DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its June 2021 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES
(J21 Special Meeting)

Report of Reference Committee G

Jayesh Shah, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 9 – Preservation of the Patient-Physician Relationship
2. Board of Trustees Report 13 – Amending the AMA's Medical Staff Rights and Responsibilities
3. Council on Medical Service Report 1 – CMS Sunset Review of 2011 House Policies
4. Council on Medical Service Report 5 – Medical Center Patient Transfer Policies
5. Resolution 711 – Opposition to Elimination of "Incident-to" Billing for Non-Physician Practitioners

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

6. Council on Medical Service Report 3 – Universal Basic Income Pilot Studies
7. Council on Medical Service Report 4 – Promoting Accountability in Prior Authorization
8. Council on Medical Service Report 6 – Urgent Care Centers
9. Council on Medical Service Report 9 – Addressing Payment and Delivery in Rural Hospitals
10. Resolution 706 – Prevent Medicare Advantage Plans from Limiting Care
11. Resolution 707 – Financial Incentives for Patients to Switch Treatments

RECOMMENDED FOR NOT ADOPTION

12. Resolution 702 – Addressing Inflammatory and Untruthful Online Ratings

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 9 - PRESERVATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 9 be adopted and the remainder of the report be filed.

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

The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that the remainder of the report be filed.

A member of the Board of Trustees introduced the report noting that many factors contribute to the patient-physician relationship, including the use of electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients. The member stated that the report discusses factors that contribute to patient-physician relationships and when those factors can detract from the physician's ability to provide high quality care or result in barriers to communication that can threaten the patient-physician relationship. The trustee highlighted that our AMA has dedicated significant resources and effort to identifying and addressing the barriers to patient care and effective patient-physician relationships, including the use of technology, documentation requirements, prior authorization, and other work environment factors and that this report also describes those efforts and relevant outcomes.

Testimony on the report was unanimously supportive and thanked the Board of Trustees for its report. Therefore, your Reference Committee recommends that Board of Trustees Report 9 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 13 - AMENDING THE AMA'S MEDICAL STAFF RIGHTS AND RESPONSIBILITIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that recommendations in Board of Trustees Report 13 be Adopted and the remainder of the report be filed.

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

The Board of Trustees recommends that the following be adopted in lieu of Resolution710-NOV-20 and that the remainder of the report be filed:
That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition and deletion:

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

Preamble

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

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

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

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

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

a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.

b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

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

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

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

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

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

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care ~~or,~~ medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body. (Modify Current HOD Policy)

Your Reference Committee heard positive testimony regarding Board of Trustees Report 13. A member of the Board of Trustees introduced the report, highlighting how the report strengthens current Rights and Responsibilities policy by bolstering protections for physicians who advocate both inside and outside of their organization. The trustee noted that this has been of particular concern in the last year as physicians throughout the country and the world have struggled with access to adequate personal protective equipment and, in some cases, even confronted barriers from their own organizations to obtaining that equipment independently. The report supports the physician's right to advocate without fear of retaliation or retribution. Additionally, the report acknowledges that physicians are entitled to the resources that are necessary to carry out their jobs and provide high-quality patient care. The report achieves these goals by adding modest and reasonable additions to the rights and responsibility articles supporting physicians' right to advocate before their organizations as well as before local, state, and federal decisionmakers while also acknowledging that physicians still bear the responsibility of doing so in ways that support the best interest of patients. Enumerating these rights and responsibilities around physician advocacy strengthens protections for physicians and will help to ensure better working conditions both in times of crisis and during regular operations.

Testimony on the report was supportive, although two delegations offered amendments to the report. The first amendment proposed adding two new subsections to section IV of the Medical Staff Rights and Responsibilities set forth in Board of Trustees Report 13. A trustee testified in opposition to this amendment, explaining that the first proposed new subsection is beyond the scope of the report and that the second proposed new subsection is adequately and more appropriately addressed by current AMA policy. Your Reference Committee notes that section IV of the Medical Staff Rights and Responsibilities as presented in Board of Trustees Report 13, as well as Policies H-215.960, H-385.990, D-383.985, and H-215.968 address the concerns raised by the second proposed new subsection. A second amendment was offered, proposing deletion of the phrase, "right to refuse to work" in section IV (c) of the Medical Staff Rights and Responsibilities set forth in Board of Trustees Report 13. A trustee testified in opposition to this amendment by deletion, emphasizing the ongoing need to protect physicians' right to refuse to work in unsafe conditions. Two delegations testified in support of Board of Trustees Report 13 as presented. Your Reference Committee agrees that Board of Trustees Report 13 should not be amended, and therefore recommends that Board of Trustees Report 13 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 1 - CMS SUNSET REVIEW OF 2011 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

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

The Council on Medical Service recommends retaining, amending, or rescinding 2011 AMA socioeconomic policies and that the remainder of the report be filed.

