the prison population when race and gender are both considered. Between 2009-2019, there was a "4 percent increase in admissions of White individuals for drug offenses…[and] a 32 percent increase in the number of White females entering prison with drug convictions. By comparison, admissions for drug offenses fell 71 percent for Black females and 4 percent for White males."[9]

Regarding youth-related drug offenses, between 2011-2020, there were an estimated 42,280 juvenile arrests.[10] Juvenile arrests for drug offenses decreased 72 percent between 2016-2020.[11] According to the U.S. Office of Juvenile Justice and Delinquency Prevention, "the peak year for juvenile drug abuse violation arrest rates was 1997 … [and] overall from 1980 to 2020, the drug abuse violation arrest rate for youth ages 15-17 decreased 64 percent , compared with a 21 percent decrease for young adults ages 18-20 and a 7 percent increase for young adults ages 21-24."[12]

Civil Infractions, Misdemeanors, and Felonies

It is beyond the scope of this report to go into extensive detail about the wide variability and extensive nuances in federal or state criminal codes concerning drug possession.[13] A brief overview, however, may be useful to underscore that the AMA's unique role for this report is to focus on public health rather than criminal law.

In general, a misdemeanor means any crime that does not amount to a felony.[14] Misdemeanors generally are those criminal offenses that carry punishments by incarceration of a year or less.[15] A felony typically denotes a crime more serious than a misdemeanor that subjects an individual to incarceration.[16] Punishments for a felony typically are incarceration for periods of one year or more.[17] An "infraction" can have different meanings depending on the state, but it generally refers to a criminal act that is less serious and carries less severe penalties than a misdemeanor, such a speeding ticket or parking meter violation.[18] Criminal codes also distinguish "simple possession"[19] from possession with intent to sell or distribute.[20]

To prove a statutory crime, it is required to show both that an individual committed a criminal act, and in so doing, acted with the state of mind requisite to constitute the crime in question.[21] For simple drug possession, the prosecutor must prove, generally, that the illicit substance was knowingly and/or intentionally in the accused individual's possession. Simple possession crimes differ from those with intent to sell, manufacture or deliver in that simple possession typically is limited to personal use or control whereas the crime of possession with intent to sell, manufacture or deliver requires proving both possession/control of an illicit substance and that the individual had the intent to sell, manufacture or deliver the substance. To prove intent to sell, manufacture or deliver, additional facts would be required, which could come from undercover law enforcement or other witness testimony, exchange of money, possession of manufacturing equipment, video surveillance, customer lists or other factual elements that show more than just an intent limited to personal use or control.
There are a limited number of states that have decriminalized certain drug-related offenses. In 2020, Oregon voters passed Ballot Measure 110, which among other things, effectively decriminalized possession of certain amounts of Schedule I Controlled Substances, including cocaine, heroin, psilocybin,

and methamphetamine. Possession of amounts greater than the law authorized, as well as possession for non-prescribed Schedule II-IV Controlled Substances, would subject an individual to a "Class E" violation. Violators would be subject to a fine or agree to undertake a screening in lieu of a fine.[22] Since the measure went into effect, more than 7,600 individuals have received a Class E violation with methamphetamine (55 percent) and Schedule II Controlled Substances (26 percent) the top reasons for violations.[23] In response to multiple factors, including considerable public concern about reported increases in public drug use, mortality and crime, the Oregon Legislature effectively ended decriminalization of illegal drugs for personal use with passage of House Bill 4002, which the governor said she will sign.[24] HB 4002 passed with wide, bipartisan margins in both the Oregon House and Senate.[25]

Additional state actions have occurred regarding psychedelics and other substances. For example, legislative efforts surrounding Schedule I psychedelics are increasing. More than two dozen states have considered or enacted measures to further study psychedelics, regulate their use, and establish pilot treatment programs. For example, certain psychedelics were decriminalized in Washington, D.C. in 2021[26] and Colorado in 2022.[27] In 2021, drug possession was decriminalized in Washington state as a result of a state supreme court decision in *State v. Blake*, which found the state's drug possession statute unconstitutional because it lacked an intent requirement.[28] The Washington Legislature re-criminalized drug possession (as a misdemeanor) several months later in a special session.[29] The Washington law also included provisions for diversion programs as an alternative to incarceration. The 2024 state legislative sessions are actively considering many similar proposals.[30]

Expungement

The Board of Trustees explained in Board of Trustees Report 17-A-22 that it is important to recognize that expungement, destruction, and sealing are legal processes.[31] An expungement process may involve multiple steps where the result is to remove a record of arrest and/or conviction from the official state or federal record. The idea is that post-expungement, the record never existed. While an expungement may "erase" a record, "sealing" hides the record from public view. More specifically, when "sealed," the record can be accessed under certain circumstances.[32] Finally, "destruction" of a record generally means to physically destroy it. When a record is "destroyed," there is no record remaining whatsoever.[33] It is important to note that specific definitions may vary by state.

Under federal law, the record of a conviction for drug possession may be able to be expunged depending on the circumstances. An individual must qualify for expungement and undertake the process to formally seek expungement. There are different requirements for those 21 years of age and older and those younger than 21. The record of the underlying expungement also offers protection against future adverse use, but it is retained by the U.S. Department of Justice.[34]

At the state level, eligibility, and procedures for expungement of drug possession crimes vary considerably[35]. State laws often are non-specific to controlled substances. In other words, eligibility and procedures would be dependent on multiple factors, including whether a drug possession crime was a misdemeanor or felony, and whether there were additional circumstances, including whether there were other crimes committed and whether they were violent or nonviolent. Other states have waiting periods after a sentence has been served, but these also are dependent on other factors that may be present, including whether the drug possession crime was a first offense. States typically have different processes and qualifications for minors.[36] In contrast, 24 states have specific procedures when the state has decriminalized cannabis for medical and/or adult use.[37]

DISCUSSION

Reclassification of Drug Possession Offenses as Civil Infractions

Proponents of decriminalizing drug possession cite multiple potential benefits, including saving money from incarceration, focusing resources on treatment and social services, and other benefits such as reducing the stigma surrounding drug use and having a substance use disorder.[38] Being incarcerated does not often lead to treatment for a substance use disorder. The Pew Charitable Trusts reported data showing that "1.1 million people with past-year illicit drug dependence or misuse reported being arrested and booked in the past year…[but] 1 in 13—85,199—reported receiving drug treatment while in jail or prison. Further, the drug- or alcohol-related mortality rate in jails increased from 9 in 100,000 in 2009 to 26 in 100,000 in 2019."[39] Proponents also point to collateral consequences of having a criminal record for drug possession, including denial of public benefits, losing custody of children, loss of voting rights, inability to secure loans or financial aid, to name a few negative effects.[40] A meta-analysis of drug decriminalization policies in 2020 focused on "evaluating effects of drug decriminalization or legal regulation on drug availability, use or related health and social harms globally."[41] The analysis concluded there was "a need for a broadening of the metrics used to assess the impacts of drug decriminalization and legal regulation."

Except for cannabis, there are few tangible examples in the United States on which to evaluate the potential public health and collateral benefits of reclassifying drug possession offenses as civil infractions. The Board of Trustees notes that our AMA Council on Science and Public Health has issued two previous reports detailing the continued public health dangers associated with cannabis. Oregon, Colorado, and Washington, D.C. are the only states to specifically decriminalize illicit substances, while multiple others have enacted measures to direct law enforcement to treat possession of, for example, certain psychedelics, as a "low priority."[42] In Oregon, the language of Ballot Measure 110 based part of its argument on the premise that, "People suffering from addiction are more effectively treated with health care services than with criminal punishments. A health care approach includes a health assessment to figure out the needs of people who are suffering from addiction, and it includes connecting them to the services they need." The reality of Ballot Measure 110's effects, however, demonstrate widespread challenges with connecting individuals to screening, treatment, or recovery.

Three main studies of the effects of Oregon Ballot Measure 110 show that it generally failed to reduce overdose-related fatality, and that it did not connect individuals to screening, treatment, or recovery. One study found that Ballot Measure 110 "caused 182 additional unintentional drug overdose deaths to occur in Oregon in 2021. This represents a 23 percent increase over the number of unintentional drug overdose deaths predicted if Oregon had not decriminalized drugs."[43] A separate study, however, found that there was no significant change in death rates.[44] Perhaps most concerning is that Ballot Measure 110's promise of increased connections to treatment and increased access to evidence-based care has not been realized. A state audit of Ballot Measure 110 discussed the widespread hopes for the ballot measure to improve access to care for substance use disorders, reduce health inequities, and other laudable goals. The reality, unfortunately, has been hampered by widespread challenges, including inefficient "program governance," "silos and fragmentation in the delivery of mental health and substance use disorder treatment," poor "stakeholder collaboration," poor data collection and reporting structures, and a lack of coordination between public health, public safety, and other agencies.[45]

The Board of Trustees understands that the original intent of Oregon Ballot Measure 110 included an effort to increase access to treatment, but there is a clear lack of evidence demonstrating public health benefits or increases in access to evidence-based mental health or substance use disorder services in the state. The available research, furthermore, does not clearly demonstrate tangible benefits on a wider scale. The Board of Trustees observes that drug-related overdoses in Oregon have increased from 1,147 deaths reported for the 12-month period between October 2020 and October 2021 to 1,683 deaths reported for

the 12-month period between October 2022 and October 2023.[46] The Board of Trustees believes that it is premature to recommend decriminalizing drug possession offenses as a public health benefit in the absence of evidence demonstrating public health benefits.

Expungement of Criminal Records for Drug Possession upon Completion of a Sentence

As noted above, there are ongoing collateral consequences experienced by individuals convicted of drug possession (or other) crimes. The Board of Trustees emphasized these consequences as part of Board of Trustees Report 17-A-22, "Expungement, Destruction, And Sealing Of Criminal Records For Legal Offenses Related To Cannabis Use Or Possession." That report recommended support for expungement of cannabis-related offenses when those offenses were no longer illegal (because of newly enacted state laws). As the Board stated in BOT Report 17-A-22,

> Even if a record is expunged or sealed, however, that may not address collateral consequences of the arrest or conviction, e.g., potential professional licensing sanctions, adverse employment actions, and qualification for government benefits, including loans and housing. These collateral consequences can also suppress the local tax base by locking people into unemployment or lower paying jobs and increase taxpayer costs due to increasing likelihood of further involvement in the criminal legal system.[47]

The Board of Trustees supports reducing barriers to address these social determinants of health, including supporting federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty. Given that individuals released from jail or prison may have limited financial means, we also support that the expungement process consider an individual's financial hardship.

Incarceration-based Penalties for Persons under Parole, Probation, Pre-trial, or other Criminal Supervision for Drug Possession.

As with different state laws and policies concerning what constitutes a drug possession felony or misdemeanor, there is likely even greater state variation in what constitutes a violation of parole, probation, pre-trial, or other supervisory agreement with an individual charged or convicted of drug possession. While drug possession while on parole might trigger an automatic revocation in some jurisdictions, in others there would be discretion. This is why some commentators argue for the "need to critically examine the revocation process for probationers and parolees who transgress the terms and conditions of their community supervision."[48] Other commentators cite drug use or drug possession as a common reason for parole, probation or other supervisory violations.[49] The Board of Trustees notes that AMA advocacy and policy focus primarily on helping ensure individuals involved with the justice system have access to evidence-based care. We certainly encourage discretion by court officers but do not believe that the AMA has the unique expertise or experience to make categorical determinations about judicial discretion.

Your Board – in a separate board report under consideration at this meeting, Board of Trustees Report 16 – explains why diversion programs should not automatically exclude individuals because they may have previously used illicit substances. Similarly, we argue that individuals should not be removed from a diversion program solely because they used an illicit substance. The National Institute of Drug Abuse explains that "The chronic nature of addiction means that for some people relapse, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse."[50] AMA support for individuals being able to continue parole or probation even if they engaged in illegal drug use is a natural extension of AMA policy to not punish people because they have a substance use disorder.

AMA POLICY

AMA policy includes "support [for] legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes." (Policy H-80-993, "Ending Money Bail to Decrease Burden on Lower Income Communities"). AMA policy also supports a broad range of elements for individuals who are incarcerated, including, "…(a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing." (Policy H-430-986, "Health Care While Incarcerated"). Whether these elements could be achieved through decriminalization of drug possession crimes is not clear, however, which is why your Board supports additional research to inform future decision making.

AMA policy also supports "automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis." (Policy H-95.910, "Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession"). AMA's cannabis-related expungement policy also extends to protections for minors and for "ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis." (Policy H-430.986, "Health Care While Incarcerated"). Finally, AMA policy also calls for "fairness in the expungement and sealing of records." (Policy H-60.916, "Youth Incarceration in Adult Facilities"). These policies highlight issues of fairness with respect to expungement as well as support for the principle that drug use or possession—by itself—should not be a cause for additional criminal penalty.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 203 and the remainder of the report be filed:

1. That the American Medical Association (AMA) will continue to monitor the legal and public health effects of state and federal policies to reclassify criminal offenses for drug possession for personal use; (New HOD Policy)
2. That the AMA will support federal and state efforts to expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; (New HOD Policy) and
3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-24

Subject: Supporting Harm Reduction

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the June 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD), Resolution 204 entitled, "Supporting Harm Reduction," was introduced by the Medical Student Section and called on the AMA to:

- Advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic;
- Support any efforts to decriminalize the possession of non-prescribed buprenorphine; and
- Amend the 4th and 6th resolves of Policy D-95.987 by addition and deletion to read as follows:

> 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.
>
> 6. Our AMA will advocate for ~~supports efforts to~~ increased access to and decriminalization of fentanyl test strip, ~~and~~ other drug checking supplies, and safer smoking kits for purposes of harm reduction.

The HOD discussed the strong evidence base supporting buprenorphine as a treatment for opioid use disorder (OUD), the uncertainty surrounding the facts of buprenorphine "diversion," and the significant concerns about the meaning and practice of "safer smoking." Ultimately, the HOD referred the resolution to the Board of Trustees for study. In response, this board report provides background information; discusses the different issues raised by the resolution; presents AMA policy; and makes policy recommendations.

BACKGROUND

Buprenorphine

Buprenorphine is a Schedule III Controlled Substance that the U.S. Drug Enforcement Administration (DEA) defines as a narcotic for purposes of drug scheduling.[1] The U.S. Food and Drug Administration (FDA) first approved buprenorphine-containing products in 2002 for the treatment of OUD.

Buprenorphine for OUD may be prescribed as a "mono-product," and some manufacturers combine it with naloxone ("combination product") to treat OUD. It may be available as a tablet, sublingual film, transdermal film, or injection.

There is widespread evidence that supports buprenorphine as an evidence-based medication to treat OUD.[2] Researchers and clinicians commonly promote statements such as, "opioid agonist therapy (OAT) with methadone or buprenorphine is the gold-standard treatment for OUD."[3] The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) provides multiple resources about buprenorphine, including clinical and safety information, treating pregnant and postpartum individuals, potential for misuse, and safety considerations.[4] Because of its evidence-base, AMA advocacy has for years called for removing all barriers to buprenorphine for the treatment of OUD—including prior authorization reforms,[5] the x-waiver,[6] telehealth restrictions,[7] and dosage caps.[8]

While prescriptions dispensed for medications to treat opioid use disorder (MOUD) have marginally increased in the past five years from 14.54 million to 16.05 million,[9] there remain millions of Americans who misuse illicit substances, prescription opioids and/or have untreated substance use disorder.[10] More than 78 million illicit fentanyl-containing pills and 12,000 pounds of fentanyl powder were seized by the U.S. Drug Enforcement Administration (DEA) in 2023.[11] The U.S. Centers for Disease Control and Prevention (CDC) advise that, "Powdered fentanyl looks just like many other drugs. It is commonly mixed with drugs like heroin, cocaine, and methamphetamine and made into pills that are made to resemble other prescription opioids."[12]

"Safer Smoking"

As a threshold matter, and discussed briefly below, the AMA does not support the concept of "safer smoking." The issue of "safer smoking" in relation to the nation's drug-related overdose and death epidemic, however, is a harm reduction concept that seeks to reduce the spread of infectious disease as well as support changes to injection drug use. The types of safer smoking supplies are often, "specific for each type of drug used, but generally includes a heat resistant pipe or foil, protective mouthpiece, tamp, screen, and lip protectant, all of which reduce heat-related injuries and infection risk."[13] In addition to reducing injection drug use, proponents of safer smoking supplies also point to, "Smoking supplies distributed by harm reduction programs [that] are clean and safer than improvised items like aluminum cans, plastic tubes, steel wool, and light bulbs that can break easily or release toxic fumes."[14] These supplies are typically considered illicit drug paraphernalia, and "Nearly all states penalize the possession and distribution of glass pipes and other devices used for smoking or inhaling illegal drugs."[15]

In addition to state law prohibitions against safer smoking supplies, federal law defines a wide variety of materials as illegal drug paraphernalia, including,

> (1) metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls; (2) water pipes; (3) carburetion tubes and devices; (4) smoking and carburetion masks; (5) roach clips: meaning objects used to hold burning material, such as a marihuana cigarette, that has become too small or too short to be held in the hand; (6) miniature spoons with level capacities of one-tenth cubic centimeter or less; (7) chamber pipes; (8) carburetor pipes; (9) electric pipes; (10) air-driven pipes; (11) chillums; (12) bongs; (13) ice pipes or chillers; (14) wired cigarette papers; or (15) cocaine freebase kits.[16]

Every state—except Alaska—has a drug paraphernalia law.[17] While state laws vary considerably, one distinction is that needles and syringes may still be considered drug paraphernalia, but they are allowed

for personal use in most states. Penalties for individuals convicted of possession or use of other drug paraphernalia can range from misdemeanors to felonies.[18]

DISCUSSION

Decriminalization of Non-prescribed Possession and Use of Buprenorphine

While penalties vary, possession of non-prescribed buprenorphine—like other non-prescribed controlled substances—is generally considered a violation of state and/or federal law and can subject an individual to monetary penalties and/or imprisonment depending on the circumstances.[19] One of the key questions for this board report, however, is whether the benefits of using non-prescribed buprenorphine in certain circumstances outweigh the risks. The National Institute on Drug Abuse (NIDA) reports that, "most data suggest that the majority of buprenorphine and methadone misuse (use without a prescription) is for the purpose of controlling withdrawal and cravings for other opioids and not to get high."[20] NIDA also points out low rates of diversion risk, illicit use, and emergency department visits related to buprenorphine. Research comparing buprenorphine-involved deaths compared to opioid-involved deaths during the COVID-19 pandemic found that, "actions to facilitate access to buprenorphine-based treatment for opioid use disorder during the COVID-19 pandemic were not associated with an increased proportion of overdose deaths involving buprenorphine; efforts are needed to expand more equitable and culturally competent access to and provision of buprenorphine-based treatment."[21] The AMA has argued that individuals' lack of access to buprenorphine is due to multiple factors, including stigma, and inadequate networks of addiction medicine physicians, psychiatrists, primary care and other physicians willing to prescribe buprenorphine. Access to buprenorphine is particularly problematic for racial and ethnic minorities.[22] The AMA and the AMA Substance Use and Pain Care Task Force has long urged that all efforts be taken to increase access to buprenorphine and other medications for opioid use disorder (MOUD). Decriminalization, however, is an issue of first impression for the AMA.

