2024
HOUSE OF DELEGATES

THE ONE HUNDRED FIFTY-NINTH
ANNUAL SESSION

May 11, 2024
The Crowne Plaza, Lansing
2024 HOUSE OF DELEGATES
Crowne Plaza Lansing West

Saturday, May 11, 2024

8:00 am – 4:00 pm   Registration – Center Lobby

10:00 – 11:00 am  Candidate Forum – Royale Ballroom
                  Report from Chair of the Board
                  Address of the President
                  Address of the President-Elect
                  Address of the CEO

10:30 am – 2:00 pm  Voting – Packard Room

11:00 am – 3:00 pm  Report of the Committee on Credentials and Tellers – Royale Ballroom
                    (with Working Lunch)
                    Nominations and Elections
                    Reports of the Reference Committees

3:00 – 4:00 pm      President’s Reception – Royale Atrium
2024 HOUSE OF DELEGATES
Reference Committee Meetings

The reference committee meetings will be held virtually in the weeks leading up to the House of Delegates meeting. They will each be held on a different evening from 6:00 – 8:00 pm, allowing you to attend more than one if you choose. The schedule is as follows:

**Tuesday, April 16, 2024**
6:00 – 8:00 pm  Reference Committee E (Scientific and Educational Affairs)

**Wednesday, April 17, 2024**
6:00 – 8:00 pm  Reference Committee A (Medical Care Delivery)

**Thursday, April 18, 2024**
6:00 – 8:00 pm  Reference Committee C (Internal Affairs, Bylaws, and Rules)

**Tuesday, April 23, 2024**
6:00 – 8:00 pm  Reference Committee D (Public Health)

**Wednesday, April 24, 2024**
6:00 – 8:00 pm  Ways and Means Committee

**Thursday, April 25, 2024**
6:00 – 8:00 pm  Reference Committee B (Legislation)

The Zoom link for all Reference Committee meetings will be the same. The link is: https://us02web.zoom.us/j/86842891675?pwd=MVBDVm9KT1Nqb01LbDRCcDlyNUdhQT09

When joining, please be sure your screen name includes both your first and last name. There will be no registration required.
Blue Cross Blue Shield of Michigan and Blue Care Network are committed to improving the health of everyone in our state. That’s why we support inclusive programs to increase access to affordable health care, helping to promote healthier people, stronger families and vibrant communities all across Michigan.

Learn more at AHealthierMichigan.org
MSMS Speakers’ Principles of Rules of Order

(Based on Sturgis)

1. Only one main motion
2. A motion may be amended only to second order
3. Motion stated affirmatively
4. Precedence of motion must be honored
5. A motion, once reiterated by Chair, belongs to assembly
6. Member may speak/vote against own motion
7. Any member may move for reconsideration
8. Unless otherwise stated, vote immediately applies only to immediately-pending issue
9. More than majority vote required when rights are limited
10. Requests are rights of member/assembly which may be asked for
11. On appeal, vote always on sustaining speaker or vice speaker
12. Nominations require no second
13. Presiding officer may vote
14. Presiding officer may not adjourn meeting
### Principal Rules Governing Motions

<table>
<thead>
<tr>
<th>Order of precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Amend³</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Postpone temporarily (Table)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority²</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td>4. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
</tr>
<tr>
<td>5. Limit debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes³</td>
<td>Yes³</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>Amend³</td>
</tr>
<tr>
<td>6. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes³</td>
<td>Yes³</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend³, close debate, limit debate</td>
</tr>
<tr>
<td>7. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes³</td>
<td>Yes³</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend³, close debate, limit debate</td>
</tr>
<tr>
<td>8. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Rewordable motions</td>
<td>Close debate, limit debate, amend</td>
</tr>
<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. a. The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Restorative, subsidiary</td>
</tr>
<tr>
<td>9. b. Restorative main motions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main motion</td>
<td>Subsidiary, restorative</td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main motion</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Previous action</td>
<td>Subsidiary</td>
</tr>
<tr>
<td>Rescind</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes³</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Resume consideration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
</tbody>
</table>

### INCIDENTAL MOTIONS

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Decision of chair</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main</td>
<td>None</td>
</tr>
<tr>
<td><strong>REQUESTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Any error</td>
<td>None</td>
</tr>
<tr>
<td>Parliamentary inquiry</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Indecisive vote</td>
<td>None</td>
</tr>
</tbody>
</table>

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1. Motions are in order only if no motion higher on the list is pending.
2. Requires two-thirds vote when it would suppress a motion without debate.
3. Debatable if no other motion is pending.
4. Withdraw may be applied to all motions.
## PRINCIPAL PARLIAMENTARY MOTIONS GUIDE

<table>
<thead>
<tr>
<th>What You Want To Accomplish, in order of precedence</th>
<th>What You Need To Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close/adjourn the meeting</td>
<td>“I move that we adjourn”</td>
</tr>
<tr>
<td>Take a break/recess</td>
<td>“I move to recess until…”</td>
</tr>
<tr>
<td>Register a complaint/raise a question of privilege</td>
<td>“I rise to a question of privilege”</td>
</tr>
<tr>
<td>Postpone an item temporarily/Table2</td>
<td>“I move that we postpone/table the item temporarily”</td>
</tr>
<tr>
<td>Close debate and vote immediately3</td>
<td>“I move to close debate”</td>
</tr>
<tr>
<td>Limit or extend debate</td>
<td>“I move to limit debate of each speaker to…”</td>
</tr>
<tr>
<td>Postpone to a certain time</td>
<td>“I move to postpone the item until…”</td>
</tr>
<tr>
<td>Refer an item</td>
<td>“I move to refer this item to the Board”</td>
</tr>
<tr>
<td>Amend (by substitution, insertion, deletion)</td>
<td>“I would like to amend the resolution by…”</td>
</tr>
<tr>
<td>Bring business before assembly, i.e. main motion4</td>
<td>“I move that…”</td>
</tr>
</tbody>
</table>

### Restorative Main Motions, no order of precedence. Introduce when nothing else is pending.

<table>
<thead>
<tr>
<th>What You Need to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amend a previous action</td>
</tr>
<tr>
<td>Reconsider an item previously votes upon</td>
</tr>
<tr>
<td>Rescind a previously considered item</td>
</tr>
<tr>
<td>Resume consideration/take from the table</td>
</tr>
</tbody>
</table>

### Incidental Motions, no order of precedence

<table>
<thead>
<tr>
<th>What You Need to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree with the ruling of the Speaker</td>
</tr>
<tr>
<td>Suspend rules</td>
</tr>
<tr>
<td>Enforce rules</td>
</tr>
<tr>
<td>Ask about parliamentary procedure</td>
</tr>
<tr>
<td>Request to withdraw a motion</td>
</tr>
<tr>
<td>Divide an issue into individual resolved clauses</td>
</tr>
<tr>
<td>Ask for a hand count of the assembly</td>
</tr>
</tbody>
</table>

---

1 Motions are in order only if no motion higher on the list is pending, e.g. if a motion to close debate is pending, a motion to amend would be out of order, but a motion to recess would be in order, since it outranks the pending motion.

2 Tabling an item effectively results in killing the item and no action being taken unless the item is moved for reconsideration.

3 Unless specifically stated, vote will be taken only on the pending item.

4 Main motions are the resolutions submitted to the HOD.
STURGIS RULES OF ORDER

MOTIONS WITH PRECEDENCE AND THEIR RANK

Order of Proposal

Order of Disposal

1 Main Motion
2 Amend
3 Refer
4 Postpone to Certain Time
5 Limit or Extend Debate
6 Close Debate and Vote Immediately
7 Postpone Temporarily (Table)*
8 Recess
9 Adjourn

Precedent Motions

- Privileged Motions
- Subsidiary Motions
- Main Motion

*Postponing temporarily or tabling a motion means no action is taken & the motion dies.
OFFICERS, 2023-2024

President
M. Salim U. Siddiqui, MD, PhD
Wayne

President-Elect
Mark C. Komorowski, MD
Bay

Immediate Past President
Thomas J. Veverka, MD
Saginaw

Secretary
Jayne E. Courts, MD
Kent

Treasurer
John A. Waters, MD
Genesee

Speaker
Phillip G. Wise, MD
Kent

Vice Speaker
Bryan W. Huffman, MD
Ottawa

Chair
Paul D. Bozyk, MD
Oakland

Vice Chair
Bradley R. Uren, MD
Livingston

Ex-Officio
Dennis M. Ramus, MD
Macomb

Ex-Officio
F. Remington Sprague, MD
Muskegon

REGIONAL DIRECTORS

Talat Danish, MD, MPH, FAAP 1 Wayne 2026
Herbert C. Smitherman, Jr., MD, MPH 1 Wayne 2026
Paul D. Bozyk, MD 2 Oakland 2025
Daniel M. Ryan, MD 2 Macomb 2026
Larry Junck, MD 3 Washtenaw 2025
Bradley J. Uren, MD 3 Livingston 2026
Robert M. Doane, MD 4 Jackson 2026
David T. Walsworth, MD 4 Ingham 2024
Mark E. Meyer, MD 5 Kalamazoo 2024
OPEN POSITION 5

Nita M. Kulkarni, MD 6 Genesee 2025
Annette Gilmer, MD 6 St. Clair 2024
Michael A. Kremer, MD 7 Bay 2026
Mildred J. Willy, MD 7 Saginaw 2025
Eric L. Larson, MD 8 Kent 2024
Brian R. Stork, MD 8 Muskegon 2024
Melanie S. Manary, MD 9 Northern Michigan 2024
Ryan J. Brang, MD 9 Marquette-Alger 2026