Testimony on Council on Medical Service Report 1 was limited to a member of the Council on Medical Service. Accordingly, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 5 - MEDICAL CENTER TRANSFER POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

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

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:

   H-130.982 Interfacility Patient Transfers ~~of Emergency Patients~~
   Our AMA: (1) supports the following principles for ~~the~~ interfacility patient transfers ~~of emergency patients~~: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer ~~of an unstabilized emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical ~~service~~ care at the receiving facility rather than the transferring

facility; and (c) all interfacility patient transfers ~~of emergency patients~~ should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to physician organizations that are ~~their county medical societies as they~~ developing such protocols and interhospital agreements with their local hospitals. (Modify Current HOD Policy)

2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows:

   d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, ~~or~~ close medical staff departments, or to transfer patients into, out of, or within the health care organization. (Modify Current HOD Policy)

3. That our AMA amend Policy H-130.965 by addition as follows:

   Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Modify Current HOD Policy)

4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:

   4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should

report to and be accountable to the medical staff committee responsible for quality improvement activities. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to unanticipated out-of-network care. (Reaffirm HOD Policy)

Your Reference Committee heard unanimously positive testimony regarding Council on Medical Service Report 5. A member of the Council on Medical Service introduced and testified in support of the report, explaining that the Council found that current AMA policy lays the groundwork to protect patients and physicians in the context of patient transfers, and this policy can be expanded. The Council member identified the policies the Council recommends amending and reaffirming to optimally protect patients who are transferred among medical facilities and the physicians who care for those patients. Additional testimony on the report was supportive and thanked the Council on Medical Service for its report. Therefore, your Reference Committee recommends that Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(5) RESOLUTION 711 - OPPOSITION TO ELIMINATION OF "INCIDENT-TO" BILLING FOR NON-PHYSICIAN PRACTITIONERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 711 be <u>adopted</u>.

HOD ACTION: Resolution 711 <u>adopted.</u>

RESOLVED, That our American Medical Association advocate against efforts to eliminate "incident-to" billing for non-physician practitioners among private and public payors. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 711. A member of the Council on Medical Service testified in support of the goals expressed in Resolution 711 but stated that current AMA, including Policy H-160.908, addresses the concerns raised by Resolution 711. Other testimony emphasized the timeliness and importance of Resolution 711 and argued strongly in support of adoption. Your Reference Committee agrees, and as such, recommends that Resolution 711 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 - UNIVERSAL BASIC INCOME PILOT STUDIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 3 be amended by addition of a new Recommendation to read as follows:

6. That our AMA reaffirm Policy H-290.997 stating that greater equity in the Medicaid program should be achieved through the creation of adequate payment levels to ensure broad access to care. (Reaffirm HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 3 be amended by addition of a new Recommendation to read:

7. That our AMA encourage Universal Basic Income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommends that Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)

5. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action)

A member of the Council on Medical Service introduced the report. The Council stated that UBI is one method that is being suggested as having the potential to address income inequality and wage stagnation, and to mitigate the loss of jobs caused by technological advances and COVID-19. The member noted that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. And, since February 2020, governments all over the world, including the US, have distributed cash payments among large portions of their populations to mitigate the loss of jobs and financial disruption of the pandemic. Importantly, the Council noted that, while there have been numerous studies on the effects of UBI, the programs have been population-based and generally have not met minimum standards for randomized control studies. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects of the program once implemented. Therefore, the Council believes it is best to activity monitor UBI studies as they unfold with a particular eye to studies that intend to measure participant health outcomes and access to care.