Decriminalization of possession of non-prescribed buprenorphine for personal use already is occurring in the United States. Vermont became the first state in 2021 to specifically decriminalize possession of 224 milligrams of non-prescribed buprenorphine for personal use.[23] Initially enacted as a two-year pilot, after positive reviews that the bill helped increase access to buprenorphine among people who use drugs (PWUD) and also increase access to other forms of treatment, the Vermont Legislature made the exemption permanent in 2023.[24] Rhode Island also decriminalized buprenorphine in 2021 by amending its criminal code.[25] Another state example is when Oregon, in 2020, effectively decriminalized a wide range of drugs for personal use, including Schedule III Controlled Substances.[26] It is not clear whether this has increased access to buprenorphine in Oregon, but a report from the Oregon Judicial Department did not cite "buprenorphine" for any of the new "Class E" violations.[27]

Multiple studies have found the mortality risk of buprenorphine is low. This includes retrospective mortality reviews showing how buprenorphine-involved mortality was commonly part of polysubstance use.[28] In a study of Medicare beneficiaries, "Buprenorphine treatment after nonfatal opioid-involved overdose was associated with a 62% reduction in the risk of opioid-involved overdose death."[29] A review of COVID-19-era opioid-involved overdose deaths found that "buprenorphine was involved in 2.6 percent of opioid-involved overdose deaths during July 2019 to June 2021"—a rate that "did not increase" even as rates of overdose overall increased.[30] Commentators suggest that while there are some risks to using non-prescribed buprenorphine, there are many benefits, including overcoming barriers that, "extend across socioeconomic, bureaucratic, and stigmatizing lines and include unemployment, insurance status, buprenorphine waiting lists, and most importantly, knowledge and physical access to providers who can and want to prescribe buprenorphine."[31] The Board of Trustees acknowledges that use of nonprescribed buprenorphine carries risks, but views the available evidence as mitigating in support of

doing all that is necessary to reduce health inequities and save lives from an opioid-related overdose, including decriminalizing the personal possession and use of nonprescribed buprenorphine.

"Safer Smoking" as a Harm Reduction Measure

The AMA has supported a broad range of what are generally considered "harm reduction" measures. This includes support for laws and other policies encouraging prescribing, distribution, and use of naloxone and other opioid-overdose reversal agents. The AMA also supports broad Good Samaritan protections to provide civil and criminal protections for individuals at the scene of an overdose event. The AMA further supports the same protections for individuals who overdose. AMA policy also supports harm reduction centers (also called overdose prevention sites), as well as the ability for syringe services programs (SSPs) to provide sterile needles and syringes to help stem the spread of blood borne infectious disease. While there will always be detractors and stigma, these harm reduction measures have been well-studied and have been shown to help reduce mortality and improve health outcomes. It is beyond the scope of this report to detail all the research for these measures, but it is important to highlight that each (to different degrees) has largely overcome stigma in the medical community. The Board of Trustees acknowledges that sigma remains a considerable barrier for SSPs and harm reduction centers.

Injection drug use continues to be a major public health issue. A Centers for Disease Control and Prevention (CDC) study found that nearly 3.7 million people in the United States injected drugs in 2018—a 5-fold increase from 2011.[32] The study also found that more than 42 percent of overdose deaths were from injections. Another CDC report found that, "During 2013–2017, reported methamphetamine, injection drug, and heroin use increased substantially among women and heterosexual men with [primary and secondary] syphilis."[33] Injection drug use may also result in the spread of skin and groin infections, Hepatitis C, bacterial endocarditis, osteomyelitis, and other preventable health conditions.[34] Prevention of the spread of blood-borne infectious disease is one of many reasons the AMA strongly supports broad access to sterile needle and SSPs.

AMA support for SSPs, however, has been based on the strong evidence-base for SSPs. We raise the question, therefore, whether the evidence supports increased use of safer smoking supplies (as defined above), including decriminalization of such supplies. A 2023 descriptive review of 550 PWUDs found that there was limited access but high interest in obtaining safer smoking supplies for heroin, crack cocaine, and methamphetamine.[35] The authors were clear about the study limitations but highlighted other research suggesting that obtaining safer smoking supplies could reduce injection drug use. A recently published meta-review of global practices reported that, "Ten studies found that when people who use drugs were provided with safer smoking materials, they engaged in fewer risky drug use behaviors (e.g., pipe sharing, using broken pipes) and showed improved health outcomes."[36] The authors concluded that, "safer smoking practices are essential forms of harm reduction," but that "Additional research is also needed to evaluate the efficacy of and access to safer smoking services, particularly in the U.S. and other similar countries, where such practices are being implemented but have not been empirically studied in the literature." We agree that more research is necessary.

It is also important to emphasize that additional research into the potential benefits of any harm reduction measure in no way condones or supports the use of illicit drugs or other substances whether through injection, inhalation, or other routes of administration. The Board of Trustees notes that while reductions in injection drug use should be considered positive, it is deeply concerning that it may be accompanied by increases in smoking illicit fentanyl.[37] We agree with comments from addiction psychiatrists such as, "I do not know that we are at a place where we can say, 'Hey, maybe you should smoke it instead,'" and "It would be hard for me to feel confident in recommending that to somebody."[38] Further, it must be stressed that there is no such thing as "safer smoking" of fentanyl, cannabis, tobacco or illicit substances, and also stressed that smoking fentanyl carries significant risks, including overdose and death.[39] Similarly, the

Board of Trustees believes that while there may be some evidence showing reduced harms associated with smoking fentanyl and certain safer smoking supplies as compared to injection use, there is a clear need for much more research before the AMA spends it resources and puts its public health and science credibility on the line.

Decriminalization of Fentanyl Test Strips

This resolution also calls for the AMA to support the decriminalization of fentanyl test strips. It is critical to note that this ask is redundant as AMA policy already effectively accomplishes this. Specifically, our policy states that, "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." (Policy D-95.987, "Prevention of Drug-Related Overdose") The AMA has advocated for this at the state and federal levels[40] and encourages all medical societies to support legislation to implement this important policy. In this regard, we appreciate the opportunity to highlight AMA advocacy and conclude that existing policy (and subsequent advocacy measures) already meet the intent and purpose of the resolution.

AMA POLICY

Extending AMA policy to support decriminalization of non-prescribed buprenorphine for personal use would become part of a broad and growing policy base supporting increased access to buprenorphine and other MOUD. Policies in this family include:

- Policy H-420.970, "Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy;"
- Policy H-95.956, "Harm Reduction Through Addiction Treatment;"
- Policy H-430.987, "Medications for Opioid Use Disorder in Correctional Facilities;"
- Policy H-290.962, "Medicaid Substance Use Disorder Coverage;"
- Policy H-320.941, "Eliminate Fail First Policy in Addiction Treatment;"
- Policy H-95.944, "Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy;"
- Policy D-95.955, "Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD);" and
- Policy D-95.972, "Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder."

It bears repeating that the Board of Trustees strongly supports the provision of MOUD to occur within a medically supervised and physician-led environment. We also recognize that given the innumerable barriers to such care, combined with the clear benefits of increasing access to buprenorphine, calling for decriminalization of non-prescribed buprenorphine for personal use is necessary to help reduce harms, including overdose and death.

AMA policy already supports efforts to increase access to a broad range of harm reduction initiatives:

> 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. (Policy D-95.987, "Prevention of Drug-Related Overdose")

It is reasonable to conclude, therefore, that this policy helps inform AMA support for SSPs, public

availability of sharps disposal units, and other areas. For example, AMA support for SSPs can be found here:

> . . . encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. strongly supports the ability of physicians to prescribe syringes and needles to patients who inject drugs in conjunction with addiction counseling to help prevent the transmission of contagious diseases. (Policy H-95.954, "The Reduction of Medical and Public Health Consequences of Drug Use")

Finally, as discussed above, the evidence base for SSPs has been demonstrated. In contrast, the evidence base in support of safer smoking supplies has not. The Board, therefore, urges increased research as it relates to the latter.

RECOMMENDATIONS

The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204, and that the remainder of the report be filed.

1. That the American Medical Association (AMA) support efforts to decriminalize the possession of non-prescribed buprenorphine <u>for personal use by</u> individuals who lack access to a physician for the treatment of opioid use disorder; (New HOD Policy)
2. <u>That the AMA oppose the concept, promotion, or practice of "safe smoking" with respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)</u>
3. That the AMA encourage additional study <u>whether</u> "safer smoking supplies" <u>may be a</u> potential harm reduction measure to reduce harms from the nation's overdose and death epidemic; and (New HOD Policy)
4. <u>That the AMA reaffirm Policy D-95.987, "Prevention of Drug-Related Overdose."</u> (Reaffirm AMA Policy)

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-24

Subject: Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication (Resolution 240-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

Resolution 240-A-23, introduced by the Illinois State Medical Society, consisted of the following proposals:

> 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)[1] and medical expert's personal tax returns within sixty days of the close of the case. (Directive to Take Action).

FIRST RESOLVED

In cases requiring physicians as medical expert witnesses, their testimony is critical to the resolution of the case. They provide an invaluable service. At the same time, it is the right of the opposing party's attorney to request discovery that allows the attorney to cross-examine the witness to show potential bias. *See United States v. Abel*, 469 U.S. 45, 49-52 (1984). This discovery often involves the expert's financial history. Still, discovery must be balanced with the expert's privacy rights and the burden imposed. *See Grant v. Rancour*, 157 N.E.3d 1083, 1094-95 (Ill. 2020). ("[W]hile cross-examination is permissible to show bias, partisanship, or financial interest, there is a point at which such inquiries trample on the legitimate bounds of cross-examination and unduly harass or unnecessarily invade the privacy of the witness.").

There is no general rule or universal leaning that courts take when it comes to an expert's personal tax returns. Personal tax returns may be relevant to show an expert's potential biases – how often they have testified, how much they have earned for that testimony, what sources are paying for that testimony, etc. Courts decide whether personal tax returns should be allowable discovery on a case-

[1] The form of citation quoted in the First Resolved refers to an Illinois-specific publication, one that might not be available to those outside of Illinois. For ease of reference and accessibility, the Board will use the citation of the case as published in the North Eastern Reporter, a widely available publication. The citation is *Haage v. Zavala*, 183 N.E.3d 830 (Ill. 2021).

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by-case basis, depending on the specific facts of the case. *See, e.g*., *Olson v. State Farm Fire & Cas. Co*., No. C14-0786RSM, 2015 WL 753501, at *3 (W.D. Wash. Feb. 23, 2015) ("there is no need for the expert to have to produce his or her tax returns, if the party seeking the discovery has accurate information regarding the percentage of income earned as an expert"); *but see Noffke v. Perez*, 178 P.3d 1141, 1150 (Alaska 2008) ("trial court determined that the income tax returns were relevant and that production of the returns would help clarify any stake the witness might have in the outcome of the case"). As with most discovery disputes, the resolution is within the court's discretion. "Courts must use their discretion to oversee the process and ensure that it is fair to both sides." *Grant*, 157 N.E.3d at 1095.

With this background, the Board agrees that seeking a medical expert's entire personal income tax returns is, in most instances, overly broad and unnecessarily invades the expert's privacy. The Board also agrees that limiting personal tax return discovery of a medical expert to miscellaneous income (1099-MISC forms) strikes a reasonable balance between allowing the probing for potential bias and protecting the expert's privacy and burdens. Miscellaneous income discovery would encompass the income that is received from serving as an expert, and the source of that income. In most cases, this should shed sufficient light on potential bias.

This position is also in line with current AMA policy, which states, "(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which he or she testified for either plaintiffs or defendants." *Expert Witness Testimony*, H-265.994.

On the other hand, the Board believes the phrase "and that entire personal tax returns (including spouse's) should not be forced by the court to be disclosed" should be removed from the First Resolved. It would be an overreach for the AMA to tell courts how to use their discretion in managing discovery, which as discussed, varies on a case-by-case basis. In any event, the first part of the Resolved makes this latter part largely unnecessary. Advocating for the limitation of tax return discovery to miscellaneous income means that the discovery of entire personal tax returns is generally unnecessary and inappropriate. Along those lines, we suggest that the word "usually" be inserted between "should" and "be."

As such, the Board believes the First Resolved should be rewritten as follows:

> RESOLVED, That our American Medical Association advocate that attorneys' discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income).

SECOND RESOLVED

The Second Resolved likely lumps together two different categories of documents: 1) client medical records, and 2) tax returns of medical experts. The first category is personal health information ("PHI"), likely protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The second category is financial information that has nothing to do with HIPAA. Yet the Second Resolved advocates for the destruction of both types of documents within 60 days of the conclusion of a case, using *Haage v. Zavala*, 183 N.E.3d 830 (Ill. 2021) as an example.

In *Haage*, a personal injury matter, the trial court issued HIPAA qualified protective orders ("QPOs") expressly requiring the destruction of PHI within 60 days after the conclusion of the litigation. The insurance company objected to the QPOs, arguing that the orders prevented insurers from performing functions related to fraud detection and deterrence. The appellate court disagreed and enforced the QPOs, finding that no law or regulations required the insurance company to use or disclose plaintiffs' PHI after the conclusion of the litigation. *See Haage*, 183 N.E.3d at 853.

Thus, *Haage* may be relevant to the return or destruction of PHI under a HIPAA QPO, but it is irrelevant to the return or destruction of an expert's tax return information. Thus, the Second Resolved does not need to mention *Haage*.

Regarding the return of client records, the American Bar Association's ("ABA") Rules of Professional Conduct state: "Upon termination of representation, a lawyer shall take steps to the extent reasonably practicable to protect a client's interests, such as . . . surrendering papers and property to which the client is entitled[.] The lawyer may retain papers relating to the client to the extent permitted by other law." ABA Rule 1.6(d). The ABA rules do not address exactly *when* attorneys are to return or destroy their client's records.

As a general matter, the Board agrees with the intent of the Second Resolved – that certain documents contain clients' or experts' sensitive and confidential information, and it is logical that those individuals do not want that sensitive information used or available for longer than absolutely necessary. Sixty days after the conclusion of litigation also seems like a reasonable time period for the return or destruction of those documents. At the same time, the Board notes that reaching this goal will likely be an uphill battle, as it would likely entail specific changes to the ABA's Model Rules of Professional Conduct, and could require changes to state and federal laws. Nonetheless, advocating for this goal seems like a worthwhile effort.

As such, the Board believes the Second Resolved should be rewritten as follows:

> RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert's personal tax returns by attorneys within sixty days of the conclusion of the litigation.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 240-A-23 and the remainder of this report be filed:

1. That our American Medical Association advocate that attorneys' discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income) (New HOD Policy); and

2. RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert's personal tax returns by attorneys within sixty days of the conclusion of the litigation (New HOD Policy).

Fiscal Note: TBD

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-24)

Introduced by: American Academy of Ophthalmology

Subject: Research Correcting Political Misinformation and Disinformation on Scope of Practice

Referred to: Reference Committee B

Whereas, state and federal policymakers are regularly exposed to political misinformation and disinformation about the benefits and safety of scope of practice expansion from non-physician practitioners; and

Whereas, members of our American Medical Association spend valuable time and resources attempting to counter this political misinformation and disinformation with varying success; and

Whereas, recent research has explored various psychological and communication strategies to correct political misinformation and disinformation[1,2,3,4,5,6]; and

Whereas, there may be differences between strategies that work to correct political misinformation and disinformation in different contexts, amongst different audiences, and on different issues; and

Whereas**,** members of our AMA may lack information about these strategies and how they might apply to correcting political misinformation and disinformation on scope of practice; therefore be it

RESOLVED, that our American Medical Association perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the I-24 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

Fiscal Note: $330,526: Perform comprehensive literature review on current research on correcting political misinformation and disinformation. Conduct field research through focus groups and surveys on ways to correct political misinformation and disinformation.

Received: 4/8/2024

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Relevant AMA Policy

G-640.050 Preserving the AMA's Grassroots Legislative and Political Mission
Our AMA will ensure that all Washington activities, including lobbying, political education, grassroots communications and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner. (Res. 619, A-00; Reaffirmed: BOT Rep. 6, A-10; CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

G-620.021 Communications and Collaboration with the Federation
Our AMA: (1) when confronted with attempts by non-physicians to expand scope of practice via state legislation, shall work at the invitation of its component societies to develop strategies to most effectively promote and protect the best interest of our patients; (2) shall continue to work with national medical specialty societies to assist them in working with and coordinating activities with state medical associations and that the AMA, when requested by either a state medical association or a national specialty society, provide a mechanism to attempt to resolve any dispute between such organizations; (3) shall become actively involved in lobbying and/or communicating with state officials at the request of the state medical associations. (4) Prior to placing targeted advertising, our AMA will contact the relevant state medical associations and/or specialty societies for the purpose of enhancing communication about AMA's planned activities. (CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

2.3.4 Political Communications
Physicians enjoy the rights and privileges of free speech shared by all Americans. It is laudable for physicians to run for political office; to lobby for political positions, parties, or candidates; and in every other way to exercise the full scope of their political rights as citizens. Physicians may exercise these rights individually or through involvement with professional societies and political action committees or other organizations.
When physicians wish to express their personal political views to a patient or a patient's family, the physician must be sensitive to the imbalance of power in the patient- physician relationship, as well as to the patient's vulnerability and desire for privacy. Physicians should refrain from initiating political conversations during the clinical encounter.
Physicians must not allow differences with the patient or family about political matters to interfere with the delivery of professional care.
When expressing political views to a patient or a patient's family, physicians should:
(a) Judge both the intrusiveness of the discussion and the patient's level of comfort before initiating such a discussion.
(b) Discuss political matters only in contexts where conversation with the patient or family about social, civic, or recreational matters is acceptable.
(c) Refrain from conversation about political matters when the patient or family is emotionally pressured by significant medical circumstances.
(d) Work towards and advocate for the reform and proper administration of laws related to health care.
Physicians should stay well informed of current political questions regarding needed and proposed reforms.