DESIGNATED DIRECTORS

At-Large Physician
Leah C. Davis, DO, Grand-Traverse 2026

Independent Small Practice Physician
OPEN POSITION

Physician Leader From Health System
OPEN POSITION

Physician Organization Leader
OPEN POSITION

Physician Serving as DIO/Representing GME Training
Robert F. Flora, MD, MBA, MPH, Genesee 2026

Physician Serving In Government/Public Health Role
Jennifer E. Morse, MD, MPD, FAAFP, Isabella-Clare 2026

SECTION DIRECTORS

Young Physicians Section
Michael J. Redinger, MD
Kalamazoo

Residents And Fellows Section
Kaitlyn D. Dobesh, MD, JD
Wayne

Medical Students Section
Ekaterina Lavroushina
Oakland
<table>
<thead>
<tr>
<th>Delegates</th>
<th>Term Expires</th>
<th>Alternates (in order of seniority)</th>
<th>Term Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul D. Bozyk, MD, Oakland</td>
<td>2024</td>
<td>Theodore B. Jones, MD, Wayne</td>
<td>2025</td>
</tr>
<tr>
<td>T. Jann Caison-Sorey, MD, MSA, MBA, Wayne</td>
<td>2025</td>
<td>Patricia A. Kolowich, MD, Wayne</td>
<td>2025</td>
</tr>
<tr>
<td>Michael D. Chafty, MD, JD, Kalamazoo</td>
<td>2024</td>
<td>M. Salim U. Siddiqui, MD, PhD, Wayne</td>
<td>2025</td>
</tr>
<tr>
<td>Betty S. Chu, MD, MBA, Oakland</td>
<td>2025</td>
<td>Edward C. Bush, MD, Wayne</td>
<td>2025</td>
</tr>
<tr>
<td>Pino D. Colone, MD, Genesee</td>
<td>2025</td>
<td>Courtland Keteyian, MD, Jackson</td>
<td>2024</td>
</tr>
<tr>
<td>Amit Ghose, MD, Ingham</td>
<td>2024</td>
<td>Michael J. Redinger, MD, Kalamazoo</td>
<td>2024</td>
</tr>
<tr>
<td>Mark C. Komorowski, MD, Bay</td>
<td>2025</td>
<td>Brooke M. Buckley, MD, Wayne</td>
<td>2025</td>
</tr>
<tr>
<td>Christie L. Morgan, MD, Oakland</td>
<td>2024</td>
<td>David W. Whalen, MD, Kent</td>
<td>2025</td>
</tr>
<tr>
<td>Rose M. Ramirrez, MD, Kent</td>
<td>2024</td>
<td>Aarti Patel, Medical Student</td>
<td>2025</td>
</tr>
<tr>
<td>Krishna K. Sawhney, MD, Wayne</td>
<td>2025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richard E. Smith, MD, Wayne</td>
<td>2024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>David T. Walsworth, MD, Ingham</td>
<td>2025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John A. Waters, MD, Genesee</td>
<td>2024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaitlyn Dobesh, MD, JD, Wayne, Resident</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Notification of Slate of Offices – 2024 House of Delegates

**REGIONAL DIRECTORS** (Three-year term to 2027 House of Delegates)

Region #4 – Clinton, Eaton, Hillsdale, Ingham, and Jackson  
David T. Walsworth, MD, Ingham: completed two terms, running for re-election.

Region #5 – Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren  
**CANDIDATE:** Ed Fody, MD, Allegan  
**OPEN:** Must be from any county except Allegan

Region #6 – Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, and Tuscola  
Annette Gilmer, MD, St Clair: completed a partial term, running for re-election.

Region #8 – Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa  
Eric L. Larson, MD, Kent: completed one term, running for re-election.  
Brian R. Stork, MD, Muskegon: completed two terms, running for re-election.

Region #9 – Northern Michigan and Upper Peninsula  
Melanie S. Manary, MD, Northern Michigan: completed one term, running for re-election.

**DESIGNATED DIRECTORS:** (Three-year term to 2027 House of Delegates)

**Academic** - Louito C. Edje, MD, MHPE, FAAFP, Washtenaw  
**Physician Organization** – Gail Gwizdala, MD, Grand Traverse  
**Health System** - Open

**SECTION REPRESENTATIVES:** The MSMS Resident and Fellow Section and the MSMS Medical Student Section will elect one representative each to serve on the MSMS Board of Directors for a one-year term to the 2025 House of Delegates. The Young Physicians Section will elect one representative to serve on the MSMS Board of Directors for a two-year term to the 2025 House of Delegates.

**Resident and Fellow Section** – Open  
**Young Physician Section** - Open
**OFFICERS:** (One-year term to the 2025 House of Delegates)

*Speaker:* Phillip G. Wise, MD, Kent  
*Vice Speaker:* Bryan W Huffman, MD, Ottawa  
*President-elect Candidates:* Amit Ghose, MD, Ingham and Brian R. Stork, MD, Muskegon

**MICHIGAN DELEGATION TO THE AMA** *(Two-year term to 2026 House of Delegates)*

*Delegates*
Paul D. Bozyk, MD, Oakland  
Michael D. Chafty, MD, JD, Kalamazoo  
Amit Ghose, MD, Ingham  
Theodore B. Jones, MD, Wayne  
Christie L. Morgan, MD, Oakland  
Rose M. Ramirez, MD, Kent  
John Waters, MD, Genesee

*Alternate Delegates:*
Louito C. Edje, MD, MHPE, FAAFP, Washtenaw  
Aliya C. Hines, MD, PhD, Wayne  
Courtland Keteyian, MD, Jackson  
Michael J. Redinger, MD, Kalamazoo

Student position will take a seat as an AMA Delegate and the Resident position will take a seat as an AMA Alternate Delegate for the years 2024 and 2025.
In Memory

The members of the Michigan State Medical Society remember with respect their colleagues who have passed away since our last annual meeting.

Raphael Addiego, MD
Isidro C. Almeda, MD
Joseph Aquilina, MD
Fred Averbuch, MD
Lloyd Bakken, MD
Leroy Barry, MD
Gerard Brennan, MD
Carter Brooks, MD
Filomena Buenafior, MD
Bader Cassin, MD
M. Gerard Cloherty, MD
Dean Dalbec, MD
Glen Douglass, MD
Gwenyth Evenhouse, MD
Michael Fetters, MD
Thomas Gordon, MD
Donald Harrell, MD
Devon Hoover, MD
Shawn Ingles, DO
Samuel Kalush, MD
Thomas Klein, MD
James LaFleur, MD

Phillip Lambert, MD
William Lincer, MD
William Macksood, MD
Richard McConnell, MD
David Milko, MD
Kathryn Moseley, MD, MPH
Purushottam Naik, MD
John Peirce, MD
Venkat Rao, MD
Jan Rival, MD
Joseph Salisz, MD
Peter Salvia, DO
Marguerite Shearer, MD
Herbert D. Sherbin, MD
Gregory Sobczak, MD
Thomas Spooner, MD
Willard Stawski, MD
Irving Weiss, MD
Vernon Wendt, MD
Michael Zarr, MD
MICHIGAN STATE MEDICAL SOCIETY
2024 HOUSE OF DELEGATES
May 11, 2024
Roster of Delegates

**OFFICERS:**
- Phillip Wise MD Speaker
- Bryan Huffman MD Vice-Speaker
- Jayne Courts MD Secretary

**County: Berrien**
- Sharon Deskins MD Delegate

**County: Genesee**
- Macksood Aftab DO Delegate
- Edward Christy MD Delegate
- Pino Colone MD Delegate
- Paul Kocheril MD Delegate
- S. Bobby Mukkamala MD Delegate
- Rama Rao MD Delegate
- Khalid Ahmed MD Alternate Delegate
- Qazi Azher MD Alternate Delegate
- John Hebert III MD Alternate Delegate
- Sunil Kaushal MD Alternate Delegate
- Ali Mohammed MD Alternate Delegate
- Ehab Youssef MD, FCR, MBA, PhD Alternate Delegate

**County: Grand Traverse - Leelanau - Benzie**
- Sam Copeland DO Delegate
- Bradley Goodwin MD Delegate
- Yelena Kier DO Delegate
- Edward Rutkowski MD Delegate
- Timothy Rutkowski MD Delegate
- Richard Schultz MD Delegate
- Frederick Brodeur Jr. MD Alternate Delegate
- Scott Monteith MD, DLFAPA Alternate Delegate

**County: Gratiot**
- Rakesh Saxena MD Delegate

**County: Ingham**
- Iftiker Ahmad MD Delegate
- Amit Ghose MD Delegate
- Ved Gossain MD Delegate
- Narasimha Gundamraj MD Delegate
- Raza Haque MD Delegate
- Richard Honicky MD Delegate
- Ronald Horowitz MD Delegate

**County: Jackson**
- Lekha Karthikeyan MD Delegate
- Courtland Keteyian MD, MBA, MPH Delegate
- Jon Lake MD Delegate
- Wardha Shabbir MD Delegate
- Jordana Woods MD Delegate

**County: Kalamazoo**
- Scott Abela DO Delegate
- Daniel Johnston MD Delegate
- Katherine Mills MD Delegate
### County: Kent