Testimony on Council on Medical Service Report 3 was unanimously supportive. One speaker proposed an amendment to add a new recommendation that our AMA encourage universal basic income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs. Your Reference Committee believes this proposal strengthens the report and recommends this amendment be adopted. Additional testimony called for a new recommendation reaffirming Policy H-290.997, which includes the principle of creating adequate payment levels in the Medicaid program to assure broad access to care. Your Reference Committee appreciates this suggestion and agrees with reaffirming the policy. Therefore, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 4 - PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 4 be <u>amended by addition of a new Recommendation</u> to read as follows:

11. That our AMA advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommends that Council on Medical Service Report 4 adopted as amended by addition of a new Recommendation to read as follows and the remainder of the report filed.

12. That our AMA advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization. (New HOD Policy)

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

1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans' coverage decisions and policies. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services. (Reaffirm HOD Policy)

6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. (New HOD Policy)

7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. (New HOD Policy)

8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable. (New HOD Policy)

9. That our AMA continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency. (New HOD Policy)

10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein. (Rescind HOD Policy)

A member of the Council on Medical Service introduced the report stating that peer-to-peer conversations (P2Ps) usually occur after an initial prior authorization (PA) denial that involves questions of medical necessity or treatment requests that are considered investigational. However, numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs, and, at times, peer reviewers are unqualified to assess the need for services for an individual patient for whom they have minimal information and with whom they have never evaluated or spoken. Therefore, the Council believes it is critical that reviewing P2P physicians have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. Additionally, the Council stated that some insurers have suggested that plans should have two business days after the P2P discussion to make a PA decision. The Council disagrees and believes that further delaying the PA determination harms all patients and has a disproportionately negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA decisions be made at the end of the P2P review discussion notwithstanding mitigating circumstances. Finally, the Council noted that it viewed this report through the lens of the COVID-19 pandemic and finds our AMA's efforts to reduce PA burdens especially important during public health emergencies such as the one before us and recommends a reduction in the overall volume of health plans' PA requirements and urges temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.

Testimony on Council on Medical Service Report 4 was unanimously supportive. One speaker called for an additional recommendation that health plans advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring P2P PA. The Council expressed support for this amendment, and your Reference Committee accepts the recommendation.

Additional testimony called for a new recommendation to advocate that health plans may not require prior authorization on any surgical or other invasive procedure if this procedure is furnished during the course of an operation or procedure that was already approved or did not require prior authorization. In response, a member of the Council on Medical Service stated that this suggestion is already covered in our AMA's PA Principles. Principle 14 states that significant time and resources are devoted to completing PA requirements to ensure that the patient will have the requisite coverage. If utilization review entities choose to use such programs, they need to honor their determinations to avoid misleading and further burdening patients and health care providers. Prior authorization must remain valid and coverage must be guaranteed for a sufficient period of time to allow patients to access the prescribed care. The Principle notes that this is particularly important for medical procedures, which often must be scheduled and approved for coverage significantly in advance of the treatment date. To allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received. The Council member also stated that this surgical and procedural exception is also in our AMA's PA model bill. Your Reference Committee finds the Council's testimony persuasive.

Further testimony requested an amendment that our AMA advocate that all insurance companies and benefit managers that require prior authorization have staff available to timely process and decide on approvals including but not limited to peer review for patients 24 hours a day, every day of the year, including holidays and weekends and within 24 hours. Though your Reference Committee agrees with this sentiment, it notes that Policy D-320.979 and Recommendation 6 of this report satisfy the proposed language. Policy D-320.979 advocates that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. Moreover, Recommendation 6 advocates that P2P PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. Taken together, your Reference Committee finds this suggestion to be a reaffirmation of current policy. Accordingly, your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(8) COUNCIL ON MEDICAL SERVICE REPORT 6 - URGENT CARE CENTERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;
b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;
c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted;
f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and
g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided; and
h. UCCs should have 24-hour call coverage to answer patient and subsequent treating physician questions after rendering UCC services. **(New HOD Policy)**

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 7 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

7. That our AMA support patient education including notifying patients if their physicians are providing extended ~~off~~-hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, ~~and~~ asking for their patients to notify their physician or usual source of care before seeking UCC services, and encourage patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommends that Council on Medical Service Report 6 adopted as amended and the remainder of the report filed.