(e) Stay well informed about needed or proposed policies concerning health care access and quality, medical research, and promoting public health so as to be able to advocate for patients' needs. (AMA Principles of Medical Ethics: I,VII**,** Issued 2016)

H-160.947 Physician Assistants and Nurse Practitioners
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. BOT Rep. 6, A-95Reaffirmed: Res 240 and Reaffirmation A-00Reaffirmed: (Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22; Reaffirmed: CMS Rep. 09, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-24)

Introduced by: American Association of Clinical Urologists

Subject: Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims

Referred to: Reference Committee B

Whereas, insurers use of Artificial Intelligence (AI) and advanced technology to analyze Health Insurance Claims is very frequent; and

Whereas, Humana, Cigna and UnitedHealthcare are facing class actions from consumers and their estates for allegedly deploying advanced technology to deny claims; and

Whereas, health plans use of AI or algorithm software managed by firms such as naviHealth and CareCentrix assist in coverage decisions; and

Whereas, insurers are using AI and algorithms to improve their bottom line under the guise of delivering better service to their policy holders; and

Whereas, doctors, diagnostic companies and others are not able to deliver appropriate medical care when insurance coverage is arbitrarily denied; and

Whereas, President Biden signed an executive order to establish AI standards in October 2023 which includes the responsible use of AI in Healthcare. This also requires the Department of Health and Human Services (HHS) to set up a safety program to take in reports of harm or unsafe health practices involving AI; and

Whereas, the HHS office of the National Coordinator for Health Information Technology issued a rule in December 2023 requiring more transparency around AI; and

Whereas, the Center for Medicare and Medicaid Services (CMS) finalized rules requiring Medicare Advantage Plans in 2024 to ensure they are making medical necessity determinations based on the circumstances of a specific individual rather than an algorithm or software that does not account for individual circumstances. Additionally, coverage denials based on medical necessity determinations must be reviewed by a physician or other health care professional; therefore be it

RESOLVED, that our American Medical Association adopt as policy that Commercial third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health plans ensure they are making medical necessity determinations based on the circumstances of the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that does not account for an individual's circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity determination must be reviewed by a physician in the same specialty or by another appropriate health care professional for non-physician health care providers. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/11/2024

REFERENCES

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-24)

Introduced by: Florida

Subject: Medicaid Patient Accountability

Referred to: Reference Committee B

Whereas, most Medicaid managed care plans assign patients who do not select their own primary care physician (PCP) randomly to a physician of the plan's choosing; and

Whereas, despite their best efforts, physicians at times are unable to persuade these Medicaid patients to come into the office for wellness visits, immunization updates, or their childhood check-up visit; and

Whereas, parents in many states have the ability to opt out of vaccines and other treatments for pediatric patients through state approved religious or medical exemptions; and

Whereas, physicians are responsible for their assigned patients completing visits to record Healthcare Effectiveness Data and Information Set (HEDIS) measures; and

Whereas, physicians may be given bonuses/incentives or be penalized based on their HEDIS star rating score; therefore be it

RESOLVED, that our American Medical Association advocate that physicians' Healthcare Effectiveness Data and Information Set and other quality scores and ratings not be affected by non-compliant patients or patients whose parents exercise state exemptions from recommended treatment. (Directive to Take Action)

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

Received: 4/3/2024

Relevant AMA Policy

Retroactive Assignment of Patients by Managed Care Entities H-285.947
Our AMA opposes the practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or last assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the patient has sought care.
Sub. Res. 719, A-97Reaffirmation I-01Modified: CMS Rep. 7, A-11Reaffirmation: A-19

Physician Payment Reform H-390.849
1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a) promote improved patient access to high-quality, cost-effective care;
b) be designed with input from the physician community;
c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;
e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute 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 (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.

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.
Policy Timeline
CMS Rep. 6, A-09Reaffirmation A-10Appended: Res. 829, I-10Appended: CMS Rep. 1, A-11Appended: CMS Rep. 4, A-11Reaffirmed in lieu of Res. 119, A-12
Reaffirmed in lieu of Res. 122, A-12Modified: CMS Rep. 6, A-13Reaffirmation I-15Reaffirmation: A-16Reaffirmed in lieu of: Res. 712, A-17
Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19
Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

Reaffirmed: Res. 212, I-21Reaffirmed: Res. 240, A-22Reaffirmation: A-22Modified: CMS Rep. 04, A-23Reaffirmed: Res. 214, A-23Reaffirmation: A-23

Work of the Task Force on the Release of Physician Data H-406.991
Principles for the Public Release and Accurate Use of Physician Data

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:

1. Patient Privacy Safeguards
- All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
- Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).

2. Data Accuracy and Security Safeguards
- Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).
- Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).
- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).

3. Transparency Requirements
- When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).
- The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).
- Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).

4. Review and Appeal Requirements
- Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).
- When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).

5. Physician Profiling Requirements
- The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).
- Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (H-450.951).

- When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used.
- Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services.
- Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes.

6. Quality Measurement Requirements
- The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).
- Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).
- These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data.

7. Patient Satisfaction Measurement Requirements
- Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).
- Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms.
- As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication.

Policy Timeline
BOT Rep. 18, A-09Reaffirmation A-10Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10
Reaffirmation I-10Reaffirmed in lieu of Res. 808, I-10Reaffirmed in lieu of Res. 824, I-10Reaffirmation A-11Reaffirmed: BOT Rep. 17, A-13Reaffirmed: Res. 806, I-13
Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-24)

Introduced by: Florida

Subject: Staffing Ratios in the Emergency Department

Referred to: Reference Committee B

Whereas, the Emergency Department is the medical safety net for the nation and provides care to vulnerable patients who may not otherwise have access to primary or specialty medical care; and

Whereas, in many states, physicians are the only health professionals authorized to practice medicine in the Emergency Department without limitation; and

Whereas, every patient presenting to an Emergency Department should be under the direct, real-time care of a licensed physician, including the on-site and real-time supervision of non-physician practitioners (NPPs); and

Whereas, state laws vary on the number of nurse practitioners and physician assistants that a physician can supervise, with some states having no limits at all; and

Whereas, a 2022 NBER paper using data from the VA shows that nurse practitioners working without supervision in the Emergency Department resulted in increased lengths of stay, increased costs, increased 30-day re-admissions, and increased mortality rates among the higher acuity patients. Nursing literature also supports that NPs should not be working unsupervised in the ED; and

Whereas, in an increasing number of states, most Emergency Physicians are employed by corporate staffing groups with private equity backing seeking to maximize profit through understaffing physicians and replacing them with non-physician practitioners (NPPs); and

Whereas, the staffing ratio of NPPs to physicians at any given time in the Emergency Department determines whether a physician has time to adequately supervise and see the patients being cared for by the NPPs; therefore be it

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper supervision of NPPs in the Emergency Department (Directive to Take Action); and be it further

RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)

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

Received: 4/9/2024

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4. American Academy of Emergency Medicine (AAEM) paper on guidelines for safe patients per hour and NPP supervision limits…in process

Relevant AMA Policy

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976
Our AMA will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department. [Res. 218, A-23]

Principles for Strengthening the Physician-Hospital Relationship H-225.957
The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body. [Res. 828, I-07 Reaffirmed in lieu of Res. 730, A-09 Modified: Res. 820, I-09 Reaffirmed: Res. 725, A-10Reaffirmation A-12 Reaffirmed: CMS Rep. 6, I-13 Reaffirmed: CMS Rep. 5, A-21]

Supervision and Proctoring by Facility Medical Staff H-375.967
Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:
(1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
(2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
(3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
(4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
(5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
(6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
(7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
(8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
(9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports. [CMS Rep. 3, A-99 Reaffirmed: CLRPD Rep. 1, A-09 Reaffirmed: CMS Rep. 01, A-19]

Medical Staff Development Plans H-225.961
All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. [BOT Rep. 14, A-98Modified: BOT Rep. 11, A-07Reaffirmation A-10Modified: CMS Rep. 01, A-20]

Credentialing and the Quality of Care H-225.971
It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges"; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital. [BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13 Reaffirmed: CMS Rep. 5, A-21]

On-Call Physicians H-130.948
Our AMA:

(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA. [CMS Rep. 3, I-99 Reaffirmation A-00Modified: Sub. Res. 217, I-00 Reaffirmation I-01Reaffirmation A-07Appended and Reaffirmed: CMS Rep. 1, I-09 Modified: Res. 818, I-17]

Professional Nurse Staffing in Hospitals H-360.986
The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;
(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;
(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;
(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and
(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured. [BOT Rep. 11, I-96Reaffirmed: CMS Rep. 8, A-06Reaffirmed: CMS Rep. 01, A-16]

Supervision of Non-Physician Practitioners by Physicians D-35.978

Our AMA will advocate: (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and (5) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation. [
Res. 017, I-22]

Emergency Department Boarding and Crowding H-130.940
Our AMA:

1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and
6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement. [CMS Rep. 3, A-09Reaffirmed: CMS Rep. 01, A-19Reaffirmed: BOT Rep. 16, A-19]

Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services H-285.950
The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services.
(1) All managed care plans shall disclose to their enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities.
(2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness.
(3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided.
(4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided.
(5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition.

(6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility. [CMS Rep. 1, I-96Reaffirmed: CMS Rep. 8, A-06Reaffirmed: CMS Rep. 01, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-24)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Medical-Legal Partnerships & Legal Aid Services

Referred to: Reference Committee B

Whereas, medical-legal partnerships (MLPs) address social determinants of health relating to civil law, such as family violence, child support and custody, workplace conditions, employment conflicts, financial exploitation, post-incarceration rehabilitation, housing, utility shutoffs, disability access, debt relief, and veteran benefits, by integrating lawyers in clinical settings team to meet patient's legal needs[1-6]; and

Whereas, 70% of low-income households experience civil legal problems, with 40% experiencing at least 5, 20% experiencing at least 10, and the average low-income individual managing 2 to 3 legal issues at a time[7-8]; and

Whereas, unmet civil legal needs may lead to or exacerbate both physical and mental illness, as seen with inadequate housing, eviction, and even threat of eviction being connected to anxiety, depression, bodily injury, asthma, and respiratory infection[9-11]; and

Whereas, MLPs demonstrate success in access to retroactive benefits, improved asthma control and neonatal preventive care use, and decreased length of hospitalization, readmission rates, and emergency department visits[7]; and

Whereas, while MLPs are found at only 26% of medical schools, studies indicate that MLPs can help educate physicians and medical students on screening for social determinants and legal needs, addressing issues impacting health through legal advocacy, and referring patients to reliable legal resources[1,12-15]; and

Whereas, civil legal aid often includes free or low-cost direct legal services by lawyers as well as legal education to help low- and middle-income people navigate social systems[16]; and

Whereas, the high cost of civil legal aid is a significant barrier to access, with low-income Americans reporting only seek aid for 1 out of 4 civil legal problems and receiving inadequate legal aid for 92% of their needs[8,17]; and

Whereas, civil legal aid services in the US are chronically underfunded, turning away an average of 50% of eligible individuals who seek services due to inadequate funds[16]; and

Whereas, the Association of American Medical Colleges and the American Bar Association both conduct initiatives relating to MLPs, including creation of models and directories[18-19]; therefore be it

RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 03/28/2024

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RELEVANT AMA POLICY

H-165.822 Health Plan Initiatives Addressing Social Determinants of Health

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. [CMS Rep. 7, I-20Reaffirmed: CMS Rep. 5, I-21Reaffirmed: CMS Rep. 5, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-24)

Introduced by: Medical Student Section

Subject: Indian Health Service Youth Regional Treatment Centers

Referred to: Reference Committee B

Whereas, nearly 13% of AI/AN youth ages 12-24 experienced a depressive episode or related mental illness in 2018, and an estimated 20% require treatment due to early alcohol use[1-2]; and

Whereas, the Indian Health Service (IHS) uses Youth Regional Treatment Centers (YRTCs) for acute behavioral healthcare for AI/AN adolescents, but national capacity only meets 4% of the need[2-3]; and

Whereas, YRTCs help adolescents develop independent living skills, provide schooling attuned to individual needs, create post-discharge sobriety plans, and coordinate prison diversion programs[4-5]; and

Whereas, while 61% of arrested AI/AN youth are eligible for YRTC diversion programs, only 14% ultimately receive care at YRTCs[2]; and

Whereas, the IHS, in consultation with Tribal leaders and key parties, has voiced concerns regarding AI/AN youth traveling across state lines to seek care at non-IHS treatment centers[6]; and

Whereas, non-IHS treatment centers are not equipped to address the complex effects of intergenerational trauma, systematic discrimination, and displacement on AI/AN youth mental health[7-9]; therefore be it

RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as a model for culturally-rooted, evidence-based behavioral health treatment, and prompt referral of eligible AI/AN youth to Youth Regional Treatment Centers (YRTCs) for community-directed care. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/5/2024

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RELEVANT AMA POLICY

H-160.963 Community-Based Treatment Centers

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities. [BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

D-350.988 American Indian / Alaska Native Adolescent Suicide

Our AMA will: 1) provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native communities; 2) encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native adolescent suicide and make these findings widely available; and 3) lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native adolescent suicide. [Sub Res. 404, A-11; Reaffirmed: BOT Rep. 7, A-21]

H-345.974 Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities

Our AMA supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates, and respected media outlets. [Res. 917, I-13; Reaffirmed: Res. 426, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-24)

Introduced by: Medical Student Section

Subject: Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse

Referred to: Reference Committee B

Whereas, biologics account for only 2% of prescriptions but 40% of US pharmaceutical spending and 90% of the net pharmaceutical spending growth over the past decade[1-6]; and

Whereas, biologics are often significantly more expensive than small-molecule drugs, costing on average $10,000 to $40,000 per patient annually with some prices up to $500,000[1-6]; and

Whereas, biosimilars exhibit no clinically meaningful differences in safety, purity, and potency compared to their corresponding “brand-name” (originator, or reference product) biologic[7]; and

Whereas, the US has only approved 50% of the biosimilars approved in other industrialized nations, with an average uptake rate of 20% compared to over 80%[8-16]; and

Whereas, average US price decreases due to biosimilar entry are only 15 to 40% compared to 70% in other industrialized nations[8-16]; and

Whereas, other industrialized nations improve biosimilar uptake through lucrative financial incentives for physicians to maintain robust reimbursement while saving on medication costs, including rewards for biosimilar usage targets and shared savings programs[17-23]; and

Whereas, “brand-name” biologics manufacturers have blocked biosimilar uptake in the US via long-term exclusivity agreements with pharmacy benefit managers (PBMs) for preferential coverage in insurance plans, such as Johnson & Johnson with Remicade (infliximab) and AbbVie with Humira (adalimumab)[24-25]; and

Whereas, biologics manufacturers’ efforts to prevent biosimilar coverage by insurers interfere with physician’s prescriptive authority, conflict with analogous AMA policy supporting physicians’ right to prescribe generic drugs, and maintain exorbitant pharmaceutical costs; and

Whereas, the Federal Trade Commission (FTC) and Department of Justice (DOJ) have the authority to investigate and block exclusive distribution clauses as antitrust violations, and AMA advocacy can help ensure that PBM exclusivity agreements are an antitrust priority[25-27]; therefore be it

RESOLVED, that our American Medical Association support economic incentives to increase physician use of less expensive biosimilars instead of their reference biologics (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed

between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (New HOD Policy)

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

Received: 4/5/2024

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RELEVANT AMA POLICY

H-125.980 Abbreviated Pathway for Biosimilar Approval
Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that 1) places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation; 2) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-24)

Introduced by: Medical Student Section and American College of Physicians

Subject: Improving Supplemental Nutrition Programs

Referred to: Reference Committee B

Whereas, food insecurity is a public health crisis, especially among American Indian and Alaska Native (AI/AN) persons, who were relocated and gave up 98% of their lands and ability to survive under coercion and threats of violence by state and federal actors[3,4]; and

Whereas, the burden of chronic diseases such as obesity and diabetes on AI/AN communities is directly attributable to settler colonialism and interruption of AI/AN knowledge systems[5,6]; and

Whereas, AI/AN persons experience food insecurity at twice the rate of whites, with 25% being consistently food insecure[4]; and

Whereas, climate change uniquely affects AI/AN communities, including disproportionate exposure of Alaska Native Villages to marine foods polluted by plastic and poor nutritional offerings with significant price markups at grocery and convenience stores[7]; and

Whereas, US nutrition programs for AI/AN persons, including the Food Distribution Program on Indian Reservations (FDPIR) and the recently launched Indian Health Service (IHS) Produce Prescription Pilot Program, differ from other nutrition programs by including staple foods and ingredients commonly used in pre-contact AI/AN societies and food systems[8-9]; and

Whereas, federally-recognized AI/AN Tribes and Villages without a reservation or land base and the 2.8 million AI/AN persons in urban areas (greater than the population on Tribal lands) are all ineligible for federal nutrition assistance programs for AI/AN persons[8-13]; and

Whereas, AI/AN persons in urban areas were 1.4 times as likely to experience food insecurity as other AI/AN persons, with rates exacerbated by COVID[4,14]; and

Whereas, the reduction of AI/AN food insecurity (by increasing AI/AN food choices, availability, and household purchasing power and intervening preventively via early education and farm-to-school programs) can decrease risk of gestational diabetes, sleep apnea, and metabolic syndrome, promote AI/AN self-determination and self-governance, and improve AI/AN youth health behavior[15-18]; therefore be it

RESOLVED, that our American Medical Association support regulatory and legal reforms to extend multieligibility for USDA Food Assistance to enrolled members of federally-recognized American Indian and Alaska Native Tribes and Villages to all federal feeding programs, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR). (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA Policy

H-150.925 Food Environments and Challenges Accessing Healthy Food

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options. [Res. 921, I-18; Modified: Res. 417, A-21; Appended: Res. 117, A-22]

H-150.937 Improvements to Supplemental Nutrition Programs
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. [Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18; Reaffirmed: Res. 259, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-24)

Introduced by: Medical Student Section

Subject: Native American Voting Rights

Referred to: Reference Committee B

Whereas, our American Medical Association "acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric"; and be it further

Whereas, the Association of American Medical Colleges (AAMC) supports medical schools and teaching hospitals facilitating nonpartisan voter registration efforts[1]; and

Whereas, health facilities' nonpartisan voter registration efforts demonstrate improved civic engagement and are protected by the National Voter Registration Act and IRS code[2-5]; and

Whereas, 1.2 million Native Americans (34%) are not registered to vote due to vast differences in experiences and opportunities, especially for voters on reservations who experience discrimination and unique challenges with voter identification laws (e.g., no addresses on reservations, inability to use tribal-federal membership cards)[6-11]; and

Whereas, the distinct political and dual citizenship status of Native Americans as members of sovereign Tribal nations underscores the importance of their voter participation, as federal and state elected officials are responsible for working with their Tribal governments to enact laws governing Tribal authority and treaty rights[8]; and

Whereas, as Native Americans comprise over 10% of the electorate in many states, Congress has repeatedly introduced the Native American Voting Rights Act, which would in part establish a Native American voting task force grant program to increase turnout[8]; and

Whereas, President Biden's Executive Order on Promoting Access to Voting strongly encourages federal agencies, including Veterans Health Administration (VHA) and Indian Health Service sites to seek designation as voter registration sites[12]; and

Whereas, other federal health and social programs such as the VHA, Medicaid, and SNAP/WIC offer voter registration services, and the Health Resources and Services Administration even offers guidance for Federally Qualified Health Centers to organize such efforts[3,13-14]; and

Whereas, civic engagement efforts are limited at Indian Health Service, Tribal, and Urban Indian Health Programs, which are crucial interfaces with Native American patients and Tribal governments[15-16]; therefore be it

RESOLVED, that our American Medical Association support Indian Health Service, Tribal, and Urban Indian Health Programs becoming designated voter registration sites to promote nonpartisan civic engagement among the American Indian and Alaska Native population. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA Policy

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes. [Res. 18, I-21; Appended: Res. 422, A-22]

AMERICAN MEDICAL ASSOCIATION HOOUSE OF DELEGATES

Resolution: 210
(A-24)

Introduced by: Oregon, American College of Physicians

Subject: Support for Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

Whereas, the American Medical Association (AMA) supports the right of physicians to engage in collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians eligible for that right under federal law; and

Whereas, while AMA policy supports expanding rights for physicians rights and abilities to collectively bargain, the last study of this policy area last occurred pre-pandemic as the paradigm shift of physician as employee continues to expand, particularly for younger generations of physicians who would be more likely to leverage and seek unionization; and

Whereas, the AMA points out that bargaining units composed entirely of physicians are presumed appropriate, a recommendation that makes sense in recognition of physicians' unique skills and ethical and professional obligations; and

Whereas, in 1999 the AMA provided financial support for the establishment of a national labor organization - Physicians for Responsible Negotiation (PRN) - under the National Labor Relations Board (NLRA) to support the development and operation of local physician negotiating units as an option for employed physicians and physicians in-training, but ultimately withdrew support in 2004 as few physicians signed up; and

Whereas, the numbers of physicians who are union members is estimated to have grown significantly since then with a 26% increase from 2014 to 2019 when 67,673 physicians were members of a union; and

Whereas, the percentage of physicians now employed by hospitals, health systems, or corporate entities has increased significant, most recently reported up to 73.9% as of January, 2022 (up from 47.4% in 2018), and the number of physician practices acquired by hospitals and corporate entities between 2019-2022 also accelerated during the pandemic; and

Whereas, dominant hospitals, healthcare systems, and other corporate entities employing physicians may present limited alternatives to physicians working in a market largely controlled by their employer or where covenants-not-to-compete may further contribute to the employer's bargaining advantage; and

Whereas, the transition from independent professional physician workforce to employed physician workforce fundamentally alters the dynamics between hospitals, health systems, corporate entities and physicians, with a risk of negatively affecting the conditions of care delivery and quality of care provided; and

Whereas, the corporatization of medicine, including involvement of private equity in healthcare, raises questions about incentive alignment, costs, and downstream effects on patients; and

Whereas, recent years have seen an increase in physician burnout, which accelerated during the COVID-19 pandemic, directly related to time spent on electronic health record documentation, bureaucratic administrative tasks, and moral injury related to an incongruence between what physicians care about and what they are incentivized to do by the health care system; and

Whereas, physicians face a dominant power when negotiating with hospital employers and may not have countervailing influence without collective bargaining; and

Whereas, collective bargaining is an effective tool for protecting patient care safety standards, improving work conditions, ensuring pay and job security, and a providing a process for grievances; and

Whereas, the National Labor Relations Board determined in 2022 that employed physicians are not in a supervisory role and are therefore eligible to unionize; and

Whereas, interest in exploring collective bargaining for residents and practicing physician groups has increased in some parts of the country including in Oregon, likely driven by dynamics seen in the profession's shift to "employed status" for the majority of physicians; therefore be it

RESOLVED, that our American Medical Association convenes an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)

Fiscal Note: $43,308; Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts.