<table>
<thead>
<tr>
<th>Name</th>
<th>County</th>
<th>Title</th>
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<tbody>
<tr>
<td>Anita</td>
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<td>Delegate</td>
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<tr>
<td>Michelle</td>
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<tr>
<td>Megan</td>
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<tr>
<td>Androni</td>
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<tr>
<td>Warren</td>
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<td>Karen</td>
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<tr>
<td>Tudor</td>
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<tr>
<td>Rose</td>
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<tr>
<td>Sonia</td>
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<tr>
<td>David</td>
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<td>Phillip</td>
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### County: Macomb

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<tr>
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<td>Adrian</td>
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<td>Delegate</td>
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<tr>
<td>Burton</td>
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<td>Delegate</td>
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<tr>
<td>Narendra</td>
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<tr>
<td>Lawrence</td>
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<tr>
<td>Khaled</td>
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<tr>
<td>Carolann</td>
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<tr>
<td>Cheryl</td>
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<tr>
<td>Akash</td>
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### County: Marquette-Alger

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### County: Medical

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<tr>
<td>Rachel</td>
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### County: Monroe

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<tr>
<td>Irving</td>
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<tr>
<td>Arun</td>
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### County: Muskegon

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<tr>
<td>Yousif</td>
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### County: Oakland

<table>
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<tr>
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<tr>
<td>Hanna</td>
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<td>George</td>
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<td>Stephanie</td>
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<tr>
<td>Shannon</td>
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<tr>
<td>Rubin</td>
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<td>Ashok</td>
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<tr>
<td>Sherwin</td>
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<tr>
<td>Patrick</td>
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</tr>
<tr>
<td>Robert</td>
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<tr>
<td>Natalie</td>
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<tr>
<td>Donald</td>
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<td>Delegate</td>
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<tr>
<td>Theodore</td>
<td>Oakland</td>
<td>Delegate</td>
</tr>
<tr>
<td>Manveen</td>
<td>Oakland</td>
<td>Delegate</td>
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</tbody>
</table>
### Roster of Delegates

#### Oakland cont.

- Dana Silver MD Delegate
- Suha Syed MD Delegate
- Karol Zakalik MD Delegate

#### County: Ottawa

- Bryan Huffman MD Delegate

#### County: Saginaw

- Christopher Allen MD Delegate
- Judy Blebea MD Delegate
- Elvira Dawis MD Delegate
- Karensa Franklin MD Delegate
- Elizabeth Marshall MD Delegate
- Kala Ramasamy MD Delegate
- Jennifer Romeu MD Delegate
- Miriam Schteingart MD Delegate
- Waheed Akbar MD Alternate Delegate
- Kai Anderson MD Alternate Delegate
- Abishek Bala MD Alternate Delegate
- Taylor Gaudard MD Alternate Delegate
- Furhut Janssen DO Alternate Delegate
- Mohammad Khan MD Alternate Delegate
- Cecilia Kraus-Horbal DO Alternate Delegate
- Mary McKuen MD Alternate Delegate
- Caroline Scott MD Alternate Delegate
- Claudia Zacharek MD Alternate Delegate

#### County: St. Clair

- G. Beau Dowden III MD Delegate
- Sara Liter-Kuester DO Delegate
- John Pelachyk MD Delegate

#### County: Washtenaw

- Richard Burney MD Delegate
- Titilola Famakinwa MD Delegate
- John Hopper MD Delegate
- Terence Joiner MD Delegate
- James Mitchiner MD, MPH Delegate
- Rebecca Daniel MD Alternate Delegate
- Joseph Nnodim MD, PhD, FACP Alternate Delegate
- Robert Sain MD Alternate Delegate
- James Szocik MD Alternate Delegate
- Jerry Walden MD Alternate Delegate

#### County: Wayne

- Susan Adelman MD, FACS Delegate
- Beena Ahsan MD Delegate
- Charles Barone MD Delegate
- Brooke Buckley MD Delegate
- E. Chris Bush MD Delegate
- Thelma Caison-Sorey MD, MSA, MBA Delegate
- Denise Collins MD Delegate
- Steven Daveluy MD Delegate
Wayne cont.

Nicolas Fletcher MD, MHSA Delegate
Cheryl Gibson Fountain MD Delegate
Brent Griffith MD Delegate
Aliya Hines MD Delegate
Robert Jackson MD Delegate
Theodore Jones MD, FACOG Delegate
Katherine Joyce MD Delegate
Naveen Kachroo MD Delegate
Neil Khanna MD Delegate
Sina Khoshbin MD Delegate
Patricia Kolowich MD Delegate
Manu Malhotra MD Delegate
Federico Mariona MD, MHSA, FACS, FACOG Delegate
Alireza Meysami MD, CPE, RhMSUS Delegate
Anita Moncrease MD, MPH Delegate
Vivian Onyewuuche MD Delegate
Geoffrey Prysak MD, MPH Delegate
Latonya Riddle-Jones MD Delegate
Michael Sandler MD Delegate
Krishna Sawhney MD Delegate
George Shade Jr. MD Delegate
Gaurav Sharma MD Delegate
Richard Smith MD Delegate
Neelima Thati MD Delegate
Neha Thawani MD Delegate
Donald Tynes MD, FACP Delegate
Lucia Zamorano MD Delegate
Edward Jankowski MD Alternate Delegate
Keith Kobet MD Alternate Delegate
Ali Moiin MD Alternate Delegate
Kaitlin Natoire MD Alternate Delegate
Ijeoma Opara MD Alternate Delegate
Amanda Sandles DO Alternate Delegate
Emily Smith MD Alternate Delegate
James Sondheimer MD Alternate Delegate
Daniel Walz MD Alternate Delegate
Patricia Wilkerson-Uddyback MD Alternate Delegate

County: Wexford-Missaukee
Martin Dubravec MD Delegate

Delegate-At-Large: Immediate Past President
Thomas Veverka MD, FACS Delegate

Delegate-At-Large: Medical School Dean, Central Michigan University
George Kikano MD Delegate

Delegate-At-Large: Medical School Dean, Michigan State University
Andrea Amalfitano DO, PhD Delegate
Aron Sousa MD Delegate

Delegate-At-Large: Medical School Dean, University of Michigan
Marschall Runge MD, PhD Delegate
<p>| Delegate-At-Large: Medical School Dean, Oakland University | Duane Mezwa MD, FACR Delegate |
| Delegate-At-Large: Medical School Dean, Wayne State University | Wael Sakr MD Delegate |
| Delegate-At-Large: Medical School Dean, Western Michigan University | Paula Termuhlen MD Delegate |
| Members-At-Large: MDHHS Chief Medical Officer | Natasha Bagdasarian MD Delegate |
| Medical Student Section | Nick Bara Student Delegate |
| | Shivapriya Chandu Student Delegate |
| | Emily Chen Student Delegate |
| | Deepthi Devireddy Student Delegate |
| | Sara Kazayak Student Delegate |
| | Nishant Kumar Student Delegate |
| | Emily Ridge Student Delegate |
| | Christian Schaaff Student Delegate |
| | Samantha Hess Student Alternate Delegate |
| | Tien Hua Student Alternate Delegate |
| | Magdalena Iannello Student Alternate Delegate |
| | Anushree Jagtap Student Alternate Delegate |
| | Brandon Leung Student Alternate Delegate |
| | Alexia Lucas Student Alternate Delegate |
| | Het Patel Student Alternate Delegate |
| | Annie Vu Student Alternate Delegate |
| International Medical Graduate Section | |
| Resident and Fellow Section | Elana Perry MD Delegate |
| | Macy Hudson MD Alternate Delegate |
| Young Physician Section | Halley Crissman MD, MPH Delegate |
| Specialty Society: MI Society of Addication Medicine | Colleen Lane MD Specialty Society Delegate |
| | Michael Danic DO Specialty Society Alternate |
| Specialty Society: MI Allergy &amp; Asthma Society | Lawrence Hennessey MD Specialty Society Delegate |
| Specialty Society: MI Society of Anesthesiologists | Neeraja Ravikant MD Specialty Society Delegate |
| | Goodarz Golmirzaie MD Specialty Society Alternate |
| Specialty Society: MI Chapter, American College of Cardiology | Sunilkumar Rao DO Specialty Society Delegate |
| Specialty Society: MI Society of Colon and Rectal Surgeons | John Bauman MD Specialty Society Delegate |
| | Alexandria Glenn MD Specialty Society Alternate |</p>
<table>
<thead>
<tr>
<th>Specialty Society: MI College of Emergency Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sara Chakel MD, FACEP</td>
</tr>
<tr>
<td>Luke Saski MD, FACEP</td>
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</table>

<table>
<thead>
<tr>
<th>Specialty Society: MI Society of Eye Physicians and Surgeons</th>
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<tbody>
<tr>
<td>Patrick Droste MD</td>
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<tr>
<td>Matthew Trese DO</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Academy of Family Physicians</th>
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<tbody>
<tr>
<td>Holli Neiman-Hart MD, FAAFP</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Society of Hematology &amp; Oncology</th>
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<tbody>
<tr>
<td>Jerome Seid MD</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Association of Medical Examiners</th>
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</thead>
<tbody>
<tr>
<td>Carl Hawkins MD</td>
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<tr>
<td>Anna Tart MD</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Association of Neurological Surgeons</th>
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<tbody>
<tr>
<td>Hazem Eltahawy MD, MHCM, FRCS, FACS</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Section, American College of OB/GYN</th>
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<tbody>
<tr>
<td>Sara Jaber MD</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Orthopaedic Society</th>
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<tr>
<td>Christopher Betzle MD</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Otolaryngological Society</th>
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</thead>
<tbody>
<tr>
<td>Charles Koopmann, Jr., MD</td>
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</table>