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

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient's primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy)

5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:

a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;

b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;

c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;

d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;

e. UCCs should use local physicians as medical directors or supervisors;

f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and

g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy)

6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy)

7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy)

A member of the Council on Medical Service introduced the report stating that urgent care centers (UCCs) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public's desire and expectation of prompt, available, and convenient care. While the Council believes that UCCs can serve as a health care access point when a patient's usual source of care is unavailable, it is acutely aware of the potential of these new clinics to duplicate, fragment, or otherwise undermine patient care. Therefore, in its report, the Council states that it offers a set of principles to which UCCs should adhere to guard against concerns and to ensure that UCCs operate as a modern component of patient-centered care.

Your Reference Committee heard overwhelming supportive testimony for Council on Medical Service Report 6. A speaker suggested an amendment to Recommendation 5(f) to add that medical directors or supervisors should be clearly identified and posted. The Council on Medical Service agreed, and your Reference Committee recommends this

amendment be accepted. Additional testimony stated that, after rendering services, UCCs should be available to answer questions or concerns from both patients and physicians 24-hours a day. Your Reference Committee believes this suggestion strengthens the Council's report and recommends an amendment accordingly.

Further testimony sought to change the mention of off-hours care to extended hours care in Recommendation 7. The Council on Medical Service agreed with the amendment, and your Reference Committee recommends the amendment be accepted. Testimony also stated that patients should familiarize themselves with their anticipated out-of-pocket financial responsibility. To address this concern, the Council on Medical Service proposed an amendment to Recommendation 7, and your Reference Committee recommends acceptance of this amendment. Another speaker requested that this report also be applied to minute clinics. Your Reference Committee does not agree and believes that this suggestion is outside of the scope of this report and highlights that minute clinics have significantly different business models than UCCs. In addition, your Reference Committee notes that AMA policy on retail clinics was established by two previous Council reports.

Therefore, your Reference Committee recommends that Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

(9) COUNCIL ON MEDICAL SERVICE REPORT 9 - ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 9 be amended by addition and deletion to read as follows:

3. That our AMA ~~support~~ advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
c. Adequately compensate ~~Pay for~~ physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver

services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 9 adopted as amended and the remainder of the report filed.

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

1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)
3. That our AMA support that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:

a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)

4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes. (New HOD Policy)

5. That our AMA support better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital. (New HOD Policy)

6. That our AMA encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

A member of the Council on Medical Service introduced the report stating that, despite legislative advances like the Affordable Care Act and Medicaid expansion bringing insurance coverage and health care accessibility to millions of Americans, rural Americans and the health care system intended to serve them continue to face a health care crisis. By most measures, the health of the residents of rural areas is significantly worse than the health of those in urban and suburban areas. On average, rural residents are older, sicker, and are less likely to have health insurance. Concurrently, from 2018 to 2020, 50 rural hospitals closed, accelerating the trend of rural hospital closures. And, of the more than 2,000 rural hospitals across the country, more than 40% of them are estimated to be at risk of closing. Most of these hospitals at risk of closure are small rural hospitals serving isolated rural communities. Long-term solutions are needed to effectively address the health needs of the rural population and protect and enhance their access to health care. Therefore, the Council recommends a set of actions that public and private payers should undertake to ensure payment to rural hospitals is adequate and appropriate.

Your Reference Committee heard testimony unanimously in support of Council on Medical Service Report 9. One speaker asked to amend Policy H-290.976 to advocate that Medicaid payments to providers be at least 101 percent of Medicare payment rates instead of the current policy of at least 100 percent of Medicare. The speaker also suggested an amendment of a new sub-recommendation in Recommendation 3 supporting the expansion of essential services to include Home Health and Hospice thereby advancing equity, given issues of access, large geographic areas, lack of public transportation and lack of internet. The Council on Medical Service replied that our AMA has undertaken significant advocacy efforts on Medicaid payment rates and is unclear what this amendment adds to our AMA's body of policy and how it advances our advocacy agenda. Regarding the second proposed amendment, the Council on Medical Service highlighted that it has two upcoming reports on home health and hospice including a report on home and community-based services and a report on end-of-life payment and hospice. The Council believes that these upcoming reports will satisfy this request. Additionally, Council on Medical Service Report 7 on Addressing Equity in Telehealth that is currently being considered at this meeting and comprehensively addresses concerns around telehealth, broadband, and access. Your Reference Committee finds the Council's testimony persuasive.