Received: 4/5/2024

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RELEVANT AMA POLICY

Collective Bargaining for Physicians H-385.946
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.
Citation: Res. 239, A-97Reaffirmation I-98Reaffirmation A-01Reaffirmation A-05Reaffirmation A-06Reaffirmation A-08Reaffirmation I-10

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.
Citation: BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19;

Employee Associations and Collective Bargaining for Physicians D-383.981
Our AMA will study and report back on physician unionization in the United States.
Citation: Res. 601, I-14; Reaffirmed: Res. 206, A-19

Investigation into Residents, Fellows and Physician Unions D-383.977
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today’s health care environment. Citation: Res. 606, A-19

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. Citation: Res. 229, A-12; Reaffirmed: Res. 206, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Deceptive Hospital Badging 2.0

Referred to: Reference Committee B

Whereas, the public is wholly unaware of the false labeling for care personnel in the hospital, with the increasing introduction of lesser trained people appearing to be equivalent caregivers; and

Whereas, the most recent addition to this group of non-physicians are certified registered nurse anesthetists (CRNAs), increasingly replacing anesthesiologists; and

Whereas, this has crept into the cardiac suites of our operating rooms with increasing fallout as surgeons are being tasked with assuming responsibility and therefore enhanced liability for these non-physician personnel; and

Whereas, anesthesia was also overing perfusion, which will now fall to surgeons who may not be up to speed to perform these additional tasks; and

Whereas, this is unquestionably a quality of care issue as well as safety related, along with a public relations, cost, and billing problem; and

Whereas, we were able to correct the previous deception at our hospital with a push by the organized medical staff taking action, along with the support of the AMA; therefore be it

RESOLVED, that our American Medical Association promote and prioritize public awareness of the difference and importance of having the proper level of training and clear identification and labeling of caregivers as that relates to quality and safety of healthcare (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state and county medical societies to highlight to physicians the growing practice of creating false equivalencies between physicians and non-physicians in the healthcare team and encourage action in local institutions to assure the quality and safety of patient care. (Directive to Take Action)

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

Received: 4/17/2024

RELEVANT AMA POLICY

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
Citation: Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: CCB/CLRPD Rep. 01, A-23

Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation D-35.992
Our AMA will: (1) work jointly with state attorneys general to identify and prosecute those individuals who misrepresent themselves as physicians to their patients and mislead program applicants as to their future scope of practice; (2) pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings; and (3) work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified either verbally, or by name badge or similar identifier, with regard to their professional licensure in order that patients are aware of the professional educational background of that person.
Citation: Res. 211, A-06; Reaffirmed: BOT Rep. 6, A-16

Professional Nurse Staffing in Hospitals H-360.986
The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;
(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;
(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;
(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and
(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.
Citation: BOT Rep. 11, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Advocacy Education Towards a Sustainable Medical Care System

Referred to: Reference Committee B

Whereas, extensive AMA policy and actions address the education of medical students and physicians on advocacy techniques and their involvement in AMA advocacy efforts; and

Whereas, our AMA believes that “better-informed and more active citizens will result in better legislators, better government, and better health care” (AMA Policy G-640.020); and

Whereas, the AMA currently facilitates some patient education and engagement in advocacy efforts via is Patient Action Network (PAN); and

Whereas, greater involvement of the public in AMA advocacy efforts potentially could make the AMA more effective in its advocacy on behalf of patients and the profession; and

Whereas, any attempt to engage the public must consider the potential difficulties that can arise from blending the perspectives of physicians and patients; therefore be it

RESOLVED, that our American Medical Association explore innovative opportunities for engaging the public in advocacy on behalf of an improved healthcare environment. (Directive to Take Action)

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

Received: 4/17/2024

RELEVANT AMA POLICY

Medical Student, Resident and Fellow Legislative Awareness H-295.953
1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103
Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy; and (4) study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in person AMA conferences.

Political Action Committees and Contributions G-640.020
Our AMA: (1) believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; (8) calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) calls upon all candidates for public office to refuse contributions from any organization that opposes evidence-based public health measures to reduce firearm violence.

Physician Health Policy Opportunity G-640.035
Our AMA encourages and supports efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy.

Our AMA: (a) recognizes, encourages, and supports the primary health policy training found in the physician specialties of Public Health / General Preventive Medicine, Occupational and Environmental Medicine, and Aerospace Medicine; (b) will significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy training opportunities and help them to apply for and participate in them; (c) will engage with alumni of health policy training programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians; (d) will include health policy content in its educational resources for members; (e) will work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service; and (f) will consider options for funding a 1-year educational training program for practicing physicians who wish to transition from clinical practice to employment within the health policy sector.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-24)

Introduced by: Private Practice Physicians Section

Subject: Access to Covered Benefits with an Out of Network Ordering Physician

Referred to: Reference Committee B

Whereas, physicians have not had inflationary increases like other service providers have for decades in the Medicare program; and

Whereas, physicians' ability to continue to serve patients independent of hospital systems, private equity, vertically and/or horizontally consolidated systems has narrowed under current reimbursement settings[6]; and

Whereas, between 2019 and 2020, 48,400 physicians left independent practice according to a 2021 Physicians Advocacy Institute study[1]; and

Whereas, as a result there is a growing number of private practice physicians using the Direct Primary Care (DPC) model not accepting insurance or otherwise treating patients in models that are not in-network with health maintenance organizations (HMOs), Medicare Advantage, or other health plans[2,3]; and

Whereas, there are 2,060 direct primary care practices spanning 48 states[4]; and

Whereas, patients with catastrophic insurance plans with high deductibles are well-served by having access to direct primary care physicians[5]; and

Whereas, physicians who care for patients under the direct primary care model or other out-of-network models are not compensated by insurers for physician services rendered to patients with these plans; and

Whereas, many of the patients served in direct primary care or out-of-network models have HMOs, Medicare Advantage or other health plans for their primary insurance while using a direct-pay physician for their medical care; and

Whereas, these health plans often will not cover laboratory studies, radiology studies, referral or even prescription medications when ordered by one of these out-of-network physicians; and

Whereas, non-coverage of valid orders for health plan benefits for the insured leads to delays in case, increased cost to patients and redundancy and inefficiency in the healthcare system; therefore be it

RESOLVED, that our American Medical Association develop model legislation to protect patients in direct primary care plans and non-network plans thus furthering the ability of direct primary care physicians and other out-of-network physicians to provide covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary

services for patients under their commercial insurance, even if it is an HMO or point of service plan (Directive to Take Action); and be it further

RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to support direct primary care and other out-of-network models. (Directive to Take Action)

Fiscal Note: Resolved 1, Modest - between $1,000 - $5,000. Resolved 2, $22,980. Develop a comprehensive portfolio of education, experts, and toolkits

Received: 4/17/2024

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RELEVANT AMA POLICY

Direct Primary Care H-385.912
1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.
Citation: Res. 103; A-16; Appended: Res. 246, A-18; Reaffirmed: A-18; Reaffirmed: I-18; Appended: Res. 102, A-19

Subacute Care Standards for Physicians H-160.945
AMA guidelines for physicians' responsibilities in subacute care include:
(1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week.
(2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care.
(3) Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings.
(4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care.
(5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations.

(6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life.
(7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs.
(8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.
(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit.
(10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.
Citation: BOT Rep. 21, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15

Out-of-Network Care H-285.904
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.
Citation: Res. 108, A-17; Reaffirmed: A-19; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, A-18; Reaffirmed: A-19; Reaffirmed: Res. 210, A-19; Appended Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.
Citation: Res. 108, A-17

Physician Penalties for Out-of-Network Services H-180.952
Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.
Citation: Res. 702, A-07; Reaffirmed: CMS Rep. 01, A-17

Out of Network Restrictions of Physicians H-285.907
Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.
Citation: Res. 126, A-15

Out of Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963
Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.
Citation: Res. 119, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-24)

Introduced by: Medical Student Section

Subject: Support for Paid Sick Leave

Referred to: Reference Committee B

Whereas, sick leave can be used by employees to recover from illness, attend medical appointments, care for sick relatives, and seek assistance for domestic violence, and access disproportionately impacts women who take on caregiver responsibilities[1-4]; and

Whereas, all but 10 countries feasibly fund paid sick leave via governments and/or employers, but the US' Family and Medical Leave Act (FMLA) only ensures unpaid leave[5-7]; and

Whereas, 75% of voters support a national paid leave policy, but currently 25% of private sector workers do not receive paid sick leave, including 62% of those in the lowest income decile, 45% of those in the lowest income quartile, 54% of Latine workers, 47% of Indigenous workers, and 38% of Black workers[8-11]; and

Whereas, multiple studies demonstrate that paid sick leave increases primary care use and reduces occupational injuries and infectious spread, with one estimating over $1 billion in annual savings from over 1 million prevented ED visits[12-22]; and

Whereas, paid sick leave is guaranteed in 15 states including DC, 4 counties, and 17 cities, with early adopters showing sustainable success for over a decade[2,23-24]; and

Whereas, the Healthy Families Act would guarantee paid sick leave and is currently being considered in both the House and Senate[25]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick Leave," as follows:

> Paid Sick Leave H-440.823
> Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with paidsick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/5/2024

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RELEVANT AMA POLICY

H-420.979 AMA Statement on Family, Medical, and Safe Leave
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
1) Medical leave for the employee, including pregnancy, abortion, and stillbirth; 2) Maternity leave for the employee-mother; 3) Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; 4) Leave for adoption or for foster care leading to adoption; and 5) Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.
Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.
Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-24)

Introduced by: Medical Student Section

Subject: American Indian and Alaska Native Language Revitalization and Elder Care

Referred to: Reference Committee B

Whereas, American Indian and Alaska Native (AI/AN) elders ages 65 and over are expected to increase from 13% of the AI/AN population in 2012 to 20% by 2030[1]; and

Whereas, AI/AN elders are considered essential to community identity, as extended family and clanship leaders are valued as protectors, mentors, teachers, and intergenerational transmitters of cultural knowledge, a well-recognized protective health factor for AI/AN youth[2-5]; and

Whereas, AI/AN elders experience significant health and socioeconomic disparities including the lowest life expectancy of all racial/ethnic groups in the US, a 25% uninsured rate, and a 25% rate of having at least one documented disability[1]; and

Whereas, a study in Canada of AI/AN elders found that Indigenous-led health service partnerships improve holistic health outcomes, as well as access to care, prevention uptake and adherence to care plans for First Nations[6]; and

Whereas, a survey with southwestern Tribal Nations found that AI/AN elders consistently shared themes of healthcare insecurity due to failed systems and IHS underfunding[7]; and

Whereas, while AI/AN elders receive primary care through the IHS, underfunding and understaffing has forced IHS to rely on non-IHS facilities for more specialized elder care, including hospice and respite care, forcing AI/AN elders to navigate unknown health systems not respective of their cultural values and traditions[8]; and

Whereas, despite the well-documented comorbidities AI/AN people carry into elderhood, AI/AN elders are less likely to create end-of-life care plans compared to non-Hispanic Whites and remain one of the least studied populations regarding their use of advance care planning[7-9]; and

Whereas, terminally ill AI/AN elders are less likely to receive hospice and palliative care than other racial/ethnic groups, with fewer than a third receiving these services compared to over 45% of the non-Hispanic white population[10]; and

Whereas, according to data collected by the Mayo Clinic Spirit of Eagles program, Tribal Health Directors reported pain management, advanced care planning, hospice contracts, care for the dying, and bereavement support as their most pressing needs, with 60% reporting limited access to end-of-life care[11]; and

Whereas, by 2060, the number of AI/AN elders with memory loss is expected to increase by 400%, requiring additional resources for the IHS to provide dementia services[12]; and

Whereas, language and cultural barriers severely restrict AI/AN elder access to federal and state programs, such as Social Security, Medicare, and Medicaid[13-14]; and

Whereas, over 20% of AI/AN elders mostly speak their native language, and in several counties on the Navajo Nation, over 40% speak their native language as their primary language[15]; and

Whereas, the National Indian Council on Aging considers Native languages as key for improving health and social services and well-being for AI/AN elders[16]; and

Whereas, the White House Office of Science and Technology Policy (OSTP) has directed the Department of Health and Human Services, Centers for Medicare and Medicaid Services, IHS, and other federal agencies to value and prioritize Indigenous knowledge, including languages and knowledge holders, in federal grantmaking and other funding opportunities[17]; and

Whereas, the Biden-Harris Administration's 2024 budget request for Indian Affairs programs makes significant investments in Tribal native language revitalization[18]; therefore be it

RESOLVED, that our American Medical Association recognize that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors (New HOD Policy); and be it further

RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action)

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

Received: 4/5/2024

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RELEVANT AMA POLICY

H-295.897 Enhancing the Cultural Competence of Physicians

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.
[CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18; Modified: Res. 322, A-22]

H-350.976 Improving Health Care of American Indians

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
[CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-24)

Introduced by: American College of Legal Medicine

Subject: The AMA Supports H.R. 7225, the Bipartisan "Administrative Law Judges Competitive Service Restoration Act"

Referred to: Reference Committee B

Whereas, Medicare and Medicaid beneficiaries and providers must appeal their coverage and payment disputes to the Health and Human Services Administrative Law Judges (ALJs); and

Whereas, from 1946 until 2018, attorney candidates who wanted to become federal ALJs were required:

a. to pass an examination on administrative law given by the U.S. Department of Personnel Management, and only the top three scoring candidates were offered positions as federal ALJs; and
b. to have at least seven years of experience in an area of law relevant to administrative proceedings; and
c. to prove they had the ability to write clear and understandable decisions following an administrative proceeding; and

Whereas, following the Supreme Court decision in Lucia v. SEC[1], Executive Order (E.O.) 13,843 was signed[2]**;** and

Whereas, E.O. 13,843 removed federal ALJs from the competitive civil service; and

Whereas, the only current requirements for a new federal ALJ are a license to practice law somewhere in the United States and an appointment made by a temporary, politically appointed agency head; and

Whereas, E.O. 13,843 politicized the federal ALJ service, potentially resulting in the appointment of questionably competent ALJs[3]; and

Whereas, Medicare and Medicaid coverage and payment disputes are more likely to be correctly decided by informed, competent, and truly neutral ALJs; and

Whereas, the bipartisan "Administrative Law Judges Competitive Service Restoration Act," H.R.7225, was introduced on February 4, 2024, by Congressman Gerry Connolly (D-VA-11) and is co-sponsored by Congressman Brian Fitzpatrick (R-PA-1) and Congressman Michael Lawler (R-NY-17) and is endorsed by the American College of Legal Medicine (ACLM), the Association of Administrative Law Judges (AALJ), and the

International Federation of Professional and Technical Engineers (IFPTE); therefore be it

RESOLVED, that our American Medical Association support H.R. 7225, the bipartisan "Administrative Law Judges Competitive Service Restoration Act" that supports the merit-based process for the selection of all Medicare/Medicaid Administrative Law Judges. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/21/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-24)

Introduced by: American Society for Reproductive Medicine, American College of Obstetricians and Gynecologists

Subject: Protecting Access to IVF Treatment

Referred to: Reference Committee B

Whereas, on Friday 2/16/24, the Alabama Supreme Court[1] ruled that
(a) "an embryo created through in vitro fertilization (IVF) is a child protected by Alabama's wrongful death act and the Alabama Constitution;" and that
(b) "a human frozen embryo is a 'child' which is an unborn or recently born [child];" and that
(c) "the Constitution … commands the judge to … upholding the sanctity of unborn life, including unborn life that exists outside the womb;" and that
(d) "the Court would not create an exception in the statute for these IVF embryo children just because they were located outside the womb;" and

Whereas, in current IVF practice in the United States, over half of embryo transfers will *not* result in live birth, as many embryos after transfer will either (a) not result in a pregnancy, or (b) result in a miscarriage, or (c) result in a non-viable ectopic or molar pregnancy; and

Whereas, cryopreserved embryos also do *not* have a 100% thaw-survival rate, and a small percentage of embryos will not survive freeze-thaw; such that if embryos in the IVF lab have the same legal status as children, then an embryology laboratory that fails to have a 100% thaw-survival rate may also have some potential liability; and

Whereas, not all IVF patients (a) can afford the long-term storage fees to cryopreserve embryos for future use or (b) wish to donate those embryos; and

Whereas, defining all embryos as "children" promotes the dangerous notion that all embryos should somehow be transferred in an IVF cycle (instead of cryopreserving extra embryos of adequate quality), which could potentially increase the rate of dangerous higher-order multiple gestation pregnancies (triplets, quadruplets, etc); and

Whereas, defining all embryos as "children" may promote the dangerous and misguided notion that an ectopic pregnancy could somehow be safely implanted into the uterus (as is erroneously reported on various "Personhood" websites[9]); and

Whereas, the American Society for Reproductive Medicine (ASRM) Position Statement on Personhood Measures states that
- "The ASRM is strongly opposed to measures granting constitutional rights or protections and "personhood" status to fertilized reproductive tissues.
- In a growing number of states, vaguely worded and often misleading measures are… defining when life begins and granting legal "personhood" status to embryos at varying stages of development.