<table>
<thead>
<tr>
<th>Specialty Society: MI Society of Pathologists</th>
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<tr>
<td>Edward Fody MD</td>
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<table>
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<th>Specialty Society: American College of Physicians, MI Chapter</th>
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<tr>
<td>Benjamin Dlaczok MD</td>
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<tr>
<td>Martha Gray MD</td>
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<table>
<thead>
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<th>Specialty Society: MI Academy of Plastic Surgeons</th>
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</thead>
<tbody>
<tr>
<td>Anthony Zacharek MD</td>
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<table>
<thead>
<tr>
<th>Specialty Society: MI Psychoanalytic Society</th>
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<tbody>
<tr>
<td>Evangeline Spindler MD</td>
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<tr>
<th>Specialty Society: MI Psychiatric Society</th>
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<tr>
<td>Theresa Toledo MD</td>
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<table>
<thead>
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<th>Specialty Society: MI Radiological Society</th>
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<tbody>
<tr>
<td>Katharine Scharer MD</td>
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<th>Specialty Society: MI Rheumatism Society</th>
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<tr>
<td>Joshua June DO</td>
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<th>Specialty Society: MI Academy of Sleep Medicine</th>
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<tbody>
<tr>
<td>Virginia Skiba MD</td>
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### Specialty Society: MI Urological Society

<table>
<thead>
<tr>
<th>Keow</th>
<th>Goh</th>
<th>MD, MPH, MBA</th>
<th>Specialty Society Delegate</th>
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</thead>
</table>
Reference Committee A – Medical Care Delivery
Lawrence R. Hennessey, MD, MI Allergy and Asthma Society, Chair
Stephanie G. Clemens, MD, Oakland
Nicolas K. Fletcher, MD, MHSA, Wayne
Bradley P. Goodwin, MD, Grand Traverse
Warren F. Lanphear, MD, FACEP, Kent
Ethiraj G. Raj, MD, Genesee
Neha Thawani, MD, Wayne
Deepthi Devireddy, Michigan State University

Board Advisors:
Dennis M. Ramus, MD
F. Remington Sprague, MD

AMA Advisors:
E. Chris Bush, MD
Betty S. Chu, MD, MBA
Krishna K. Sawhney, MD

Staff:
Stacey P. Hettiger
Stacie J. Saylor

Reference Committee B – Legislation
Cheryl Gibson Fountain, MD, Wayne, Chair
Christopher J. Allen, MD, Saginaw
Barry I. Auster, MD, Oakland
Denise D. Collins, MD, Wayne
John A. Hopper, MD, Washtenaw
Courtland Keteyian, MD, MBA, MPH, Jackson
Jon M. Lake, MD, Jackson
Katherine J. Mills, MD, Kalamazoo
Nishant Kumar, Wayne State University

Board Advisors:
Leah C. Davis, DO
Kate Dobesh, MD, JD

AMA Advisors:
Brooke Buckley, MD
Michael D. Chafty, MD, JD
Pino D. Colone, MD
Kate Dobesh, MD, JD

Staff:
Rebecca J. Blake
Kate Dorsey
Reference Committee C – Internal Affairs, Bylaws, and Rules
David W. Whalen, MD, Kent, Chair
Edward A. Christy, MD, Genesee
Martha L. Gray, MD, MI Chapter, American College of Physicians
Bryan W. Huffman, MD
S. Bobby Mukkamala, MD, Genesee
Rose M. Ramirez, MD, Kent
Phillip G. Wise, MD

Board Advisors:
Mark C. Komorowski, MD
M. Salim Siddiqui, MD, PhD

AMA Advisors:
Mark C. Komorowski, MD
Christie L. Morgan, MD
M. Salim Siddiqui, MD, PhD

Staff:
Rebecca J. Blake

Reference Committee D – Public Health
Sherwin P.T. Imlay, MD, Oakland, Chair
Titilola A. Famakinwa, MD, Washtenaw
Daniel J. Johnston, MD, Kalamazoo
Natalie Mironov, DO, Oakland
Tudor D. Moldovan, MD, Kent
Rama D. Rao, MD, Genesee
Anthony M. Zacharek, MD, MI Academy of Plastic Surgeons
Tien Hua, Michigan State University

Board Advisors:
Annette S. Gilmer, MD, MPH
Melanie S. Manary, MD

AMA Advisors:
Theodore B. Jones, MD
Patricia Kolowich, MD
Richard E. Smith, MD

Staff:
Dara J. Barrera
Trisha L. Keast
Reference Committee E – Scientific and Educational Affairs
Steven D. Daveluy, MD, Wayne, Chair
Sara Jaber, MD, MI Section, American College of OB/GYN
Neil K. Khanna, MD, Wayne
Viktoria Koskenoja, MD, Marquette-Alger
Sara Liter-Kuester, DO, St. Clair
Latonya A. Riddle-Jones, MD, Wayne
James F. Szocik, MD, Washtenaw
Brandon Leung, Michigan State University

Board Advisors:
Robert Francis Flora, MD, MBA, MPH
David T. Walsworth, MD

AMA Advisors:
Amit Ghose, MD
Charlotte Jackson
Aarti Patel
David T. Walsworth, MD

Staff:
Leah Flanigan
Josh C. Richmond

Reference Committee on Ways and Means
Edward J. Rutkowski, MD, Grand Traverse, Chair
Anita R. Avery, MD, Kent, Vice-Chair
E. Chris Bush, MD, Wayne
T. Jann Caison-Sorey, MD, MSA, MBA, Wayne
Amit Ghose, MD, Ingham
John M. Pelachyk, MD, St. Clair
Richard C. Schultz, MD, Grand Traverse

Board Advisors:
Paul D. Bozyk, MD
Brian R. Stork, MD
Bradley J. Uren, MD
John A. Waters, MD

Staff:
Lauchlin W. S. MacGregor
**Fiscal Note Formula/Narrative**

Resolutions are submitted each year requiring various levels of staff time and outsourced activities to accomplish. Historically, fiscal notes would be assigned only to those resolutions requiring unbudgeted outsourced expenses. The 2018 Ways and Means Committee requested that both staff time and outsourced costs be reported for each resolution to better measure the costs associated with accomplishing each resolution. The estimated costs include outsourced costs, staff time and related overhead costs. These amounts represent the estimated costs to accomplish the resolution.

The process to develop estimated fiscal note costs includes all staff expected to be involved in each type of resolution and the estimated amount of time it will take to accomplish the resolution from beginning to end. The time required to accomplish a resolution includes direct activities, various levels of prep/review/approvals/follow up, committee structures, department meetings, staff meetings, CEO meetings, board reference committees, board meetings, website updates, database updates, etc.

The staff costs are projected based on salaries, benefits, taxes and overhead allocated and the number of estimated hours needed to accomplish the resolution. Overhead is applied based on the same IRS approved methodology as used on the MSMS annual tax return. Overhead includes a portion of all costs associated with an employee performing their duties including but not limited to: desks, chairs, office supplies, office space, computers, printers, IT infrastructure, phone system, heating, cooling, electric, HR, accounting, office maintenance/repairs, cleaning, etc. The final component is any outsourced costs, if needed.

Below is a table of resolution activity types and the related estimated fiscal note costs:

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Activity Name</th>
<th>Estimated Staff Cost Range</th>
<th>Estimated Outsourced Cost Range</th>
<th>Total Estimated Cost Range</th>
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<td>Advocacy</td>
<td>Messaging Campaign</td>
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<td>4,500 - 9,000</td>
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<td>Advocacy</td>
<td>Legislative</td>
<td>16,000 - 32,000</td>
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<td>Advocacy</td>
<td>Ask AMA to Advocate</td>
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<td>Collaborative Outreach Efforts</td>
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<td>Board Study</td>
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<td>Bylaws Amendments</td>
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<td>Bylaws Changes With Study</td>
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<tr>
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<td>New/Revised MSMS/AMA Policy</td>
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<td>25,000 - 50,000</td>
<td>27,000 - 54,000</td>
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<td>Request Cost Increase to Budget</td>
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<td>-</td>
<td>specific amount</td>
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House of Delegates Conflict of Interest Policy

All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest, including regulatory capture*, to the House of Delegates and its Reference Committees prior to testimony. The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or a non-member testifying on the floor of the House of Delegates or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters.