An amendment was offered to add a new recommendation calling for appropriate reimbursement to rural hospitals for services offered via telehealth and support increased investment in telemedicine technology at rural facilities. While your Reference Committee appreciates the intent of this amendment, it believes that current AMA policy satisfies this request. Policy D-480.963 advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

Additional testimony called for an amendment to support residency training programs in rural hospitals. While a goal with which the Reference Committee agrees, we believe that amendment is outside the scope of this report. We also highlight Policy H-465.988 calling

for our AMA to work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas and to formulate and action plan of advocacy with the goal of increasing residency training in rural areas.

Further testimony called to change Recommendation 3 from "support" to "advocate" and to provide clarifying language to ensure adequate compensation for physician time in Recommendation 3(c). Your Reference Committee agrees with these changes. Testimony also called for deletion of Recommendation 3(f) stating that Recommendation 3(c) accomplishes this goal. Your Reference Committee strongly disagrees and recommends Recommendation 3(f) be adopted.

Accordingly, your Reference Committee recommends that Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 706 - PREVENT MEDICARE ADVANTAGE PLANS FROM LIMITING CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization ~~Medicare~~ guidelines are followed for ~~all~~ both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities. ~~and that care is not limited for patients who chose an Advantage Plan~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that ~~against applying~~ proprietary criteria shall not supersede the professional judgment of the patient's physician when ~~to determine~~ determining ~~eligibility of~~ Medicare and Medicare Advantage patient~~s~~ eligibility for procedures and admissions ~~when the criteria are at odds with the professional judgment of the patient's physician~~. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 706 be adopted as amended.

HOD ACTION: Resolution 706 adopted as amended.

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to more tightly regulate Medicare Advantage Plans so that Medicare guidelines are followed for all Medicare patients and care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions should not overrule the professional judgment of the patient's physician. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony on Resolution 706. Amendments were offered to both the first and second Resolve clauses to clarify that patient care should be driven by physician judgement and evidence-based guidelines and protocols rather than the varying dictates of health plans and insurance companies. The author of the resolution welcomed these amendments. Your Reference Committee agrees with the amendments and proposes an amendment to the first Resolve clause to specifically mention inpatient rehabilitative facility admissions. Your Reference Committee believes that patient-centered guidelines for admission to inpatient rehabilitation facilities is the primary goal of the resolution.

One speaker called for referral of Resolution 706. Your Reference Committee does not recognize the merits of referral in light of the substantial support for Resolution 706.

Additional testimony called for an amendment stating that our AMA should ask CMS to add another tool that compares coverage in Medicare Advantage plans vs traditional Medicare and include minimum criteria for coverage/benefits for severe chronic conditions like stroke, cancer or diabetes. Though your Reference Committee agrees with the intent to provide patient education, it notes that our AMA already has significant policy on this issue. Policy D-330.951 directs that our AMA urge CMS to require companies that participate in the MA 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. Additionally, Policy H-285.913 states that our AMA will pursue legislation to require that MA policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. […]" Policy D-330.930 states that 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. Policy H-330.913 opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who cannot must choose new doctors. Importantly, Policy H-285.902 urges CMS to develop a

marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website and requiring MA plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network.

Accordingly, your Reference Committee recommends that Resolution 706 be adopted as amended.

(11) RESOLUTION 707 – FINANCIAL INCENTIVES FOR PATIENTS TO SWITCH TREATMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 707 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing ~~financial incentives~~ payments to ~~for~~ patients as financial incentives to switch treatments from those recommended by their physicians (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 707 be amended by addition to read as follows:

RESOLVED, That our AMA support legislation that would ban insurer policies that provide ~~patients financial incentives~~ payments to patients as financial incentives to switch treatments from those recommended by their physicians, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the third Resolve of Resolution 707 be amended by addition to read as follows:

RESOLVED, That our AMA engage with state and federal regulators to alert them to identified ~~urging review of the legality of such~~ policies providing ~~financial incentives~~ payments to patients as financial

incentives who switch to payer-preferred drugs, and encourage state and federal regulators to prohibit and/or discourage such policies. (Directive to Take Action)

HOD ACTION: Resolution 707 amended by addition and deletion.