- …, these broadly worded measures will have significant effects on a number of medical treatments available to women of reproductive age.
    - Personhood measures would make illegal some commonly used birth control methods.
    - Personhood measures would make illegal a physician's ability to provide medically appropriate care to women experiencing life-threatening complications due to a tubal pregnancy.
    - Personhood measures would consign infertility patients to less effective, less safe treatments for their disease.
    - Personhood measures would unduly restrict infertile patients' right to make decisions about their own medical treatments, including determining the fate of any embryos created as part of the IVF process.
- ASRM will oppose any personhood measure;" and

Whereas, partly in response to a movement to allow the establishment of college savings accounts for undelivered pregnancies; our AMA established policy H-140.835 which states that:

"our AMA opposes any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries." therefore, be it

RESOLVED, that our American Medical Association oppose any legislation or ballot measures that could criminalize in-vitro fertilization (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose any legislation or ballot measures or court rulings that equate gametes (oocytes and sperm) or embryos with children (New HOD Policy); and be it further

RESOLVED, that our AMA report back at A-25, on the status of, and AMA's activities surrounding, ballot measures, court rulings, and legislation that equate embryos with children. (Directive to Take Action)

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

Received: 4/23/2024

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RELEVANT AMA POLICY

D-5.999 "Preserving Access to Reproductive Health Services"
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
(Res 028, A-22; Reaffirmed: Res 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res 317, I-22; Reaffirmation: A-23, Appended: Res 711, A-23)

G-605.009 "Establishing a Task Force to Preserve the Patient-Physician Relationship when Evidence-Based Appropriate Care is Banned or Restricted"
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender

affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.
(Res 621, A-22; Appended: Res 816, I-23)

H-160.954 Criminalization of Medical Judgment
(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.
(Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09)

H-160.946 The Criminalization of Health Care Decision-making
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09)

D-160.999 Opposition to Criminalizing Health Care Decisions
Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."
(Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-24)

Introduced by: Michigan

Subject: Designation of Descendants of Enslaved Africans in America

Referred To: Reference Committee B

Whereas, the designation of African American and Black has been expanded to include any person who immigrated from Africa or Caribbean countries and obtained American citizenship at any point in recent history; and

Whereas, since 2003 the United States Supreme Court, ruled the definition of "Black" included every person who identifies as Black on a census form including people who check the box for Black and any other racial or ethnic category such as white, Asian, and Hispanic or Latino, which the federal government considers to be an ethnicity that can be of any race; and

Whereas, anyone Black or White who was born in Africa, immigrated to the United States, and legally becomes an American citizen is considered an African American (i.e., Elon Musk); and

Whereas, the number of immigrants entering the United States legally rose from 3.3 million in the 1960s to a record 7.3 million in the 1980s; and during the 1990s, some 900,000 Black immigrants came from the Caribbean; another 400,000 came from Africa; still many others came from Europe, Pacific Rim, Arab and Asian countries; and

Whereas, today, nearly one in ten Black Americans is an immigrant or the child of an immigrant in the United States; and

Whereas, the “Intelligent” survey found 34 percent of white students who applied to colleges and universities falsely claimed they were a racial minority on their application; 81 percent of students who faked minority status did so to improve their chances of getting accepted and 50 percent did it to get minority-focused financial aid; and

Whereas, the “Intelligent” survey found that 3 in 4, or 77 percent, of white applicants who faked minority status on their applications were accepted to those colleges; and

Whereas, Descendants of Enslaved Africans in America are the only people in U.S. history classified as nonhuman and property, to undergo chattel slavery, and to be deemed by the U.S. constitution 3/5 of a human, according to the 13th, 14th, and 15th amendments; and

Whereas, the Descendants of Enslaved Africans in America are the only people for whom it was illegal to attend school or learn how to read and write in the United States; and

Whereas, it is important to disaggregate data to make sure everyone is recognized and that the data influencing policies, programs, and solutions is accurate; therefore be it

RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate if from the generic terms African American and Black in glossaries and on medical school applications. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

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Definition of African American(s)

1. African Americans are an ethnic group consisting of Americans with partial or total ancestry from sub-Saharan Africa. The term "African American" generally denotes descendants of enslaved Africans who are from the United States (Ref)
2. The glossary that is available on the AAMC FACTS website, as well as the FACTS tables that display the full race/ethnicity response options does not include DOESAA: FACTS Glossary: https://www.aamc.org/data-reports/students-residents/interactive-data/facts-glossary Example FACTS Table with response options: https://www.aamc.org/media/6046/download?attachment
3. AAMC DATA FACTS TABLE 12-A of the freshman class acceptees for medical schools in the United States in 2021: 456 African Americans, who are not distinguished as immigrant or non-immigrant; 203 individuals indicating more than 1 Black or African American response, which implies an immigrant status or admixture; 33 “other Black or African American” which implies immigrant status.

RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-24)

Introduced by: American College of Obstetricians and Gynecologists

Subject: Bundling for Maternity Care Services

Referred to: Reference Committee B

Whereas, maternal mortality in the US continues to rise, up from 861 deaths in 2020 to 1,205 deaths in 2021[1]; and

Whereas, rates of severe maternal morbidity (SMM) continues to climb and of particular significance, the increasing gap in SMM between the national average (88.2/10,000 in 2020) and among Black mothers (139.0/10,000)[2]; and

Whereas, access to maternity care continues to decline, with 35.6 percent of counties classified as "maternity care deserts" and only 45.4 percent of counties classified as having "full access" to maternity care and 56 counites losing obstetric providers[3]; and

Whereas, state Medicaid programs and private commercial plans are developing Alternative Payment Models and that inappropriately bundle community and wrap-around services under the physician payment[4,5]; and

Whereas, insurers are not recognizing separate billing for services such as immediate postpartum long-acting reversible contraception, care coordination, transfers during labor, increased time in delivery, screening, counseling and treatment for health-related social needs or co-morbid conditions that increase pregnancy risk, postpartum care, and many other services[6,7]; and

Whereas, the American Medical Association opposes the incorrect use of CPT by insurers and others (Improper Use of AMA-CPT by Carriers/Software Programs (H-70.954); and

Whereas, the AMA has several policies that call for advocacy to third party payers for inappropriate bundling of services (D-70.983, H-70.983); and

Whereas, the AMA CPT instructions for use of the maternity global codes includes "services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care" and that services for high-risk pregnancies and hospital stays more than 24 hours before delivery should be reported separately; therefore be it

RESOLVED, that our American Medical Association advocates for the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services. (Directive to Take Action)

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

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RELEVANT AMA POLICY

H-70.954 Improper Use of AMA-CPT by Carriers/Software Programs

Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement;
(2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and
(3) seeks legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers.

D-70.983 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices;
(2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment;
(3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate;
4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician;
(5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and.
(6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue.

H-70.937 Bundling and Downcoding of CPT Codes

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;
(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and
(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

H-70.949 Bundling of Codes for Physician Services
Our AMA: (1) advocates and will take steps to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines; and (2) will enhance and fully coordinate its activities to prevent the inappropriate bundling of CPT codes (and other coding systems for supplies, injections, etc) used for payment by both public and private payers.

H-70.962 Changes in the Bundling of Medical Services by Managed Care Plans
Our AMA will introduce or support legislation or regulation that would require that managed care plans be monitored and prohibited from the arbitrary and inappropriate bundling of services to reduce payment to participating physicians; and that the medically indicated patient services such as consultations and diagnostic procedures provided by physicians on the same day be paid on a separate basis in conformity with the AMA Current Procedural Terminology (CPT) coding policy and not inappropriately bundled as they currently are by managed care plans.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-24)

Introduced by: California

Subject: Restorative Justice for the Treatment of Substance Use Disorders

Referred to: Reference Committee B

Whereas, Restorative Justice (RJ) is a correctional model featuring relationship building, rehabilitation, and community empowerment. Examples of Restorative Justice models include Restorative Community Conferencing (RCC) and Drug Treatment Courts, which have reduced recidivism, cut costs (one RCC estimates a cost savings of $18,500 per case per year), and promoted familial connectedness, particularly among people of color; and

Whereas, police brutality, racist sentencing practices, and implicit biases that created health inequities have contributed to the US having the highest incarceration rate in the world, with one in three black men currently incarcerated; and

Whereas, the “war on drugs” prioritized punishment over treatment for non-violent drug offenses, leading to an eight-fold increase in incarceration to 400,000 people by 1997. The Anti-Drug Abuse Act diverted $1.7 billion away from education, drug treatment, and research towards law enforcement and now the U.S. spends $12 billion annually on the war on drugs; and

Whereas, during the crack cocaine epidemic of the mid 1980s where there were an estimated 1.6 million users, the black community was devastated because of an inequitable response by law enforcement and mass incarceration due to racist sentencing practices, such as unequal mandatory minimum sentences for crack cocaine - as 80% of crack users were black (due to its affordability) as compared to more expensive powdered cocaine used preferentially by white users; and

Whereas, injected powdered cocaine delivers a fast, intense high similar to crack, and has been found to have the highest risk of overdose and death; and

Whereas, the U.S. Sentencing Commission reported in 1995 that 52% of all crack users were white and 38% were black. However, only 4.1% of those sentenced for crack offenses were White and 88% were Black. Prisoners have a higher rate of suicide, self harm, violence, HIV, and other infectious diseases and public health experts recommend that substance abuse impacts are best addressed through community resources such as family counseling, and mental health programs; and

Whereas, black patients are less likely to receive pain medication and decreasing opiate prescriptions increases the use of fentanyl and heroin. Conversely, increasing services such as medication-assisted addiction treatment, needle exchange, naloxone availability, and psychosocial treatment improve outcomes; and

Whereas, the U.S. Office of National Drug Control Policy estimated that in 1996, 3.6 million people required medical treatment for their addiction, but only one million were receiving

treatment because 19% of the $13.5 billion budget was dedicated to drug treatment as compared to 58% for criminal justice and thus, the crack cocaine epidemic caused a multitude of negative health outcomes including a four-fold increase in emergency room visits, as well as a significant increase in Sexually Transmitted Diseases; and

Whereas, some minor steps in line with “Restorative Justice” have been taken, such as The Fair Sentencing Act of 2010 and The First Step Act of 2018 which applied the Fair Sentencing Act retroactively, and reduced the sentencing disparity from 100:1 to 18:1; and

Whereas, by contrast, the opioid epidemic, which has predominantly affected white individuals, has been combatted using a “Disease Model” featuring a reduction in stigmatizing language, the expenditure of $59 million by the U.S. Department of Justice for community health interventions, and sentencing individuals to rehabilitation as opposed to incarceration; and

Whereas, in 2019 alone, the Centers for Disease Control and Prevention (CDC) granted $475 million for opioid overdose prevention and has (1) funded research to identify effective strategies for combating the epidemic, (2) worked with health departments and community-based organizations to implement evidence-based prevention strategies, (3) created an evidence-based “CDC Guideline for Prescribing Opioids for Chronic Pain” and implemented quality-improvement measures, (4) created the “Rx Awareness” campaign to educate users on the risks of opioid use, and (5) partnered with first responders, including police, with an emphasis on saving lives through naloxone administration rather than incarceration; and
Whereas, approaches, such as the CDC models for the opioid epidemic, are examples of the application of the Restorative Justice model and can be applied retroactively to those negatively impacted by the crack cocaine epidemic; therefore be it

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports providing incentives for incarcerated individuals to overcome substance use disorders, such as participation in treatment as a condition for early release, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy); and be it further

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy)

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

Received: 4/23/2024

RELEVANT AMA POLICY

H-95.931 AMA Support for Justice Reinvestment Initiatives
Our American Medical Association supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs. [Reaffirmed: CSAPH Rep. 4, I-23, Res. 205, A-16.]

H-430.986 Health Care While Incarcerated

1. Our American Medical Association 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, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
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 departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports:
    a. linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
    b. the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
    c. the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and
    d. collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
    a. MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
    b. knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
    c. knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles

[Appended: Res. 429, A-23; Appended: Res. 244, A-23; Modified: Res. 127, A-22; Reaffirmed: Res. 229, A-21; Modified: Res. 503, A-21; Modified: Res. 216, I-19; Appended: Res 420, A-19; Appended: Res. 417, A-19; CMS Rep. 02, I-16.]

H-430.997 Standards of Care for Inmates of Correctional Facilities
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
[Modified: CSAPH Rep. 1, A-22; Reaffirmation: I-12; Modified in lieu of Res. 502, A-12; Reaffirmation I-09; Reaffirmed: CEJA Rep. 8, A-09; Amended: Res. 416, I-99; Reaffirmed by CLRPD Rep. 3 – I-94; Res 60, A-84.]

H-95.922 Substance Use and Substance Use Disorders
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
[Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: BOT Rep. 14, I-20; CSAPH Rep. 01, A-18]

H-95.975 Substance Use Disorders as a Public Health Hazard
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.
[Reaffirmed: CSAPH Rep. 01, A-19; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Sunset Rep., I-99; Appended: Sub. Res. 401; Res. 7, I-89.]

D-95.962 Enhanced Funding for and Access to Outpatient Addiction Rehabilitation
Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. [BOT Rep. 14, I-20]

H-430.987 Medications for Opioid Use Disorder in Correctional Facilities
1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.
[Modified: Res. 503, A-21; Appended: Res. 223, I-17; Reaffirmed: CSAPH Rep. 1, A-15; Res. 443, A-05.]

D-405.970 Racism - A Threat to Public Health
Our American Medical Association advocates for the creation of an International Classification of Diseases (ICD) code for patients presenting with conditions related to experiencing racism (including systemic racism and unconscious bias), a code that will provide physicians with a tool to document the clinical impact of racism, and capture the data needed to help provide more effective patient care.
[Modified: Res. 503, A-21; Appended: Res. 223, I-17; Reaffirmed: CSAPH Rep. 1, A-15; Res. 443, A-05]

H-65.952 Racism as a Public Health Threat
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
[Modified: Speakers Rep., A-22; Reaffirmed: Res. 013, A-22; Res. 5, I-20]

H-65.943 Redressing the Harms of Misusing Race in Medicine
1. Our American Medical Association recognizes the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field.
2. Our AMA will revise the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine.
3. Our AMA advocates for and promotes racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine.
[Modified: Speakers Rep., A-22, Reaffirmed: Res. 013, A-22, Res. 5, I-20.]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-24)

Introduced by: California

Subject: Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability

Referred to: Reference Committee B

Whereas, the skyrocketing cost of drugs is a key driver of U.S. healthcare costs; In 2021, Medicare spent $215B and $33B on Part D and Part B drugs respectively, with Part B clinically-administered drugs costs rising at an average rate of 9.2% annually from 2008-2021;[1,2] and

Whereas, Medicare Part B reimburses for Part B drugs under the “Buy and Bill” method, in which healthcare systems or physicians purchase, stock, maintain inventory for and administer drugs, and are reimbursed at an amount equal to the Average Sales Price (ASP) of the drug plus 6% of the ASP;[3,4] and

Whereas, multiple factors contribute to the high cost of Part B drugs, including longer patent exclusivity periods, lack of market competition and generic alternatives, and historical prohibition of Medicare in negotiating drug prices; and

Whereas, the “Buy and Bill” reimbursement structure which ties reimbursement directly to drug prices disincentivizes healthcare systems or physicians to choose the lowest-cost drugs;[5] and

Whereas, Part B drugs have high levels of patient cost-sharing, as patients are charged a coinsurance of 20% of the cost of the drug rather than a fixed copay;[6] and

Whereas, more than half of patients with a chronic illness are in medical debt, and 25% of cancer patients experience eviction, home foreclosure or bankruptcy;[7] and

Whereas, The Inflation Reduction Act authorized Medicare to begin drug price negotiations for Part B drugs in 2026, with these prices taking effect in 2028;[8] and

Whereas, while lower drug prices will undoubtedly improve affordability for patients, as noted in an AMA Letter to CMS in 20189, tying reimbursement to the ASP over time as prices drop “may no longer be sufficient to cover the administrative costs to the practice”, threatening practice viability and therefore patient access to care; and

Whereas, ASP-based Medicare reimbursement for physicians has a six-month lag period, contributing to the financial vulnerability of small/medium-sized physician practices, practices in rural and/or underserved areas, and practices serving a significant proportion of Medicare patients;[10] and

Whereas, While the administration of Part B drugs is most prevalent in the fields of oncology, rheumatology, ophthalmology, dermatology and gastroenterology, this issue affects all physicians serving Medicare patients, as the anticipated billions saved annually through drug price negotiations could be reappropriated towards improving physician reimbursement across-the-board; therefore be it

RESOLVED, that our American Medical Association support the creation of a new reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug, and 2) Ensures adequate compensation for the cost of acquisition, inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price (New HOD Policy); and be it further

RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/23/2024

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RELEVANT AMA POLICY

H-330.888 Exempt Physician-Administered Drugs from Medicare Sequestration
Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013. [Reaffirmed: Res. 212, I-21; Reaffirmation A-15; Res. 235, A-13]

D-330.960 Cuts in Medicare Outpatient Infusion Services
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.
[Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation A-15; Reaffirmed and Modified: CMS Rep. 3, I-08; Res. 926, I-03]

D-330-.904 Opposition to the CMS Medicare Part B Drug Payment Model
1. Our AMA will request that the Centers for Medicare &Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
[Res. 241, A-16]

H-110-983 Medicare Part B Competitive Acquisition Program (CAP)
Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices that choose not to participate;
(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.
[Reaffirmed: CMS Rep. 4, A-22; Reaffirmed: CMS Rep. 4, I-19; Res. 216, I-18]

H-110.987 Pharmaceutical Costs
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
[Reaffirmed: Res. 801, I-23; Reaffirmed in lieu of: Res. 810, I-22; Appended: Res. 113, I-21; Reaffirmed: Res. 105, A-19; Appended: BOT Rep. 14, A-19; Appended: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 14, A-18; Appended: Alt. Res. 806, I-17; Modified: Speakers Rep. 01, A-17; Reaffirmed in lieu of Res. 107, A-17; Appended: Res. 201 A-17; Reaffirmed in lieu of: Res. 817, I-16; CMS Rep. 2, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-24)

Introduced by: Resident and Fellow Section

Subject: Studying Avenues for Parity in Mental Health & Substance Use Coverage

Referred to: Reference Committee B

Whereas, the Mental Health Parity Act passed in 1996 and was the first law to impose any sort of parity between mental and physical health care, with an imposition on the annual or lifetime dollar limits on mental health benefits being any less favorable than those imposed on medical/surgical benefits[1]; and

Whereas, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 took this concept further by preventing group health plans and health insurance insurers from imposing less favorable benefit limitations for mental health or substance use disorder benefits than on medical/surgical benefits[1]; and

Whereas, prior to and since the inception of these federal laws, our AMA has been advocating for parity in insurance benefits for those receiving mental health and substance use care (H-185.974, H-168.888); and