*Regulatory capture refers to the corruption of the regulatory process such that public good is sacrificed in favor of the commercial interests of the regulated entity.
As a not-for-profit, MSMS is a business advocate and practice resource for Michigan physicians.
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**BOARD ACTION REPORT**

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**2nd READING**

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### Reaffirmation Calendar

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Title: Repeal Ineffective Pain Management Laws and Mandates

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Original Author: Richard E. Burney, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, in 1994, the Legislature passed a law (MCL 333.17033) that called for improvements in pain and symptom management because of the perception that pain was inadequately managed and calling attention to doctors reluctance to prescribe Schedule II drugs, and

Whereas, in 2017, in time, this voluntary approach to behavior modification was with an amended law (MCL 333.17033(2)) specifying that each applicant for license renewal complete as part of the continuing education requirement of subsection (1) an appropriate number of hours or courses in pain and symptom management, as well as medical ethics and the subsequent Rule (R 338.2443) set the minimum continuing medical education (CME) credits for these courses to be three hours and one hour, respectively, and

Whereas, also in 2017, in response to the opioid crisis, the legislature passed MCL 333.7303, creating a regulatory framework which severely limited opioid prescribing, and

Whereas, there is no evidence that these laws and rules have had any salutary effect on pain management, which has seen rapid changes that no legislative body can keep up with, and

Whereas, physicians in Michigan remain encumbered by these laws and rules, including meaningless mandatory CME requirements; therefore be it

RESOLVED: That MSMS call for the repeal of the ineffective, burdensome laws and rules requiring three hours of pain and symptom management.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000 - $2,000

Relevant MSMS Policy

Pain Management Education and CME Credit
MSMS supports the concept of requiring physicians to be educated in pain management techniques but opposes mandating this type of education through CME credit.

Opposition to Compulsory Content of Mandated Continuing Medical Education
MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan.
Relevant AMA Policy

Support for Continuing Medical Education H-300.958

Our AMA:

(1) supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education;

(2) encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform;

(3) assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies;

(4) encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education;

(5) supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians;

(6) supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location; and

(7) affirms that lifelong learning is a fundamental obligation of our profession and recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education appropriate to that physician’s medical practice as determined by the relevant specialty society.
Title: Remove Legal Impediments to Women’s Reproductive Rights

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Original Author: Richard E. Burney, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, in 2022 the people of Michigan passed an amendment to the Michigan Constitution that made abortion a constitutional right, and

Whereas, many Michigan laws have been passed and still exist unnecessarily restricting abortion care, such that the constitutional right to abortion care is inaccessible to many, and

Whereas, the 2022 constitutional amendment did not remove or invalidate many existing Michigan laws intended to regulate many aspects of reproductive health, including but not limited to 1) the 24-hour waiting period; 2) unnecessarily onerous abortion clinic health standards; 3) the ban on public funding for abortions; and 4) the so-called partial birth abortion ban, and

Whereas, the Reproductive Health Act passed in the fall of 2023 by the Michigan Legislature removed some, but not all, unnecessary legislative interference in the provision of abortion care, and

Whereas, this leaves uncertainty regarding access to reproductive rights, which may take years to resolve in the courts, and

Whereas, the people of Michigan after passage of this constitutional amendment should not have to wait years to achieve effective reproductive freedom; therefore be it

RESOLVED: That MSMS lobby the Legislature to invalidate any, and all, laws that restrict access to evidence-based reproductive health care, including but not limited to: mandatory delays prior to obtaining abortion care, the provision of state mandated consents or materials (such as depictions of fetal development), state mandated scripting of the patient-provider interaction, or any other legislative interference singling out abortion care for additional administrative or regulatory burdens differentially from other health care most notably pregnancy loss management.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Physician-Patient Relationship and Health Care Decisions
MSMS believes: 1) the physician-patient relationship is deeply personal and must be respected and protected at all costs; 2) physicians and their patients should be free to consider, discuss, and
pursue medical procedures guided by a physician’s best medical judgment and a patient’s physical health and safety; and 3) as a Society, MSMS has always been and continues to be opposed to the potential criminalization of physicians and their patients in making health care decisions.

Repeal of Michigan’s Abortion Law
MSMS supports the repeal of Michigan Compiled Laws 750.14 and 750.15, due to the criminalization of physicians.

Relevant AMA Policy:

Expanding Support for Access to Abortion Care D-5.996
1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.
RESOLUTION 28-24

Title: Streamline Payer Quality Metrics

Introduced by: Beau Dowden, MD, for the St. Clair County Delegation

Original Author: Dawn Lambrecht, MD

Referred To: Reaffirmation Calendar

House Action:

Whereas, quality of patient care should be independent of the insurance carried by the patients, and

Whereas, Medicare and various third-party insurances currently use several parameters at their whims and fancy to assess primary care physicians’ performance, and

Whereas, those criteria usually change every year and it is difficult to track and perform all the quality measures by the offices of primary care physicians, which are severely resource constrained, and

Whereas, all such quality programs have a vital influence on a primary care physicians’ bottom-line and the sustainability of their practices; therefore be it

RESOLVED: That MSMS work with various Michigan-based insurance companies to formulate a streamlined “quality track” to evaluate and reward primary care physician practices in Michigan; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Centers for Medicare and Medicaid Services and major national insurance carriers to streamline each year’s patient quality metrics across their respective programs.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

Patient Centered Medical Home
MSMS presently accepts the Joint Principles and footnotes as originally proposed while working within the Michigan Primary Care Consortium to assure appropriate physician oversight of nurse practitioners and physician assistants is maintained as the Patient Centered Medical Home is promoted.

Quality Metrics
MSMS encourages public and private third-party payers to align quality metrics and limit the number of metrics that are introduced and modified each year in order to allow more consistency in quality and cost in the delivery of health care.
Relevant AMA Policy

Pay-for-Performance Principles and Guidelines H-450.947

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA’s “Principles for Pay-for-Performance Programs” and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.

2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.

3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship
- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
  - Programs must neither directly nor indirectly encourage patient de-selection.
  - Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation
- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
  1. Programs should provide physicians with tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
  1. Programs should use accurate administrative data and data abstracted from medical records.
  2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
  3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
  1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
  2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.
Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Source:
# RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE A – MEDICAL CARE DELIVERY

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RESOLUTION 01-24

Title: Guaranteed Access to Subcutaneous Immune Globulin Therapy

Introduced by: Lawrence R. Hennessey, MD, for the Michigan Allergy and Asthma Society

Original Author: Lawrence R. Hennessey, MD

Referred To: Reference Committee A

House Action:

Whereas, subcutaneous immune globulin is considered to be standard treatment for immune globulin deficiency and is considered to be safer, more convenient and more cost effective than intravenous immune globulin as it can be self-infused at home, and may be more effective than intravenous immune globulin for certain patients, and

Whereas, certain insurers are denying access to subcutaneous immune globulin to patients, requiring them to undergo intravenous infusions at an outpatient infusion center, which would limit access to care for patients in remote rural areas, and which would force patients to incur the risk of side effects and interruption in treatment, and

Whereas, determining the route of administration of immune globulin replacement therapy should be based on a shared decision between the patient and their physician, and

Whereas, the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 supports the concept that patients should have access to immune globulin therapy via the route that is deemed most appropriate for them; therefore be it

RESOLVED: That MSMS affirms the decision to administer subcutaneous versus intravenous immune globulin in the treatment of immune globulin deficiency should be left to the discretion of the patient and their physician and not to the patient’s insurer; and be it further

RESOLVED: That MSMS opposes insurers limiting access to indicated therapy that would be the safest, most effective, and most convenient option for treatment of immune globulin deficiency; and be it further

RESOLVED: That MSMS opposes insurers requiring patients to first undergo intravenous immune globulin therapy and only be allowed to receive subcutaneous immune globulin therapy after first suffering debilitating and potentially dangerous side effects; and be it further

RESOLVED: That MSMS affirms the decision to proceed with subcutaneous versus intravenous immune globulin therapy should be a choice made by the patient and their physician without third party interference.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
Relevant MSMS Policy

Determination of Medical Necessity of Medical Case Management
The treating physician shall be the sole determinant of medical case management and medical necessity. MSMS believes that an insurer, a health care corporation or a government agency may not interfere with the patient/physician relationship by determining medical necessity or medical case management without a fair and reasonable appeals process and independent binding arbitration in a timely fashion.

Physician’s Rights in Treatment Decisions
Neither physicians, hospitals nor hospital personnel shall be required to perform any act that violates good medical judgment or is contrary to moral principles of the individual. In such circumstances, the physician or other professional may withdraw from the case as long as the withdrawal is consistent with good medical practice.

Relevant AMA Policy

Protecting the Patient-Physician Relationship H-165.837
Our AMA: (1) supports protecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision-making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements; and (2) will continue to advocate protecting the patient-physician relationship in the context of bundled payment methodologies, comparative effectiveness research and physician profiling.