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing financial incentives for patients to switch treatments (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would ban insurer policies that provide patients financial incentives to switch treatments, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with state regulators urging review of the legality of such policies providing financial incentives to patients who switch to preferred drugs. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony on Resolution 707, and several amendments were offered. One amendment was offered that would broaden the proposed policy to govern not only financial incentives to change medical treatments but also changes in health care professionals. Members of both the Council on Medical Service and the Council on Legislation opposed this amendment. The Council on Medical Service member explained that in CMS Report 2-I-19, the Council on Medical Service recently studied the increasingly common practice of insurance companies implementing programs that offer patients financial incentives when they compare prices on health care items and services and choose lower-cost options. In CMS Report 2-I-19, the Council found that while such programs can pose risks to patients, they can provide benefits such as reducing care avoidance and cost-related non-adherence to treatment plans. Policy H-185.920 addresses this dynamic in providing principles to guide programs that offer financial incentives to patients who shop for lower-cost health care. Your Reference Committee agrees with the Council on Medical Service's assessment. Several delegations, including the Resolution Sponsors, offered amendments to clarify the text of Resolution 707. The amendment offered by the Resolution Sponsors incorporated amendments from other delegations. The Council on Medical Service supported the Resolution Sponsor's amendment and proposed an additional amendment to provide regulators and AMA Advocacy and with greater flexibility in deterring policies providing financial incentives to patients who switch to payer-preferred drugs. A member of the Council on Legislation testified in support of the Council on Medical Service's amendment. Your Reference Committee notes the consistent intentions expressed by the clarifying amendments, appreciates the compelling testimony provided, and notes that no single amendment incorporated all of the essential clarifying elements. Your Reference Committee has compiled the amendments here and recommends that Resolution 707 be adopted as amended.

RECOMMENDED FOR NOT ADOPTION

(12) RESOLUTION 702 - ADDRESSING INFLAMMATORY AND UNTRUTHFUL ONLINE RATINGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 702 not be adopted.

HOD ACTION: Resolution 702 referred.

RESOLVED, That our American Medical Association take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 702. A member of the Council on Medical Service testified neither in support nor opposition to Resolution 702 but addressed a comment on the member forum calling for changes to the Health Insurance Portability and Accountability Act (HIPAA) and would like to highlight AMA advocacy activity on this issue. The Council member stated that seeking a change in the HIPAA statute is significant to contemplate and something that our AMA has historically tried to avoid given that the changes may not bode well for physicians. Additionally, in our AMA's most recent attempt to address this issue, it included language in our AMA's HIPAA Notice of Proposed Rulemaking (NPRM) comments from May 2021 asking the Office for Civil Rights (OCR) to develop a process for physicians to respond to online complaints without running afoul of HIPAA's privacy protections. The member noted that patients may not understand how HIPAA permits an organization to share information without the patient's authorization and that covered entities may experience the consequences of such misunderstanding in ways including, but not limited to, complaints to OCR. For example, patients may post complaints on social media about a covered entity for any number of reasons, including misunderstandings around privacy practices. The Council member noted that our AMA receives many complaints from our members who feel that they are unable to respond to such complaints without compromising their confidentiality obligations. Therefore, our AMA continues to encourage OCR to develop a mechanism for physicians to respond to such complaints without violating HIPAA.

A member of the Council on Legislation (COL) underscored the Council on Medical Service's testimony. The COL member stated that it agreed that seeking amendment to the HIPAA statute would be a substantial legislative request requiring considerable AMA expenditure of resources and political capital. And importantly, the Council on Legislation expressed concern that opening HIPAA to such amendments may result in undesirable changes for physicians. Your Reference Committee agrees.

Additionally, your Reference Committee notes that the Code of Medical Ethics addresses physician conduct only. Your Reference Committee does not believe that our AMA can police what individuals post online. Moreover, removing reviews from review sites would likely require an investigation and determination of fact, which the Reference Committee believes is the role of licensing boards. Additionally, your Reference Committee believes

that, in extreme circumstances, libel law would be triggered to protect a physician. Taken together, your Reference Committee recommends that Resolution 702 not be adopted.

Madam Speaker, this concludes the report of Reference Committee G. I would like to thank Peter Fenwick, MD; Ronald Giffler, MD; Rachelle Klammer, MD; Alma Littles, MD; Parag Mehta, MD; Peter Rahko, MD; and all those who testified before the Committee.

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