Whereas, despite violations being found in every investigation of insurance companies, as well as multiple AMA policies supporting parity and calling for compliance with parity laws (D-180.998, H-185.916, H-185.974), parity still does not exist and health plans are not remotely close to following parity laws regarding mental health/substance use benefits[2,3]; and

Whereas, both the 2022 DOL/HHS/IRS Report to Congress & July 2023 MHPAEA Comparative Analysis Report to Congress showed widespread violations and repeated failure of health plans to provide sufficient, accurate information to regulators to perform the comparative analyses required by law[2,3]; and

Whereas, a 2023 Robert Wood Johnson Foundation Report found that cost-sharing was decreased for mental health when compared to primary care visits, such that 17% of plans required that a deductible be satisfied for mental health visits but not primary care visits, and that despite reporting these deficits year after year, they remain unchanged[4,5]; and

Whereas, in Georgia, 24 health plans provided no information to the state Department of Insurance (DOI) to perform its statutorily-required comparative analyses and of the 28 plans that did submit information, none submitted sufficient information for the DOI to perform the comparative analyses[6]; and

Whereas, lack of compliance occurs at both the federal and the state level, without significant consequences including continuing to allow insurer participation in state-delivered insurance plans[6]; therefore be it

RESOLVED, that our American Medical Association study potential penalties to insurers for not complying with mental health and substance use parity laws. (Directive to Take Action)

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

Received: 4/24/2024

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RELEVANT AMA POLICY:

Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care H-185.916
Our AMA supports requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws. [Res. 216, I-22]

Parity for Mental Health and Substance Use Disorders in Health Insurance Programs H-185.974
1. Our AMA supports parity of coverage for mental, health, and substance use disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders. [Res. 212, A-96, Reaffirmation A-97, Reaffirmed: Res. 215, I-98, Reaffirmation A-99, Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99, Reaffirmation A-00, Reaffirmed: CMS Rep. 9, A-01, Reaffirmation A-02, Reaffirmation I-03, Modified: CMS Rep. 2, A-08, Reaffirmed: CMS Rep. 5, I-12, Reaffirmed in lieu of Res. 804, I-13, Reaffirmation A-15, Modified: Res. 113, A-16, Modified: Res. 216, I-22]

Insurance Parity for Mental Health and Psychiatry D-180.998
Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. [Res. 215, I-98, Reaffirmation I-03, Reaffirmed in lieu of Res. 910, I-06, Reaffirmation A-15]

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with

significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
[Res. 116, A-12, Reaffirmation A-15, Reaffirmed: Res. 414, A-22]

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
[Res. 118, I-91, Res. 102, I-92, BOT Rep. NN, I-92, BOT Rep. S, A-93, Reaffirmed: Res. 135, A-93, Reaffirmed: BOT Reps. 25 and 40, I-93, Reaffirmed in lieu of Res. 714, I-93, Res. 130, I-93, Res. 316, I-93, Sub. Res. 718, I-93, Reaffirmed: CMS Rep. 5, I-93, Res. 124, A-94, Reaffirmed by BOT Rep.1- I-94, CEJA Rep. 3, A-95, Reaffirmed: BOT Rep. 34, I-95, Reaffirmation A-00, Reaffirmation A-01, Reaffirmed: CMS Rep. 10, A-03, Reaffirmed: CME Rep. 2, A-03, Reaffirmed and Modified: CMS Rep. 5, A-04, Reaffirmed with change in title: CEJA Rep. 2, A-05, Consolidated: CMS Rep. 7, I-05, Reaffirmation I-07, Reaffirmed in lieu of Res. 113, A-08, Reaffirmation A-09, Res. 101, A-09, Sub. Res. 110, A-09, Res. 123, A-09, Reaffirmed in lieu of Res. 120, A-12, Reaffirmation: A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-24)

Introduced by: American Academy of Pediatrics, American College of Obstetricians and Gynecologists

Subject: Increase in Children's Hospital Graduate Medical Education Funding

Referred to: Reference Committee B

Whereas, the Children's Hospitals Graduate Medical Education (CHGME) program has been a vital component of supporting pediatric residency training programs in the United States since its inception in the 1990s[1,4] and was established to address the unique funding challenges faced by children's hospitals in providing quality graduate medical education, recognizing the importance of specialized pediatric training[1,3] for pediatricians and other specialties who care for children; and

Whereas, since the 1990s, the funding for the CHGME program has not kept pace with the evolving needs of pediatric residency programs, leading to a widening gap between the funding provided and the increasing demands on pediatric healthcare[2,3,6-7]; and

Whereas, the lack of adequate adjustments to CHGME funding over the years has created financial strains on children's hospitals and pediatric residency programs, limiting their ability to expand training capacities and adequately respond to the growing healthcare needs of children[4,7]; and

Whereas, investing in pediatric medical education contributes to the overall improvement of child health outcomes and strengthens the healthcare system as a whole[5]; and

Whereas, the American Medical Association has a longstanding commitment to advocating for policies that enhance medical education and improve the healthcare workforce; therefore be it

RESOLVED, that our American Medical Association collaborate with other relevant medical organizations to support and advocate for increased funding for the Children's Hospitals Graduate Medical Education program, recognizing the vital role it plays in shaping the future of pediatric healthcare in the United States. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Increasing Coverage for Children H-165.877

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GMEfunding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and

other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary

care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

Securing Funding for Graduate Medical Education H-310.917
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-24)

Introduced by: Medical Student Section

Subject: Antidiscrimination Protections for LGBTQ+ Youth in Foster Care

Referred to: Reference Committee B

Whereas, 30% of youth in foster care are LGBTQ+, triple the rate of those not in care[1–4]; and

Whereas, in the foster care system, LGBTQ+ identifying youth encounter unique and significant threats associated with their identity including rejection, harassment, violence, and discrimination from social workers, foster parents, residential staff, and peers in addition to poorer health outcomes compared to their non-LGBTQ+ counterparts including worse physical, mental, and sexual health alongside higher prevalence of trauma, substance use, survival sex, sexual victimization, and unintended pregnancy [1–19]; and

Whereas, studies demonstrate LGBTQ+ youth are twice as likely to enter foster care, more likely to spend longer time in care, be removed from placements due to hostility based on LGBTQ+ identity, and to age out of care without adequate preparation for higher education, employment, and housing[6,7,20–26]; and

Whereas, in 2016, the United States Children's Bureau confidentially collected data on foster youth's sexual orientation as well as family conflicts related to a child's gender identity, sexual orientation, and or gender expression, demonstrating the ability of the system to obtain demographic information confidentially to improve the system for LGBTQ+ youth[27]; and

Whereas, in 2020, the United States Children's Bureau eliminated requirements for collection of demographics on sexual orientation in the Foster Care Analysis and Reporting System, which limited child welfare agencies' ability to analyze LGBTQ+ youth in foster care and increase programs, laws, and funds protecting LGBTQ+ foster youth[27–30]; and

Whereas, social care professionals at religiously-affiliated foster care facilities in the United States were found to propagate negative stereotypes about same-sex relationships[31]; and

Whereas, in recent years, New Jersey child welfare officials successfully recruited and licensed 120 new foster homes that affirm and support LGBTQ+ youth, demonstrating through local LGBTQ+ community organization, home studies, and training sessions that child services can successfully recruit inclusive families for the foster care system[32]; and

Whereas, the Children's Bureau and Child Welfare League of America provide fact sheets and brochures with passive guidance on supporting LGBTQ+ youth in foster care as an accessible and feasible means of improving care for LGBTQ+ youth[33–38]; and

Whereas, implementation of the *RISE Care Coordination Team Program* in Los Angeles helped LGBTQ+ youth in the Los Angeles foster care system feel supported in their identities and demonstrated an accessible model by which other programs can support LGBTQ+ youth[39]; and

Whereas, the Civil Rights Act of 1964 does not protect against discrimination of LGBTQ+ individuals in federally-funded programs, including adoption and foster care, with recent attempts to expand nondiscrimination protections failing to pass[40–46]; and

Whereas, the lack of inclusive protections for LGBTQ+ individuals in federal legislation, such as the Civil Rights Act of 1964, the Fair Housing Act, and the Affordable Care Act, has enabled rule changes and proposals that permit discrimination against LGBTQ+ individuals[47–49]; and

Whereas, only 28 states and the District of Columbia have specific laws and policies in place to protect LGBTQ+ foster youth from discrimination based on both sexual orientation and gender identity, six other states include sexual orientation but not gender identity as a protected class in child welfare, and some states have no protections at all[21,33,50]; and

Whereas, only four states had regulatory guidance regarding placement of transgender youth in out-of-home care in alignment with gender identity as of 2016, and child welfare agency officials from three states reported placing transgender youth in gender-segregated residential facilities by their sex assigned at birth rather than their gender identity[32,51]; and

Whereas, the relationship between LGBTQ+ protections and availability of foster families is unclear, but court cases in states challenging those protections are pending[52,53]; and

Whereas, because youth may begin to identify as LGBTQ+ after being placed with a family not supportive of those identities, screening for unsupportive families is necessary to reduce harm toward LGBTQ+ youth[54–56]; and

Whereas, though AMA policies H-60.910 and H-160.991 separately address the healthcare needs of youth in foster care and of LGBTQ+ individuals, the AMA has only written one letter to the Department of Housing and Urban Development opposing the removal of protections for housing allocation based on gender identity[57]; therefore be it

RESOLVED, that our American Medical Association collaborate with state medical societies and other appropriate stakeholders to support policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist (New HOD Policy); and be it further

RESOLVED, that our AMA encourage child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) adopt programs to prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA Policy

Addressing Healthcare Needs of Children in Foster Care, H-60.910
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care. [Res. 907, I-17]

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. [CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18]

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations, H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. [Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-24)

Introduced by: Medical Student Section

Subject: Humanitarian Efforts to Resettle Refugees

Referred to: Reference Committee B

Whereas, “refugee” is defined in the Immigration and Nationality Act as an individual experiencing persecution or a well-founded fear of persecution on account of their race, religion, nationality, membership in a particular social group, or political opinion[1-3]; and

Whereas, refugees in the US undergo an extensive and complex admission process involving evaluation and referral by UNHCR (the UN’s refugee agency) to the US State Department’s Refugee Admissions Program (USRAP), and are a distinct population from asylum seekers or migrants crossing at the US’ southern border, who follow a completely separate process[1]; and

Whereas, the US consistently admits fewer refugees than its cap, leading to 5,000 to 40,000 unallocated refugees[4]; and

Whereas, 29 million refugees are estimated in 2023, including 14 million children[5-6]; and

Whereas, over a 20-year period, refugees in the US ages 18 to 45 pay on average $21,000-$43,707 more in taxes than they receive in benefits[7-10]; and

Whereas, refugees in general contribute $21 billion in taxes annually, including to Social Security and Medicare, offsetting the costs our aging population[13]; and

Whereas, analyses from Ohio, Michigan, and Minnesota demonstrate how refugees produce billions of dollars in economic activity annually and create thousands of jobs[9,11]; and

Whereas, 77% of refugees are working age, as opposed to the 39.7% of the US-born population and male refugees participate in the labor force at higher rates than US males[7,12,14]; and

Whereas, under 3% of refugees return to their country of origin, and 84% of long-term refugees make the US their home by taking steps to become citizens[6,10,15]; and

Whereas, when annual refugee admissions decreased 86% between 2016-2020, the 295,000 person gap actually harmed the US economy by nearly $10 billion annually[8]; and

Whereas, decreased resettlement caps and worsening backlogs delay family reunification and leave people displaced for decades, remaining indefinitely in refugee camps[16]; and

Whereas, forced displacement and restrictions on refugee admissions result in distinct chronic physical and mental phenomena and generational trauma[16-18]; therefore be it

RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

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RELEVANT AMA Policy

D-65.984 Humanitarian and Medical Aid Support to Ukraine

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-24)

Introduced by: Missouri

Subject: Protecting Access to IVF Treatment

Referred to: Reference Committee B

Whereas, on Friday, 2/16/24, the Alabama Supreme Court ruled that “an embryo created through in vitro fertilization (IVF) is a child protected by Alabama’s wrongful death act and the Alabama Constitution;” and that “a human frozen embryo is a ‘child’ which is an unborn or recently born children;” and that “the Constitution … commands the judge to … upholding the sanctity of unborn life, including unborn life that exists outside the womb;” and that “the Court would not create an exception in the statute for these IVF embryo children just because they were located outside the womb; and

Whereas, historically, multiple states have already rejected attempts through legislation, constitutional amendments or ballot measures to establish and expand the definition of personhood and associated rights:

1. In 2008 and 2010, Colorado voters rejected ballot measures, to give constitutional rights to individuals “at the beginning of biological development;” and
2. In 2011, Mississippi considered Proposition 26: "Should the term ‘person’ be defined to include every human being from the moment of fertilization, cloning, or the equivalent thereof?" which was voted down; and
3. In 2012, the Virginia House of Delegates passed House Bill 1 that was subsequently tabled by the state Senate until 2013, which if passed would “construe the word ‘person’ under Virginia Law … to include unborn children” and enact that “the life of each human being begins at conception;” and
4. Similar “Personhood” bills have also been passed by a single legislative chamber in North Dakota, Oklahoma, and Mississippi; and

Whereas, these “Personhood” bills and ballot measures define a person as being a legal entity from the moment of conception, and thus define fertilized eggs and embryos, as persons with constitutional rights; and

Whereas, giving constitutional rights to a fertilized oocyte or embryo would interfere with the physician-patient relationship in the provision of in vitro fertilization (IVF) services; and

Whereas, in current IVF practice in the United States, over half of embryo transfers will *not* result in live birth, as many embryos after transfer will either (a) not result in a pregnancy, (b) result in a miscarriage, or (c) result in a non-viable ectopic or molar pregnancy; and

Whereas, cryopreserved embryos also do *not* have a 100% thaw-survival rate, and a small percentage of embryos will not survive freeze-thaw; and if embryos in the IVF lab have the same legal status as children, then an embryology laboratory that fails to have a 100% thaw-survival rate may also have some potential liability; and

Whereas, not all IVF patients can afford the long-term storage fees to cryopreserve embryos for future use or to donate those embryos to others; and

Whereas, defining all embryos as “children” promotes the dangerous notion that all embryos should somehow be transferred in an IVF cycle (instead of cryopreserving extra embryos of adequate quality), which could potentially increase the rate of dangerous higher-order multiple gestation pregnancies (triplets, quadruplets, etc.); and

Whereas, defining all embryos as “children” may promote the dangerous and misguided notion that an ectopic pregnancy could somehow be safely implanted into the uterus (as is erroneously reported on various “Personhood” websites); and

Whereas, considering embryos to be “children” also raises potential legal complications, such as how inheritance and probate laws would apply to embryos; and

Whereas, defining all embryos as “children” may promote the dangerous and misguided notion that a molar pregnancy can somehow be “rescued” instead of being a potential cancer; and

Whereas, considering abandoned embryos to be “children” raises questions about whether states would then be liable to provide support for cryopreserved embryos and long-term storage costs, such as under Medicaid as if they were “wards” of the state; and

Whereas, giving “rights” to embryos in the IVF lab will potentially complicate the practice of IVF by inappropriately pressuring physicians to transfer abnormally-growing and arrested embryos; and

Whereas, the American Society for Reproductive Medicine (ASRM) Position Statement on Personhood Measures states that:

1. The ASRM is strongly opposed to measures granting constitutional rights or protections and “personhood” status to fertilized reproductive tissues.
2. In a growing number of states, vaguely worded and often misleading measures are appearing either in legislation or as proposed constitutional amendments, defining when life begins and granting legal “personhood” status to embryos at varying stages of development. If approved, these measures will have profound consequences for women and their families.
3. …, these broadly worded measures will have significant effects on a number of medical treatments available to women of reproductive age.
    a. Personhood measures would make illegal some commonly used birth control methods.
    b. Personhood measures would make illegal a physician's ability to provide medically appropriate care to women experiencing life-threatening complications due to a tubal pregnancy.
    c. Personhood measures would consign infertility patients to less effective, less safe treatments for their disease.
    d. Personhood measures would unduly restrict infertile patients’ right to make decisions about their own medical treatments, including determining the fate of any embryos created as part of the IVF process.
4. ASRM will oppose any personhood measure that is unclear, confusing, ambiguous, or not based on sound scientific or medical knowledge, and which threatens the safety and effective treatment of patients; therefore be it

RESOLVED, that our American Medical Association oppose any legislation that could criminalize in-vitro fertilization (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose Court rulings that equate gametes (oocytes and sperm) or embryos with children. (Directive to Take Action)

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

Received: 4/16/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-24)

Introduced by: Missouri

Subject: Medicare Reimbursement for Telemedicine

Referred to: Reference Committee B

Whereas, during the COVID-19 pandemic, Medicare billing rules were revised to enable and facilitate reimbursement to clinicians for services rendered by telemedicine links to their patients; and

Whereas, these rules were adopted during the COVID-19 pandemic, and did not differentiate reimbursement rates for office-based vs telemedicine-based patient care; and

Whereas, commercial insurers have generally adopted Medicare's methodology for reimbursement; and

Whereas, reimbursement for telemedicine services has had two salutatory effects: 1) greater convenience for patients, and 2) decreased need to utilize petroleum-powered vehicles for patients' and doctors' transit from their homes to physicians' offices; and

Whereas, for mobility-challenged patients telemedicine links offer an increased level of convenience; and

Whereas, American Medical Association Policy D-135.966, "Declaring Climate Change a Public Health Crisis", states that a goal for America's health care sector is to decrease its greenhouse gas emissions by 50% by 2030, and to achieve "carbon neutrality" by 2050; and

Whereas, under Medicare, through December 31, 2024, Medicare will reimburse physicians for charges that accrue for the provision of medical care to patients via telehealth services; and

Whereas, the remission of the COVID pandemic has enabled much medical care to again be provided in "brick and mortar" offices, which makes it imperative that reimbursement rates for office-based care should be greater than reimbursement rates for telemedicine-based care, due to the greater overhead expenses associated with office-based care; and

Whereas, to extend indefinitely the policy of reimbursement to physicians for services provided via telemedicine links (at rates lower than provided for office-based care) would be salutatory toward patient convenience and toward reducing the greenhouse gas emissions attributable to the healthcare sector, a previously-established goal of our AMA via its Policy D-135.9661; therefore be it

RESOLVED, that our American Medical Association support removal of the December 31, 2024 "sunset" date currently set for Medicare to cease reimbursement for services provided via telemedicine, such that reimbursement of medical services provided by telemedicine be continued indefinitely into the future, consistent with what would be determined by the Relative Value Update Committee ("RUC"). (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/16/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-24)

Introduced by: Missouri

Subject: Waiver of Due Process Clauses

Referred to: Reference Committee B

Whereas, the right to and access to due process protections is a fundamental right enjoyed by all employed Americans, unless specifically waived by the employee; and

Whereas, approximately half of all physicians are employed by employers that are not local, physician-owned groups; and

Whereas, many employment agreements offered to such employed physicians contain “Waiver of Due Process” clauses, which the non-physician employer has inserted to nullify the physician-employee’s due process rights; and

Whereas, by working at the patient care interface, physicians are uniquely situated to detect threats to patients’ health and well-being that have not been recognized or acknowledged by members of hospitals’ administrations; and