Interference in the Practice of Medicine D-125.997
Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.
Title: Abortion is Healthcare

Introduced by: Halley Crissman, MD, for the Michigan Section of the American College of Obstetricians and Gynecologists

Original Author: Halley Crissman, MD

Referred To: Reference Committee A

House Action:

Whereas, abortion can be spontaneous, incomplete, induced by medications, or as an in-office or in-hospital procedure; the care for each of these treatments, all fall under the abortion umbrella, and should be governed by relevant overarching policies on scope of practice, and

Whereas, scope of practice guidelines exist under Public Health Law and the regulations set by professional licensing boards, as well as education and training standards set by national organizations for health professions, and

Whereas, physicians or any other healthcare professional who inappropriately provide care outside of the scope of their practice, education, training and credentialing are liable for criminal and civil penalties, and

Whereas, advanced practice providers play a critical role in access to reproductive health care, especially within the significant maternal care deserts and rural communities that exist throughout the state of Michigan, through the provision of procedures such as endometrial biopsies, IUD and contraceptive implant placement, and pregnancy and childbirth related care, and

Whereas, existing MSMS policy restricting abortion care to physicians raises concern that this policy was developed as a result of abortion stigma, given lack of MSMS policy specifically prohibiting advanced practice providers from providing any number of other medical procedures - most notably miscarriage management which requires the same medical expertise and procedural skills, and

Whereas, advanced practice providers provide abortion care in nearly one-third of states in the United States, and

Whereas, several robust studies show no differences in outcomes in medication and aspiration abortion by health care practitioner type and indicate that trained advanced practice clinicians can safely provide abortion services, and

Whereas, in 2018, the National Academies of Sciences, Engineering, and Medicine published a report that concluded: "Aspirations are minimally invasive and commonly used for a variety of purposes in gynecology practices, including for early pregnancy loss (miscarriage). Aspiration abortions are performed safely in office-based settings and can be provided by appropriately trained APCs, as well as family practice physicians and OB/GYNs," and
Whereas, a Cochrane review found no significant differences in the risk of complications between advanced practice clinicians and doctors for abortion procedures, and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) asserts the pool of healthcare providers who provide medication and aspiration abortion should be expanded to appropriately trained and credentialed advanced-practice clinicians, and

Whereas, Michigan law continues to stipulate advanced practice clinicians must get their prescriptive authority for scheduled 2 thru 5 drugs from a physician; including mifepristone - used in medication abortion and early pregnancy loss care - which is a schedule 4 drug, and

Whereas, the AMA recognizes that healthcare, including abortion, is a human right, and opposes limitations on access to evidence-based reproductive health services; therefore be it

RESOLVED: That MSMS replace existing policy, “Abortion as a Medical Procedure” to read as follows:

Abortion is healthcare. MSMS opposes limitations on access to evidence-based reproductive health services.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

Abortion as Medical Procedure
Abortion is a medical procedure and should be performed only by a licensed physician in conformance with standards of good medical practice and the Public Health Code of the state of Michigan. (Prior to 1990)

Relevant AMA Policy

Preserving Access to Reproductive Health Services D-5.999
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.

**Expanding Support for Access to Abortion Care D-5.996**

1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs. 2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

**Oppose the Criminalization of Self-Managed Abortion H-5.980**

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than as a provider of treatment.

**Sources:**

Title: Insurance Coverage of Abortion

Introduced by: Halley Crissman, MD, for the Michigan Section of the American College of Obstetricians and Gynecologists

Original Author: Halley Crissman, MD

Referred To: Reference Committee A

House Action:

Whereas, abortion is healthcare, and

Whereas, abortion care should be considered essential health care by public and private insurance and should not be singled out for exclusion or additional administrative or financial burdens, and

Whereas, the inclusion of the federal Hyde amendment in annual federal budgets has restricted the use of federal Medicaid funds for abortion care, but states have the jurisdiction to use state Medicaid funds to cover abortion care, and

Whereas, insurance coverage restrictions related to abortion care, constitute a substantial barrier to abortion access and increase reproductive health inequities, and

Whereas, bans on Medicaid coverage of abortion care disproportionally impact people who face systemic barriers to health care, including Black and Indigenous people, rural residents, people with disabilities, and people who are working to make ends meet, and

Whereas, communities most affected by the lack of Medicaid coverage of abortion care include those who are most likely impacted by unacceptably higher maternal death rates - particularly Black women who are 2-3 times more likely to die in pregnancy compared to white women, and

Whereas, maternal death rates are higher in states with abortion restrictions, and

Whereas, evidence suggests that people who do not have access to public or private insurance coverage are delayed in their ability to obtain abortion care due to raising money for abortion care, and

Whereas, a major study comparing people who have been turned away from abortion care to those who were able to receive abortion, found that years after abortion denial, those turned away were less likely to have enough money to cover basic living expenses and were more likely to remain in contact with violent partners, and
Whereas, decisions about abortion care are complex and include factors related to health, relationships, finances, safety, and life planning - coverage for abortion care should not be predicated on a physician’s judgment of necessity, and

Whereas, denying someone abortion care just because they are enrolled in a public insurance program denies them the freedom to make the decision best for their circumstances;

Therefore be it

RESOLVED: That MSMS replace existing policies, “Medicaid Funding” and “Insurance Coverage,” with a single policy to read as follows:

MSMS recognizes that abortion is healthcare, and as such, that public and private health insurance should include abortion care as a covered benefit.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

Medicaid Funding
The state of Michigan should fund abortions for Medicaid patients deemed necessary by a physician.

Insurance Coverage
Medical insurance companies should make provision for adequate coverage of abortions.

Automatic and Affordable Health Insurance Coverage for All
MSMS supports affordable health insurance coverage for Americans.

Opposition to Government Regulations Limiting Scope of Women’s Health Coverage
MSMS supports maintaining the privacy and confidentiality of anyone who purchases additional coverage riders for any benefits including abortion and opposes any limitations on the scope of health care coverage that private insurance companies can offer in a comprehensive health plan.

Relevant AMA Policy

Expanding Support for Access to Abortion Care D-5.996
1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs. 2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

Preserving Access to Reproductive Health Services D-5.999
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.

Public Funding of Abortion Services H-5.998
The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Sources:
5. Roberts SCM, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. September 2014. BMC Medicine, 12:144
Whereas, throughout the United States, pregnant people have been prosecuted for a variety of actions during pregnancy that allegedly caused harm or risk of harm to fetuses they were carrying, and

Whereas, self-managed abortion is common; for example a representative survey of Texas women aged 18-49 years estimated that 1.7 percent - or approximately 100,000 women in that state - had attempted to self-manage an abortion at some point in their lives, and

Whereas, reasons why people attempt to self-manage an abortion are varied and include barriers to accessing clinic-based care, including cost, distance to the facility, and lack of knowledge of where and how to access care, as well as a preference for self-care, and

Whereas, due to the growing restrictions on abortion access and the closure of facilities providing this service, self-managed abortion attempts may become more common, and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) opposes the prosecution of pregnant people for conduct alleged to have harmed their fetus, including the criminalization of self-managed abortion, and

Whereas, ACOG also opposes administrative policies that interfere with the legal and ethical requirement to protect private medical information by mandating obstetrician gynecologists and other clinicians to report to law enforcement if they suspect a person has attempted self-managed abortion. Such actions compromise the integrity of the patient-physician relationship, and

Whereas, the AMA opposes the criminalization of self-managed abortion and opposes efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients or health care providers, and

Whereas, the criminalization of self-managed abortion increases patients’ medical risks and deters patients from seeking medically necessary services; therefore be it

RESOLVED: That MSMS opposes the prosecution of pregnant people for conduct alleged to have harmed their pregnancy or fetus(es), including the criminalization of self-managed abortion. MSMS will advocate against any legislative efforts to criminalize self-managed abortion, will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these
patients, and will oppose requirements that physicians function as agents of law enforcement - gathering evidence or reporting suspected occurrences or attempts to procure self-managed abortion.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

**Oppose Criminalization of Physicians and Patients for Evidence Based Standard of Medical Care**
MSMS opposes the criminalization of a procedure and prosecution of physicians for delivering evidence-based standard of medical care, as well as for refusing to engage in care that is neither safe nor evidence based.

**Physician-Patient Relationship and Health Care Decisions**
MSMS believes: 1) the physician-patient relationship is deeply personal and must be respected and protected at all costs; 2) physicians and their patients should be free to consider, discuss, and pursue medical procedures guided by a physician’s best medical judgment and a patient’s physical health and safety; and 3) as a Society, MSMS has always been and continues to be opposed to the potential criminalization of physicians and their patients in making health care decisions.

**Substance Use During Pregnancy**
MSMS encourages routine drug screening of pregnant women. MSMS opposes 1) making the use of controlled substances during pregnancy a felony; and 2) the removal of a child from its mother during the hospital stay solely due to evidence from a single positive drug test without an evaluation from a social worker.

Relevant AMA Policy

**Oppose the Criminalization of Self-Managed Abortion H-5.980**
Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than as a provider of treatment.

**Preserving Access to Reproductive Health Services D-5.999**
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.

Sources:
Title: Shield Laws - Protecting Access to Care

Introduced by: Halley Crissman, MD, for the Michigan Section of the American College of Obstetricians and Gynecologists

Original Author: Halley Crissman, MD

Referred To: Reference Committee A

House Action:

Whereas, legislators outside of Michigan have passed laws that attempt to criminalize out-of-state travel for abortion and gender-affirming care, and laws that try to criminalize the conduct of healthcare providers who care for patients from the state attempting restriction, and

Whereas, extraterritorial actions from restrictive states create uncertainty, chill the provision of essential health care services in states where care is legal, and discourage citizens of restrictive states from traveling to states where abortion and gender-affirming care are legal to seek needed health care, and

Whereas, states where abortion and gender-affirming care are legal have begun to draft and pass “shield laws” which at their core, seek to protect healthcare providers, helpers, and patients seeking care in states where abortion and gender-affirming care remain legal from legal attacks taken by restrictive states; therefore be it

RESOLVED: That MSMS opposes criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions, the termination of medical liability coverage or clinical privileges, against patients, patient advocates, patients’ families, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services (including abortion care) and gender-affirming care; and be it further

RESOLVED: That MSMS opposes extradition of patients and healthcare providers based upon accusations of providing or receiving health care (including care related to self-managed abortion, other abortion care, and gender-affirming care) that is legal in Michigan; and be it further

RESOLVED: That MSMS will advocate for legal protections for patients who cross state lines to receive health care (including care related to self-managed abortion, other abortion care, or gender-affirming care), or who receive medications for abortion or gender-affirming care from across state lines, and will advocate for legal protections for those that provide, support, or refer patients to these services; and be it further

RESOLVED: That MSMS will advocate for legal protections for medical trainees and physicians who cross state lines to receive education in, or deliver, reproductive health care (including abortion care) and gender-affirming care.
Relevant MSMS Policy

Oppose Criminalization of Physicians and Patients for Evidence Based Standard of Medical Care
MSMS opposes the criminalization of a procedure and prosecution of physicians for delivering evidence-based standard of medical care, as well as for refusing to engage in care that is neither safe nor evidence based.