Whereas, hospital administrators have occasionally retaliated against physicians who have reported threats to patient or hospital worker safety in a manner that adversely impacts the physician’s employment security, income stream and access to ongoing opportunities to provide patient care, especially after within-organization reporting has failed to result in the employer addressing or resolving those threats; and

Whereas, due process protections are thus essential for physicians, because they are duty-bound to advocate for the best interest of patients and co-workers, without fear of adverse job actions on the part of their employer; and

Whereas, federal legislation proposing to ban waiver of due process provisions in the employment contracts of some physicians was introduced in the 116th Congress of the United States of America, the “ER Hero and Patient Safety Act”, also known as HR 69102, a proposed law that was not enacted; and

Whereas, the AMA House of Delegates adopted Resolution I-205-2022, advocating that our AMA work for the abolition of waiver of due process clauses in physicians’ employment agreements; and

Whereas, the AMA has since developed model state legislation on this topic, yet has not developed model federal legislation regarding this matter as had been envisioned within the “ER Hero and Patient Safety Act”; therefore be it

RESOLVED, that our American Medical Association advocate that waiver of due process clauses be eliminated from all employment agreements between employed physicians and their non-physician employers, and be declared unenforceable in physicians’ previously-executed

employment agreements between physicians and their non-physician employers that currently exist (Directive to Take Action); and be it further

RESOLVED, that our AMA will engage in advocacy for adoption of such legislation at the federal level. (Directive to Take Action)

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

Received: 4/16/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-24)

Introduced by: Illinois

Subject: Opposition to Legalization of Psilocybin

Referred to: Reference Committee B

Whereas, the effects of psilocybin, psilocin, baeocystin, norbaeocystin, and indole alkaloids similar to LSD (d-lysergic acid) are primarily central (hallucinogenic) but there are some peripheral effects, probably through the serotonin-norepinephrine pathways similar to bufotenine; and

Whereas, according to the Drug Enforcement Administration (DEA), “The physical effects include: nausea, vomiting, muscle weakness, and lack of coordination. The psychological consequences of psilocybin use include hallucinations and an inability to discern fantasy from reality. Panic reactions and a psychotic-like episode also may occur, particularly if a user ingests a high dose.” (https://www.dea.gov/factsheets/psilocybin); and

Whereas, mild to moderate effects of hallucinogenic mushrooms include dilated pupils (develops in over 90% of cases), confusion, vertigo, drowsiness, nausea, vomiting, tachycardia, and mild hypertension. Psychotropic effects include sense of exhilaration, hallucinations including vivid bright colors and shapes, euphoria, distortion of sense of time, dysesthesias, anxiety, perceptual distortions (may result in either a pleasant or apprehensive mood; "good" or "bad" trip), and impaired judgement. Although hallucinations usually do not persist after 4 to 5 hours, prolonged hallucinations persisting for up to 4 days have rarely been reported. Flashback phenomena have occurred from 2 weeks to 8 months after ingestion; and

Whereas, severe toxic physical effects include: muscular weakness, increased deep tendon reflexes, fever (particularly in children), flushing (primarily face and upper trunk), tachycardia, hypertension, ataxia, paresthesias, seizures (more common in children), rhabdomyolysis (very rarely), renal failure, or cardiopulmonary arrest. Intravenous injection of mushroom extract can cause fever, hypoxia, or mild methemoglobinemia. Severe psychotropic effects include: mood alterations, acute psychosis, panic reactions, and powerful distortions of space and time; and

Whereas, psilocybin can induce complex changes at various levels of the brain which lead to altered states of consciousness; and

Whereas, there is little correlation between the quantity ingested and clinical effects. One to four large Psilocybes (10 to 30 grams fresh weight) may yield 5 to 15 mg of psilocybin, and produce hallucinations. A dose of 12 mg or more of psilocybin can produce vivid hallucinations; and

Whereas, Psilocybin or it’s related substances should not be used in any safety sensitive position in that impairment is likely to occur; and

Whereas, quality control (for dose confirmation and contaminant detection) is difficult to obtain for a fungal based product; and

Whereas, Psilocybin is not detected with usual toxicological screening methods and blood/urine concentrations of the active ingredient (Psilocin or 4-hydroxy-dimethyltryptamine; 4-OH-DMT) is not possible for the clinical application (requiring at least one-week turnaround from most reference labs (https://www.nmslabs.com/tests?test=psilocybin); and

Whereas, therapeutic drug monitoring, dose titration to effects and prediction of toxic sequelae is not possible with Psilocybin; therefore be it

RESOLVED, that our American Medical Association oppose any legislative efforts relatable to legalization of Psilocybin/Psilocin or its related substances use. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-24)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Contact Dermatitis Society and American College of Mohs Surgery

Subject: Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion

Referred to: Reference Committee B

Whereas, procedures performed by any means, methods, devices, or instruments that can alter or cause biologic change or damage the skin and subcutaneous tissue constitute the practice of medicine and surgery; and

Whereas, there are increased legislative and regulatory efforts to allow dentists and dental hygienists to administer neurotoxins and dermal fillers for therapeutic or cosmetic purposes without physician supervision; and

Whereas, in order to ensure patient safety, administration of neurotoxins and dermal fillers requires supervision by a trained physician, education, training, specific knowledge of facial anatomy (particularly in the periocular region), and the ability to manage complications that may arise; and

Whereas, the focus of dental education is on oral health, rather than the skin and facial tissue; and

Whereas, dentists and dental hygienists are not required to demonstrate competency in procedures that augment skin and soft tissues using products that can alter or damage such living tissue; and

Whereas, the American Dental Association and the American Dental Hygienist Association are silent on the issue of dentists and dental hygienists performing medical procedures related to fillers and neurotoxins; and

Whereas, in 2023 the Food and Drug Administration (FDA) updated consumer guidance to state that anyone considering a neurotoxin or dermal filler should consult with a licensed health care provider who has experience in the fields of dermatology or plastic surgery, who is experienced in injecting dermal fillers, who is knowledgeable about fillers, anatomy and managing complications, and who knows the risks and benefits of treatment[3]; and

Whereas, preventing and treating adverse events of injectable fillers requires the development of evidence-based clinical practice guidelines to support decision-making in daily practice and knowledge of vascular anatomy is *crucial* for all filler injections[4]; and

Whereas, intravascular injection is possible at any location on the face, but certain locations carry a higher risk of filler embolization, necrosis, visual abnormalities, blindness and stroke[5]; and

Whereas, allowing dentists and dental hygienists to administer neurotoxins and dermal fillers for therapeutic or cosmetic purposes jeopardizes patient safety and disregards what is considered adequate and appropriate medical education and training; therefore be it

RESOLVED, that our American Medical Association advocacy efforts recognize the threat posed to patient safety when dentists and dental hygienists are authorized to practice medicine and administer procedures outside their level of education and training (New HOD Policy); and be it further

RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists and dental hygienists to practice outside their level of education and training. (Directive to Take Action)

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

Received: 4/24/2024

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RELEVANT AMA POLICY

D-35.983 Addressing Safety and Regulation in Medical Spas

Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies. (Res. 209, I-11; Reaffirmed: BOT Rep. 7, A-21)

D-160.995 Physician and Nonphysician Licensure and Scope of Practice

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various

analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation. (CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19)

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-24)

Introduced by: American College of Medical Genetics and Genomics

Subject: Supporting the Establishment of Rare Disease Advisory Councils

Referred to: Reference Committee B

Whereas, a rare disease is defined as a disease or condition that impacts fewer than 200,000 people in the United States[1]; and

Whereas, given the current estimate for the number of known rare diseases is more than 10,000, the rare disease population comprises of more than 30 million people in the United States[2]; and

Whereas, the economic burden of rare diseases surpasses that of some of the most prevalent chronic diseases in the United States[3]; and

Whereas, rare diseases are often chronic, progressive, and debilitating, and lead to significant morbidity and mortality[4]; and

Whereas, rare disease patients continue to face hurdles with accessing new available medications due to costs and payor policies, including prior authorizations and denials[5]; and

Whereas, patients with rare disorders face other unique challenges in healthcare including limited access to specialists, the cost-sharing mechanism of prescriptions, insurance coverage issues without a proper diagnosis, and more[5,6]; and

Whereas, rare patients report significantly lower quality of life scores due to facing these hurdles and experiencing a longer diagnostic journey than typical patients[5,6]; and

Whereas, a Rare Disease Advisory Council (RDAC) is an advisory body that informs policymakers on the issues relevant to the rare community and gives said community a stronger voice[7]; and

Whereas, since 2015, Rare Disease Advisory Councils have been established in 27 states, leaving many states without advocates for proper rights for rare patients[7]; and

Whereas, Rare Disease Advisory Councils have been actively working on state and federal policies addressing barriers to obtaining proper care for patients with rare diseases such as Medicaid eligibility, newborn screening processes, coverage of medical nutrition, out-of-pocket prescription drug costs, reforming step therapy, and more[8]; and

Whereas, AMA Policy H 460.880 recognizes the under-treatment and under-diagnosis of orphan diseases but fails to sufficiently include how to act on this recognition to actively support rare disease patients and their families; therefore be it

RESOLVED, that our American Medical Association will support state legislation for the establishment of Rare Disease Advisory Councils in each state (New HOD Policy).

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-24)

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

Subject: Medicare Advantage Part B Drug Coverage

Referred to: Reference Committee B

Whereas, 66% of Medicare beneficiaries have been diagnosed with at least two chronic diseases; and

Whereas, the majority of patients enrolled in traditional (fee-for-service) Medicare have additional coverage that limits their financial exposure to the 20% coinsurance required for Part B drugs and biologicals; and

Whereas, over half of all Medicare-eligible patients were enrolled in a Medicare Advantage (MA) plan in 2023; and

Whereas, Medicare patients are increasingly choosing MA plans because many of those plans have lower premiums and are more affordable for less affluent patients; and

Whereas, more MA plans are listing specialty drugs and biologicals as either non-covered benefits or are covering only 80% of the cost of physician administered drugs and biologicals; and

Whereas, patients enrolled in MA are prohibited from purchasing Medigap policies; and

Whereas, less affluent patients may not be able to afford the remaining 20% coinsurance for essential drugs and biologicals required by most MA plans, potentially leading to disparities in health outcomes; and

Whereas, prior to a chronic disease diagnosis, patients enrolling in MA can have no knowledge of which expensive drugs and biologicals they may require and, further, that those drugs and biologicals may be designated as non-covered by the plan or require a 20% coinsurance payment; and

Whereas, when a patient enrolled in MA is diagnosed with a chronic disease where costly physician-administered drugs and biologicals are necessary, they cannot revert to traditional (fee-for-service) Medicare or purchase a Medigap policy; therefore be it

RESOLVED, that our American Medical Association will advocate with Congress, through the appropriate oversight committees, and with the Centers for Medicare & Medicaid Services (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 4/24/2024

REFERENCES
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RELEVANT AMA POLICY

Medicare Advantage Policies H-330.878
1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870
Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans; (2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and (3) advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to such programs.

Medicare Cost-Sharing D-330.951
Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-24)

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

Subject: Prohibiting Mandatory White Bagging

Referred to: Reference Committee B

Whereas, many health insurers and pharmacy benefit managers (PBMs) have adopted policies that condition coverage of a clinician-administered drug, such as an IV infusion, on the drug being dispensed from a PBM-affiliated mail order pharmacy; and

Whereas, this practice is commonly referred to as “white bagging”; and

Whereas, mandatory white bagging policies exclude payment for medically necessary drugs from any health care provider that is not under common ownership with the insurer or PBM, including in-network pharmacies; and

Whereas, drugs commonly subject to mandatory white bagging policies are often needed to treat the most vulnerable patient populations with complex treatment plans who require efficient and timely delivery of clinician-administered drugs for successful outcomes; and

Whereas, white bagging requires each individual patient-specific treatment dose to be shipped in a separate parcel, via common carrier, to the administering provider, even if the administering provider already has the drug in stock and available for administration; and

Whereas, shipments from specialty pharmacies can be delayed and are difficult for providers to track; and

Whereas, if a patient’s clinical status changes from when the medication was ordered, the adjusted medication must be re-ordered from the third-party pharmacy, which can result in increases in canceled appointments, days to initiation of therapy, and frequency of past-due administrations; and

Whereas, day-of treatment changes lead to drug waste when an unused portion of the drug cannot be used for another patient, and practices and hospitals must then discard the unused portion of highly toxic drugs according to state and federal safety standards, creating additional administrative burden; and

Whereas, providers have no control over the shipping process, limiting their ability to prevent improper storage or mishandling of white bagged drugs; and

Whereas, a 2023 analysis found that, on average, bagging increased oncology patients’ out-of-pocket costs by $180 per month, or $2,160 per year; and

Whereas, since 2021, eight states have prohibited the use of payer-mandated white bagging; therefore be it

RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging (Directive to Take Action).

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

Received: 4/24/2024

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RELEVANT AMA POLICY

Medication Brown Bagging H-100.951

1. Our AMA affirms that decisions to accept or refuse "brown bagged" (patient-acquired, physician-administered) pharmaceuticals be made only by physicians responsible for administering these medications.
2. Our AMA affirms that "brown bagged" pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or his or her agent, is fully capable of safely handling and transporting the medication.
3. Our AMA will work with interested national medical specialty societies and state medical associations to oppose third party payer policies and legislative and regulatory actions that require patients to utilize "brown bagging" to ensure coverage of office-administered medications.
4. Our AMA will work with interested national medical specialty societies and state medical associations to oppose third party payer policies that reimburse office-administered drug costs at less than the provider's cost of acquiring the drug if the provider does not accept "brown bagging."

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-24)

Introduced by: Association for Clinical Oncology, American Academy of Dermatology Association, American College of Mohs Surgery, American Contact Dermatitis Society, American College of Rheumatology

Subject: State Prescription Drug Affordability Boards - Study

Referred to: Reference Committee B

Whereas, in an effort to control high prescription drug costs, states are increasingly considering prescription drug affordability boards (PDABs); and

Whereas, PDABs in Colorado, Maryland and Minnesota have the authority to set upper payment limits (UPLs) for certain high-cost medications; and

Whereas, a UPL is the maximum reimbursement rate above which purchasers throughout the state may not pay for prescription drug products; and

Whereas, Medicare pays most separately payable Part-B covered drugs and biologics at a rate of the drug's average sales price plus 6%; and

Whereas, the 6% add-on payment for Medicare Part B drugs is intended to cover expenses associated with administering drugs in-office, including storage and handling; and

Whereas, similar to the concept of an upper payment limit, the Inflation Reduction Act (IRA) establishes a "maximum fair price" for a negotiated drug; and

Whereas, under the IRA, Medicare's payment to providers for Part B drugs with negotiated prices will be at 106% of the maximum fair price; and

Whereas, reimbursement for physician administered drugs can be up to 125% of a drug's average sales price in the private insurance market; and

Whereas, state PDAB legislation that includes UPL authority often lacks language that would allow physicians to seek reimbursement for storage and handling of a physician-administered drug subject to a UPL; therefore be it

RESOLVED, that our American Medical Association conduct a study to determine how upper payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will impact reimbursement for physician-administered drugs and what impact state UPLs will have on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at A-25. (Directive to Take Action)

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

Received: 4/24/2024

REFERENCES

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RELEVANT AMA POLICY

Reducing Prescription Drug Prices D-110.993
Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Medicare Part B Competitive Acquisition Program (CAP) H-110.983
Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices that choose not to participate;
(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-24)

Introduced by: New Jersey

Subject: Establish a Cyber-Security Relief Fund

Referred to: Reference Committee B

Whereas, Cyber-attacks are becoming frequent and that they will continue to escalate and become more complex; and

Whereas, the recent cyber-attack on “Optum” resulted in thousands of Physician payments to be withheld for several weeks or months resulting in devastating consequences to the several thousand families because of inability to meet the payroll of the physicians and their employees; and

Whereas, the financial impact is global, affecting private practicing Physicians, Medical groups, and healthcare systems; and

Whereas, United Healthcare’s full year 2023 earnings from operations were $32.4 billion; therefore be it

RESOLVED, that our American Medical Association, through appropriate channels, advocate for a ‘Cyber Security Relief Fund” to be established by Congress (Directive to Take Action); and be it further

RESOLVED, that the “Cyber Security Relief Fund” be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer (Directive to Take Action); and be it further

RESOLVED, that the “Cyber Security Relief Fund” only be utilized for ‘uninterrupted’ payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/3/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-24)

Introduced by: Delaware

Subject: Support of Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

Whereas, the American Medical Association supports physicians' entitlement to engage in collective bargaining, and it is AMA policy to advocate for broadening the scope of eligibility for this right under federal law, thereby expanding the number of physicians eligible to join unions[1]; and

Whereas, the AMA highlights that bargaining units consisting solely of physicians are presumed appropriate,[1] a recommendation that aligns with the acknowledgment of physicians' unique skills, distinct expertise, and ethical and professional obligations; and

Whereas, in 1999 the AMA provided financial support for the establishment of a national labor organization, the Physicians for Responsible Negotiation (PRN), under the National Labor Relations Board (NLRB), an initiative aimed to support the development and operation of local physician negotiating units as an option for employed physicians and physicians in-training, but due to limited participation from physicians, the AMA withdrew this support in 2004[1]; and

Whereas, since 2004, the number of physicians belonging to unions in the United States has reportedly surged, with a notable 26% increase from 2014 to 2019 reaching a total of 67,673 physicians that were union members[1]; and

Whereas, the percentage of physicians in the United States now employed by hospitals, health systems, or corporate entities has seen a substantial rise, reaching 73.9% as of January 2022, compared to 47.4% in 2018, and the acquisition of physician practices by hospitals and corporate entities escalated between 2019-2022 during the pandemic[2,3]; and

Whereas, the shift from a workforce of independent professional physicians to one composed of employed physicians fundamentally alters the dynamics among hospitals, health systems, corporate entities and physicians, with a risk of adversely affecting the conditions under which care is delivered and quality of care provided,[4] consequently altering the physician-patient relationship; and

Whereas, major hospitals, health care systems, and other corporate entities that employ physicians may restrict employment options available to these professionals in a market largely influenced by their employer or where covenants not to compete may further contribute to an employer's bargaining advantage[1]; and

Whereas, the increasing corporatization of medicine, encompassing private equity involvement in health care, raises concerns about alignment of incentives, costs, impacts on physician wellness, and subsequent downstream effects on patients[5,6]; and

Whereas, in recent years, there has been a rise in physician burnout, exacerbated by the COVID-19 pandemic, primarily stemming from the excessive time dedicated to electronic health record documentation, bureaucratic administrative duties, and moral distress arising from a misalignment between physicians' values and the incentivized actions dictated by the health care system[7-11]; and

Whereas, as physicians increasingly transition to employment, there's a trend toward standardization of work schedules, time of appointments, and other aspects of work conditions. Studies indicate that burnout is directly impacted by a lack of control over work conditions and that granting more autonomy can mitigate stress and burnout, and even reduce cardiovascular risk[12]; and

Whereas, physicians encounter significant power differentials when negotiating with hospital systems as employers and may lack sufficient influence without collective bargaining to counterbalance the dynamic[1]; and

Whereas, collective bargaining serves as an effective mechanism for safeguarding patient care safety standards, enhancing work conditions, securing fair compensation and job stability, and establishing a structured process for addressing grievances; and

Whereas, unionization is linked with enhanced wages and benefits, as well as diminished disparities in compensation for minority groups[13]; and

Whereas, in 2022, the National Labor Relations Board concluded that employed physicians are not in a supervisory role simply by virtue of their position in the organization and, therefore, may be eligible to unionize[14]; and

Whereas, collective bargaining and unionization do not necessarily require resorting to strikes. For example, first responder unions often utilize binding arbitration as an alternative tactic. Other potential strategies may include work slowdowns, picketing, mass resignation, whistleblowing to regulatory and accrediting bodies, boycotting administrative tasks, and suspending billing activities, among other options; therefore be it

RESOLVED, that our American Medical Association investigate avenues for the AMA and other physician associations to aid physicians in initiating and navigating collective bargaining efforts, encompassing but not limited to unionization. (Directive to Take Action)

Fiscal Note: $43,308: Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts.

Received: 5/3/2024

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RELEVANT AMA POLICY

D-383.977 Investigation into Residents, Fellows, and Physician Unions

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. [Res. 606, A-19]

D-383.988 Collective Bargaining and the Definition of Supervisors

Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al*. [BOT Action in response to referred for decision Res. 248, A-01; Modified: BOT Rep. 22, A-11; Reaffirmed: Res. 206, A-19]

Update:

2022: In Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (the Act) simply by virtue of their position in the healthcare institution.

This DDE is notable, as it confirms that physicians will not automatically be considered supervisors under the Act and may seek union representation. Indeed, Piedmont's physicians and providers ultimately voted in favor of union representation. Healthcare employers should consider reviewing their physicians' job descriptions and job duties to determine whether they potentially can be considered supervisors under the Act.

H-385.946 Collective Bargaining for Physicians
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. [Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 206, A-19]

H-383.998 Resident Physicians, Unions and Organized Labor
Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients. [CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17; Reaffirmed: BOT Rep. 13, A-19]

H-385.976 Physician Collective Bargaining
Our AMA's present view on the issue of physician collective negotiation is as follows:

(1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

[BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19]

H-383.988 Physicians' Ability to Negotiate and Undergo Practice Consolidation
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. [Res. 229, A-12; Reaffirmed: Res. 206, A-19]

AMA Code of Medical Ethics
1.2.10 Political Action by Physicians
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

AMA Principles of Medical Ethics: I,III,VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
[Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-24)

Introduced by: American College of Preventive Medicine

Subject: Encouraging the Passage of the Preventive Health Savings Act (S.114)

Referred to: Reference Committee B

Whereas, the Congressional Budget Office (CBO) was established in 1974 to provide objective, nonpartisan information to support the U.S. budget process and aid Congress in making effective budget and economic policy[1]; and

Whereas, the CBO is directed to estimate and project the cost of legislation approved by Congressional committees for a specified period of time, usually 10 years[2]; and

Whereas, the CBO estimates the United States Federal Budget deficit will increase substantially over the next 30 years[3]; and

Whereas, the CBO is evaluating the economic impact of legislation pertaining to roles of health behaviors and preventive measures beyond the 10-year budget window in specific cases[4]; and

Whereas, the 118th House of Representatives has passed legislation in a bipartisan vote to direct the CBO to expand the scoring window to estimate the budgetary effects of legislation related to preventive health care services up to a 30-year period[5]; and

Whereas, expanding the CBO scoring window to estimate the budgetary effects over a 30-year period of legislation related to preventive health care services would not significantly increase the cost of generating economic estimates for legislation[6]; and

Whereas, the United States spends $4.1 trillion in annual health care expenditure[7]; and

Whereas, 70% of the U.S. health care expenditure is spent on the management and treatment of chronic disease[7]; and

Whereas, the American Medical Association encourages the CBO to more comprehensively measure long-term budget deficit reductions and costs associated with legislation related to the preventive health services[8]; therefore be it

RESOLVED, that our American Medical Association encourages continued advocacy to federal and state legislatures of the importance of more accurately and effectively measuring the health and economic impacts of investing in preventive health services to improve health and reduce healthcare spending costs in the long term. (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm the following policy: D-155.994, “Value-Based Decision Making in the Health Care System” to encourage legislation and efforts to allow the Congressional Budget Office to more effectively project long-term budget deficit reductions and costs associated with legislation related to preventive health services. (Reaffirm HOD Policy)

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

Received: 5/8/2024

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RELEVANT AMA POLICY

Value-Based Decision-Making in the Health Care System D-155.994

1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress. [CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 230, I-14; Reaffirmation I-15]

American Medical Association House of Delegates

Resolution: 238
(A-24)

Introduced by: New York

Subject: AMA Supports Efforts to Fund Overdose Prevention Sites

Referred to: Reference Committee B

Whereas, the federal “Defund Heroin Injections Centers of 2023” Act prohibits federal funding for injection sites; and

Whereas, this Act states: No Federal funds may be used by any Federal agency to operate or control, or to pay the salaries of officers and employees of such an agency to operate or control, an injection center in violation of section 416 of the Controlled Substances Act (21 U.S.C. 856; commonly referred to as the “Crack House Statute”); and

Whereas, OPS (Overdose Prevention Sites) have been shown to be effective at reducing overdoses, refer patients for ongoing drug treatment, prevent communicable disease and decrease health care costs; therefore be it

RESOLVED, that our American Medical Association support legislation or regulation that would fund overdose prevention sites. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/7/2024

REFERENCES

https://www.congress.gov/117/bills/hr6741/BILLS-117hr6741ih.pdf

American Medical Association House of Delegates

Resolution: 239
(A-24)

Introduced by:	New York
Subject:	Requiring stores that sell tobacco products to display NYS Quitline information
Referred to:	Reference Committee B

Whereas, state laws already only allow only certain stores (not pharmacies) to sell to certain persons (those over age 20) in certain locations (not near schools); and

Whereas, the states various Tobacco Control Programs allow Quitline phone number and website which offers to persons who smoke the ability to get help with stopping by texting, calling, or chatting; free nicotine patches, gum or lozenges, and other tools for cessation assistance, therefore be it

RESVOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the CDC hotline 1-800-QUIT-NOW in multiple languages and/or the information for the corresponding state or territory. (Directive to Take Action)

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

Received: 5/8/2024

REFERENCES

https://www.nysmokefree.com/
https://www.health.ny.gov/prevention/tobacco_control/current_policies.htm

American Medical Association House of Delegates

Resolution: 240
(A-24)

Introduced by: New York

Subject: Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas

Referred to: Reference Committee B

Whereas, the most common visa that international medical graduates (IMG) use to participate in US graduate medical education programs is the J-1 visa[1]; and

Whereas, the J-1 visa traditionally requires a mandatory two-year foreign residency after completion of their graduate medical education , forcing many IMGs who may wish to begin practice inside the US to undergo a long and painful transition out of the country before reapplication under a new visa[2]; and

Whereas, the Conrad 30 waiver program is a federal exemption to the J-1 visa residency requirement, which allows up to 30 IMGs per State under a J-1 visa to avoid the two-year foreign residency requirement after graduation if they practice in a federally designated medically underserved area or with a medically underserved population[3]; and

Whereas, some studies have suggested that US residency-trained IMG physicians may yield superior patient outcomes relative to their US medical graduate peers[6]; and

Whereas, reapproval or expansion of the Conrad 30 waiver program is unlikely to meaningfully harm the economic competitiveness of native New York physicians or physician practices due to requirements that waiver recipients be employed by health systems that have been unsuccessful in attracting US medical graduates to the same position[9]; and

Whereas, the Conrad State 30 and Physician Access Reauthorization Act would extend and expand the Conrad 30 waiver exemption program, allowing for approximately ~50% additional waivers to be granted on a per-year basis over the next decade[11]; therefore be it

RESOLVED, that our American Medical Association supports reauthorization and expansion of the Conrad-30 J-1 visa waiver program, including permitting reallocation of unused slots to states that have already used the maximum number of waivers. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/8/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-24)

Introduced by: New York

Subject: Healthcare Cybersecurity Breaches

Referred to: Reference Committee B

Whereas, cybersecurity attacks by malicious criminals on Healthcare entities: Insurers, Health systems and Medical Practices are becoming more and more common; and

Whereas, the recent 2024 attack on Change Healthcare website has crippled Healthcare operations across multiple insurers and threatens the financial viability of thousands of practices and healthcare systems; and

Whereas, the timely delivery of healthcare to millions of patients is jeopardized by healthcare Cybercrime, thus jeopardizing the health and safety of New Yorkers and the US population as a whole ; making Healthcare Cybercrimes especially heinous and deserving of more vigorous punishment and prevention efforts than are currently in effect; therefore be it

RESOLVED, that our American Medical Association advocate for the development of an adequately funded multidisciplinary task-force including representation of AMA, health insurers, the FBI and other pertinent stakeholders to prevent future healthcare cyberattacks throughout the country and to increase the apprehension of cybercriminals who prey on patients and healthcare entities, and to recommend appropriate penalties for their crimes. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/8/24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-24)

Introduced by: Minority Affairs Section

Subject: Cancer Care in Indian Health Services Facilities

Referred to: Reference Committee B

Whereas, cancer is the leading cause of death among American Indian and Alaska Native (AI/AN) persons in the United States (US)[1,2]; and

Whereas, AI/AN Tribes and Villages are sovereign governments that have unique needs and challenges; and

Whereas, AI/AN patients, as dual citizens of their Tribal Nations and the US, are entitled to the same rights and privileges of US citizens, including those relating to healthcare (H-350.976 and H-350.977); and

Whereas, the Indian Health Service (IHS) was established by Article I, Section 8 of the Constitution to provide adequate and timely healthcare, in honoring the government-to-government relationship between the United States and these Tribal organizations[3,4]; and

Whereas, federal IHS facilities do not offer on-site cancer care or provide payment for cancer treatment, unlike other federal health programs like the VA, unless funds are available for referral[5,6]; and

Whereas, several Indian Health Service Areas do not have a single comprehensive cancer care center, increasing the likelihood that AI/AN patients have to obtain care from other public and private payors and shoulder out-of-pocket costs[7]; and

Whereas, funding limitations to the IHS primarily limit health care to direct ambulatory care services, thus denying access to comprehensive, specialty healthcare services to their patients (H-350.977); and

Whereas, many cancers, including liver, stomach, kidney, lung, melanoma, and colorectal cancer have a significantly higher prevalence among AI/AN persons[8]; and

Whereas, for the ten most populated AI/AN reservations, the median travel distance to a National Cancer Institute (NCI) cancer center is 186.5 miles (range 77.8 - 629 miles), and the median travel time is 3.37 hours (range 1.32 - 10.42 hours), while 45.2% of the general US population lives <1 hour from an NCI cancer center[9]; and

Whereas, 14% of the US population lives >2 hours from an NCI cancer center, with 37% of these individuals being identified as AI/AN persons[9]; and

Whereas, a study analyzing the effects of distance on cancer treatment outcomes found that patients who traveled 50 miles or 1+ hour in driving time were associated with a more advanced

disease at diagnosis, and patients in rural areas were found to be twice as likely to have unstaged cancer and/or more advanced disease when compared to urban counterparts[10]; and

Whereas, counties with poor access to healthcare are known to have statistically lower cancer screening rates and higher cancer-related mortality rates[11]; and

Whereas, oncology patients not first seen at NCI-designated Comprehensive Cancer Care Centers have worse outcomes, even when adjusting for sociodemographic and clinical factors[12]; and

Whereas, it is unethical to deny appropriate and timely cancer care to American Indian and Alaska Native patients; therefore be it

RESOLVED, that our American Medical Association actively advocate for the federal government to continue enhancing and developing alternative pathways for American Indian and Alaska Native patients to access the full spectrum of cancer care and cancer-directed therapies outside of the established Indian Health Service system (Directive to Take Action); and be it further

RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS cancer care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage cancer linkage studies between the IHS and the CDC to better evaluate regional cancer rates, outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/4/2024

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RELEVANT AMA Policy

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

Cancer and Health Care Disparities Among Minority Women D-55.997
Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment. [Res. 509, A-08; Modified: CSAPH Rep. 01, A-18]

Clinical Preventive Services H-410.967
The AMA: (1) recommends the USPSTF guidelines to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. [CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12; Modified: CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-24)

Introduced by: Minority Affairs Section

Subject: Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes

Referred to: Reference Committee B

Whereas, the Indian Health Service (IHS) is a health care system for federally recognized American Indians and Alaska Natives in the United States;[1] and

Whereas, the Snyder Act of 1921 and the Indian Health Care Improvement Act (IHCIA) of 1976 recognized treaty obligations in codifying federal responsibility for Native American health in the creation of the IHS; and

Whereas, the Supreme Court decision of Morton v. Mancari 417 U.S. 535 (1974) ruled that members of federally recognized tribes possess a unique political status of quasi-sovereign tribal entities; and

Whereas, the IHS currently delivers care to over 2.8 million American Indians and Alaska Natives;[2] and

Whereas, eligibility for IHS services is strictly restricted to members of federally recognized American Indian or Alaska Native tribes;[3] and

Whereas, the Indian Health Service (IHS) Physician Scholarship program, as well as many other Native scholarship programs, require applicants to be enrolled members of federally recognized tribes;[4] and

Whereas, the IHS has severe physician vacancy issues;[5] and

Whereas, American Indians and Alaska Natives carry the lowest life expectancy (65.2 years old) of all races;[6] and

Whereas, American Indians and Alaska Natives have the least representation in the physician workforce of any racial group per capita;[7] and

Whereas, the American Medical Association and its partners, such as the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME), currently do not collect demographic data on federally recognized tribal members; and

Whereas, demographic data of federally recognized tribal members is a necessary first step towards better aiding the Indian Health Service (IHS); therefore be it

RESOLVED, that our American Medical Association add “Enrolled Member of a Federally Recognized Tribe” on all AMA demographic forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the use of "Enrolled Member of a Federally Recognized Tribe" as an additional category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education (Directive to Take Action); and be it further

RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of "Enrolled Member of a Federally Recognized Tribe" on all AAMC demographic forms (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include "Enrolled Member of a Federally Recognized Tribe" on all ACGME demographic forms. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 5/24/2024

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RELEVANT AMA POLICY

Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) descent D-350.979
Our AMA will: (1) add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and (3) study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients. [Res.19, I-21]

Disaggregation of Demographic Data Within Ethnic Groups H-350.954
1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. [Res. 001, I-17; Appended: Res. 403, A-19]

AMA Race/Ethnicity Data D-630.972
1. Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.
2. Our AMA will: (a) adopt racial and ethnic demographic data collection practices that allow self-identification of designation of one or more racial categories; (b) report demographic physician workforce data in categories of race and ethnicity whereby Latino, Hispanic, and other identified ethnicities are categories, irrespective of race; (c) adopt racial and ethnic physician workforce demographic data reporting practices that permit disaggregation of individuals who have chosen multiple categories of race so as to distinguish each category of individuals' demographics as alone or in combination with any other racial and ethnic category; and (d) collaborate with AAMC, ACGME, AACOM, AOA, NBME, NBOME, NRMP, FSBM, CMSS, ABMS, HRSA, OMB, NIH, ECFMG, and all other appropriate stakeholders, including minority physician organizations, and relevant federal agencies to develop standardized processes and identify strategies to improve the accurate collection, disclosure and reporting of racial and ethnic data across the medical education continuum and physician workforce. [BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CME Rep. 1, A-22; Appended: Res. 612, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244
(A-24)

Introduced by: Minority Affairs Section

Subject: Graduate Medical Education Opportunities for American Indian and Alaska Native Communities

Referred to: Reference Committee B

Whereas, the federal government has a unique government-to-government relationship with 574 federally recognized tribes based on Article I, Section 8 of the U.S. Constitution; and

Whereas, the federal government has committed itself to provide health care services to Tribal nations under the enforceable federal Indian trust responsibility, a legal fiduciary obligation to provide basic social, medical, and educational services for American Indians and Alaska Natives (AI/ANs);[1] and

Whereas, AI/AN are disproportionately affected by many chronic conditions, including heart disease, cancer, diabetes, stroke, and accidental injuries;[2] and

Whereas, AI/AN have the lowest life expectancy of any racial group (65.2 years), with AI/AN communities experiencing a 6.6-year decline between 2019 and 2021;[3] and

Whereas, the Indian Health Service (IHS) provides health care to over 2.8 million AI/AN through IHS and Tribal Health Programs and Urban Indian Organizations, often referred to as the I/T/U or the Indian Health system;[4] and

Whereas, the IHS is chronically under-funded compared to other federal health care systems, and the lack of funds has contributed to health disparities in Tribal communities;[5] and

Whereas, the IHS is the only large federal health care system to lack formalized partnerships with academic medical centers, unlike the Veterans Health Administration and the Military Health System;[6] and

Whereas, IHS and Tribal medical facilities often suffer from high physician staffing vacancy rates, contributing to negative outcomes;[7] and

Whereas, Congress mandated that IHS form workforce partnerships with teaching hospitals in the Indian Health Care Improvement Act of 1976 but has failed to appropriate funds to that effect;[8] and

Whereas, the President of the United States in the FY 2023 and FY 2024 Budget Proposals to Congress has recommended establishing and funding a Division of Graduate Medical Education in the IHS that would be tasked with expanding and supporting graduate medical education programs to create a pathway and an enhanced ecosystem for future physicians to address longstanding vacancy issues at IHS;[9] and

Whereas, the AMA reaffirmed its recommendation in 2023 to support efforts in Congress to enable the IHS to meet its obligation to bring American Indian health up to the general population level, and support efforts to establish closer ties with teaching centers to increase both the available manpower and the level of professional expertise available in Tribal clinics;[10] and

Whereas, the AMA also reaffirmed its commitment to advocate that the IHS establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs, and encourage the development of funding streams to promote rotations and learning opportunities at IHS, Tribal, and Urban Indian Health Programs;[11] and

Whereas, the AMA reaffirmed its recommendation in 2023 that the federal government provide sufficient funds to support needed health services for American Indians, and encourage further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs;[12] and

Whereas, the AMA acknowledges the importance of graduate medical education in training the next generation of physicians, reducing physician shortages, and benefiting communities;[13] and

Whereas, the AMA reaffirmed in 2022 that it will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation;[14] and

Whereas, the AMA also is committed to strongly advocate that Congress fund additional graduate medical education positions for the most critical workforce needs;[15] and

Whereas, the AMA is also committed to utilizing its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research, and education;[16] and

Whereas, the AMA included in its Recovery Plan for America's Physicians the need to expand the number of residency training slots and remove caps to Medicare-funded positions;[17] therefore be it

RESOLVED, that our American Medical Association supports policy and communication efforts to (1) advance legislative and regulatory policies and actions that establish, authorize, fund, and incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities and (2) establish associated partnerships with accredited medical schools and teaching hospitals (New HOD Policy); and be it further

RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal organizations, academic medical centers, policy professionals, medical schools, teaching hospitals, coalition builders, and other stakeholders to advocate to Congress, The White House, the Department of Health and Human Services, and other government entities to establish dedicated graduate medical education funding and programs that benefit Tribal communities, increase physician training sites, and reduce physician shortages, particularly among underserved populations. (New HOD Policy)

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

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RELEVANT AMA Policy

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration

should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23]

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]