Physician-Patient Relationship and Health Care Decisions
MSMS believes: 1) the physician-patient relationship is deeply personal and must be respected and protected at all costs; 2) physicians and their patients should be free to consider, discuss, and pursue medical procedures guided by a physician’s best medical judgment and a patient’s physical health and safety; and 3) as a Society, MSMS has always been and continues to be opposed to the potential criminalization of physicians and their patients in making health care decisions.

Protecting Access to Gender-Affirming Care
MSMS supports patient access to gender affirming care and opposes efforts to ban or restrict patient access to such care. MSMS also opposes punishing, imprisoning, or fining health care providers for providing gender-affirming care as recommended by established medical guidelines.

Relevant AMA Policy

Preserving Access to Reproductive Health Services D-5.999
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.
Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

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.

Oppose the Criminalization of Self-Managed Abortion H-5.980

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than as a provider of treatment.

Source:
Whereas, 42 percent of births in the United States in 2020 were covered by Medicaid, including 64.8 percent of births to Black women, 65.3 percent of births to American Indian/Alaska Native women and 58.8 percent of births to Hispanic women, and

Whereas, many Medicaid programs require obstetrician-gynecologists to utilize global obstetric codes to bill for the obstetrical services provided from the visit after the confirmation of pregnancy through 60 days of postpartum care, and

Whereas, with Medicaid payments for global obstetric codes being notoriously low, there is tremendous concern that many providers will elect to not participate in the Medicaid program and hence will lead to access to care challenges for many Medicaid beneficiaries, particularly groups that are already marginalized and live in poverty, and

Whereas, the financial stability of physician practices and the future viability of the United States' healthcare system relies on equitable, sustainable physician pay, and

Whereas, Medicare payment rates represent the reference standard for all physician reimbursements including payments from Medicaid programs and private payers, and

Whereas, the Centers for Medicare and Medicaid Services (CMS) is required by statute to update the Medicare Physician Fee Schedule on a yearly basis and maintain budget neutrality, and

Whereas, despite a projected 4.5 percent inflation in medical practice costs in 2024, the current laws obligated CMS to execute a 3.36 percent across-the-board cut in Medicare physician payment rates in 2024, and

Whereas, hospitals and skilled nursing facilities receive yearly payment increases linked to inflation, physician practices on the other hand have had to fight to lower or delay payments cuts almost every year, and

Whereas, the Medicare physician payment rates dropped by 26 percent from 2001 to 2023, while costs of maintaining practices increased by 47 percent during the same time, which in turn has affected Medicaid reimbursements, and
Whereas, Medicaid coverage for birth in Michigan fluctuated between 42.5 percent and 39.7 percent from 2016 to 2020, with 66.1 percent coverage for birth among Black women and 59.6 percent coverage for Hispanic women from 2018 to 2020, and

Whereas, the Michigan Medicaid Program fee-for-service rate for global obstetric codes is 77.2 percent of the geographically adjusted Medicare Physician Fee Schedule rate, and

Whereas, two hospitals in Michigan closed their labor and delivery units and one hospital closed entirely, with two out of three of these hospitals being in rural areas in Michigan, and

Whereas, Medicaid covers close to 50 percent of birth in Michigan and with Medicaid payouts being low, is creating financial strain on the healthcare systems leading to closure of maternity units, and

Whereas, the consequence is additional gaps in access to care especially among marginalized groups and the further increase in the rates of maternity care deserts in Michigan, and

Whereas, MSMS “opposes all cuts in Medicaid reimbursement budgets and supports an increase in payments to a level that covers physician and hospital costs;” therefore be it

RESOLVED: That MSMS advocate with the Michigan State Medicaid Program to seek payment rates for obstetric services at a minimum of 100 percent of the geographically adjusted Medicare Physician Fee Schedule rate; and be it further

RESOLVED: That MSMS advocate that obstetric care for high-risk obstetrics patients enrolled in Medicaid may be billed outside of the global obstetric codes to reflect the amount and complexity of the care and improve outcomes; and be it further

RESOLVED: That MSMS advocate for increases in the states’ Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

Equitable Medicaid Reimbursement
MSMS opposes all cuts in Medicaid reimbursement budgets and supports an increase in payments to a level that covers physician and hospital costs.

Medicaid Financing Policies
MSMS opposes Medicaid financing policies that result in reduced funding for Medicaid in Michigan. Such policies could include block grants and per-capita funding.

Relevant AMA Policy

Cuts in Medicare and Medicaid Reimbursement H-330.932
Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient’s and the physician’s constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Sources:
3. Equitable Payment Rates for Maternity and Surgical Care. ACOG. (n.d.).
Whereas, patient non-adherence is a very complex phenomenon, and
Whereas, patients refuse preventative screening programs such as breast cancer screening, and
Whereas, patients or parents can refuse necessary vaccinations, and
Whereas, patients may not follow advice or recommendations given by their primary care physicians, and
Whereas, such decisions adversely affect the health of the patients and subsequently, the quality metrics tracked by Medicare and various third-party insurers; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to study the issue of patients and parents not adhering to primary care physicians' recommendations such as preventive screening and vaccinations resulting in a deficiency of quality metrics by primary care physicians for which the physicians are penalized and identify equitable and actionable solutions.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Quality Metrics
MSMS encourages public and private third-party payers to align quality metrics and limit the number of metrics that are introduced and modified each year in order to allow more consistency in quality and cost in the delivery of health care. (Res17-18)

Relevant AMA Policy:

Pay-for-Performance Principles and Guidelines H-450.947
PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:
1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS
Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care
- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship
- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation
- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
  1. Programs should provide physicians with tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting
- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
  1. Programs should use accurate administrative data and data abstracted from medical records.
  2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
  3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
  1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
  2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

**Source:**
Whereas, a quarter of women in the United States will have an abortion in their lifetime, and

Whereas, 39 percent of all abortions were medication abortions, and

Whereas, telehealth improves access to medication abortion that would typically be limited by barriers to travel, but state restrictions on telehealth continue to provide further barriers against access to medication abortion, and

Whereas, medication abortion such as mifepristone and misoprostol are safe, reliable, and effective to be self-administered at home, and

Whereas, the Food and Drug Administration notes that serious bleeding risks or infection, are "exceedingly rare, generally far below 0.1 percent for any individual adverse event," and

Whereas, medication abortion such as misoprostol and mifepristone is already approved for over-the-counter (OTC) distribution in other countries, and

Whereas, there are high levels of comprehension of drug labels and instructions for usage of a potential OTC medication abortion without clinical supervision, and require minimal changes to a medication abortion drug label for the general consumer to safely self-administer, and

Whereas, the Advancing New Standards in Reproductive Health research group at the University of California San Francisco states medication abortion including "mifepristone and misoprostol meet many of the FDA's criteria for being available over the counter. They are safe, have no risk of overdose, are not addictive, and people are already using them safely on their own in many parts of the world," and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) advocates that “Risk Evaluation and Mitigation Strategies (REMS) restrictions on the use of mifepristone do not make the care safer, are not based on medical evidence or need, create barriers to clinician and patient access to medication abortion, and disproportionately burden communities already facing structural barriers to care," and

Whereas, the American Medical Association is already resolved to support that abortion is a human right, and to support mifepristone availability for reproductive health indications, including
via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and
Drug Administration to lift the “Risk Evaluation and Mitigation Strategy” on mifepristone, and

Whereas, MSMS is already resolved to advocate for maintaining the privacy and
confidentiality of any purchasers of abortion insurance riders and telehealth access to abortions in
the first trimester; therefore be it

RESOLVED: That MSMS will advocate for access to over-the-counter medication abortion.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy

Hormonal Contraceptives Available Over-the-Counter
MSMS supports the American College of Obstetricians and Gynecologists’ Committee Opinion 788
which supports access to over-the-counter contraception including oral pills, vaginal rings,
contraceptive patches, and depot medroxyprogesterone acetate.

Over-The-Counter Contraception as a Qualified Medical Expense
MSMS supports inclusion of over-the-counter contraception as a qualified medical expense under
tax-advantaged accounts including but not limited to health savings accounts and flexible
spending accounts.

Telemedicine for Access to Early Medical Abortion Care
MSMS supports access for medical abortions via telemedicine for first trimester pregnancies
consistent with American College of Obstetricians and Gynecologists clinical management
guidelines.

Relevant AMA Policy

Preserving Access to Reproductive Health Services D-5.999
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.

**Supporting Access to Mifepristone (Mifeprex) H-100.948**
Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

**Sources:**
1. Updated MiFePristone REMS requirements. AGOG. https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2023/01/updated-mifepristone-REMS-requirements
Whereas, infertility affects 20 percent of married women of reproductive age, with 12.2 percent of women having ever received infertility treatment in 2019, and

Whereas, 42 percent of American adults claim to have used fertility treatments or personally know someone who has, and

Whereas, 31 percent of lesbians with insurance seek fertility and reproductive services, compared to 10 percent of heterosexual individuals, and

Whereas, the collective clinical definitions of infertility among several health organizations (i.e., the Centers for Disease Control, World Health Organization, and American College of Obstetricians and Gynecologists) can be summarized as “failure to become pregnant after 1 year of regular, unprotected sexual intercourse,” and

Whereas, social infertility explores the relational or biographical factors, such as being single or in a same-sex relationship, limit one’s ability to conceive, and

Whereas, the aforementioned clinical definitions, which serve as a basis for infertility diagnoses and subsequent access to care, endorse a physiological basis, though fail to recognize that infertility and the inability to conceive have both biological and social roots, and

Whereas, while recognizing infertility as a medical diagnosis has broadened heterosexual couples’ access to fertility care and insurance coverage, the majority of patients undergoing in-vitro fertilization (IVF) pay out of pocket, as many insurance policies regularly exclude fertility care, only cover an infertility diagnosis, or do not cover IVF, and

Whereas, insurance companies offering IVF coverage only do so after patients reach an infertility diagnosis defined as “failing to conceive after six or twelve months of receiving fertility treatment” (i.e., IUI), thereby necessitating out of pocket payments for those navigating social infertility before gaining access to fertility insurance coverage, and

Whereas, the median price of IVF in the United States is $19,200 for one cycle, with the full course of treatment costing significantly more, and

Whereas, transgender and gender diverse individuals undergoing hormonal therapy or surgical treatment risk impaired fertility as potential side effects, and
Whereas, in Michigan, there is no state mandate requiring insurers to offer coverage for fertility care or preservation, and

Whereas, insurance coverage in Michigan is dependent on the insurance carrier and an employer’s discretion to purchase an insurance rider for fertility diagnosis and treatment, and

Whereas, Nebraska is the only state to offer Medicaid coverage of infertility treatments, though this is only available to patients with an underlying medical problem, thus excluding same-sex couples and single individual, and

Whereas, even states that mandate coverage for fertility services, such as Utah, New York, New Jersey, Delaware, Connecticut, Rhode Island, Maine, and New Hampshire, continue to exclude same-sex couples and unmarried individuals from the definition of infertility required to qualify for fertility service coverage, and

Whereas, Colorado, Illinois, Washington D.C., and Maryland are the only states that mandate coverage for fertility services for all individuals, including same-sex couples and single individuals attempting to access fertility services, and

Whereas, the American Society of Reproductive Medicine (ASRM), in October 2023, issued an expanded infertility definition to incorporate “the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner” alongside traditional definitions, and

Whereas, the World Professional Association for Transgender Health recommends health care providers offering gender-affirming care to transgender and gender diverse individuals should ensure they receive timely information about fertility preservation services prior to undergoing treatment, and

Whereas, acknowledging both the physiological and social causes of infertility through a formal definition legitimizes access to care and treatment, regardless of relationship status or sexual orientation; therefore be it

RESOLVED: That MSMS formally recognizes the concept and experiences of social infertility amidst the American Society of Reproductive Medicine’s (ASRM) recently expanded infertility definition that incorporates “the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner;” and be it further

RESOLVED: That MSMS support legislation for insurance coverage and local and state efforts to promote reproductive health insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and be it further

RESOLVED: That MSMS support legislation for insurance coverage of fertility treatment and preservation based on established definitions of infertility, etiologies of infertility, and evidence-based medicine recommended by the American Society for Reproductive Medicine and American College of Obstetrics and Gynecology; and be it further
RESOLVED: That MSMS support legislation for insurance coverage for fertility counseling and preservation in accordance with the recommended practices by the World Professional Association for Transgender Health.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy - None

Relevant AMA Policy

Preserving Access to Reproductive Health Services D-5.999
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.

Sources:
1. Updated MiFePristone REMS requirements. AGOG. https://www.acog.org/clinical/clinical-guidance/practice advisory/articles/2023/01/update-d-mifepristone-rems-requirements
4. Over-the-Counter Medication Abortion. ANSIH. https://www.ansirh.org/research/ongoing/over-counter-medication-abortion
ACTION REPORT #04-24 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 50-23
Patient’s Right to Choose Non-Participating Physician Practices

REFERRED TO: Reference Committee A

HOUSE ACTION:

RECOMMENDATION: THAT THE 2024 HOUSE OF DELEGATES APPROVE RESOLUTION 50-23, “PATIENT’S RIGHT TO CHOOSE NON-PARTICIPATING PHYSICIAN PRACTICES” AS AMENDED TO READ AS FOLLOWS:

RESOLVED: That MSMS investigate the policies of Michigan health insurers as they relate to recognition of direct primary care physicians and the ability of direct primary care physicians to prescribe medication, order tests, and make referrals for patients who have health insurance plans. MSMS shall report back to the 2025 MSMS House of Delegates.

Resolution 50-23 asks MSMS to work with Michigan health insurers to:
- Educate them on the role of Direct Primary Care physicians and other practices which may not be associated with hospital system offices, in promoting high quality care while decreasing health care costs for patients with health insurance.
- To allow Direct Primary Care physicians to prescribe medication, order tests, and referrals on patients who have health insurance plans.

There was discussion regarding the differences between the Direct Primary Care model and concierge medicine, as well as payers’ treatment of physicians providing Direct Primary Care as out-of-network providers and the impact on patients. Although Committee members agreed conceptually with the intent of the resolution, they thought it would be beneficial to have a better understanding of the breadth of the problems faced by physicians and patients providing and receiving services through Direct Primary Care, respectively, in order to better advocate for necessary changes.

Therefore, the Committee recommends consolidating the two Resolved statements into one and directing MSMS to gather additional information and share its findings with the MSMS House of Delegates at its 2025 meeting.

The Health Care Delivery Committee makes the following motion:
MOTION: THAT THE MSMS BOARD OF DIRECTORS RECOMMEND TO THE 2024 MSMS HOUSE OF DELEGATES THAT IT APPROVE RESOLUTION 50-23, "PATIENT'S RIGHT TO CHOOSE NON-PARTICIPATING PHYSICIAN PRACTICES" AS AMENDED.

Attachment
Resolution 50-23
Resolved, that the State of Michigan recognize the right of the patient to choose non-participating physician practices or other health care practices that meet the following criteria:

1. Michigan Compiled Law 500.129 recognizes Direct Primary Care (DPC) or other similar practices by clarifying that a medical retainer agreement is not insurance and not subject to the Michigan Insurance Code if certain criteria is met, and

2. DPC and other practices may not participate with, or bill any insurance companies, allowing DPC practices to provide high quality individualized care at affordable rates for patients, and

3. The DPC option offers a plan that provides individuals and families with unlimited access to their personal physician for a flat, monthly fee, and

4. Patients choose DPC practices or other practices which provide longer office visits with their physician, increased access via phone calls, text messages, and video chat, all while being cost conscious, and

5. DPC plans are not health insurance, and DPC patients often carry high deductible insurance plans and are responsible for the majority of the cost of outpatient testing, medications, and consults, and

6. DPC physicians and other physician office teams have to become very skilled at finding and negotiating low-cost medication, referrals, and studies for their patients, and

7. Some insurance companies consider DPC physicians “out-of-network,” and will not allow them to order medications, tests, or referrals on patients who have health insurance, even when the patient pays 100 percent of the cost of the medical treatment due to high deductibles, and

8. Insurance companies will require a patient to visit an insurance-based doctor solely to make the referral, thereby increasing healthcare costs and delaying care, and

9. Unlike traditional insurance-based physicians who may be out of network with particular insurance companies, DPC physicians are, by definition and legal distinction, a unique class of physicians, and out-of-network with all insurances, and

10. The State of Maine recognized this distinction, and has passed legislation prohibiting denial of referrals by DPC physicians; therefore be it
RESOLVED: That MSMS work with Michigan health insurers to educate them on the role of Direct Primary Care physicians and other practices which may not be associated with hospital system offices, in promoting high quality care while decreasing health care costs for patients with health insurance; and be it further

RESOLVED: That MSMS work with health insurers to allow Direct Primary Care physicians to prescribe medication, order tests, and referrals on patients who have with health insurance plans.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy:

Promotion of Direct Primary Care Services (Resolution 23-15)
RESOLVED: That MSMS study and educate its members regarding alternative payment models for primary care including direct primary care contracts and “concierge” medicine using methods such as email, website, and webinar programs.

Increasing Insurance and Access Options for Patients (Resolution 50-14)
RESOLVED: That MSMS explore and monitor new programs and initiatives in health care such as those involving direct patient primary care and high deductible health care plans with health savings accounts; and be it further
RESOLVED: That MSMS educate physicians regarding new programs and initiatives in health care such as those involving direct patient primary care and high deductible health care plans with health savings accounts.

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.
# RESOLUTIONS BY COMMITTEE

## REFERENCE COMMITTEE B – LEGISLATION

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Whereas, patients’ active participation in their health care is critical to good outcomes and predicated on access to their health information, not limited to laboratory test results, and

Whereas, the federal 21st Century Cures Act requires that patients receive health information without delay, and

Whereas, the immediate release of sensitive and confusing information to patients can occur without the treating or ordering physicians' knowledge or interpretation, and

Whereas, the immediate release of health information via electronic means (e.g., patient portals) can precipitate emotional and physical injury to patients who are not properly prepared to receive and interpret such information without assistance from their physician or other health care practitioner, and

Whereas, violation of the information blocking provision of the 21st Century Cures Act can result in civil and monetary penalties for physicians, information technology developers, and health care networks/systems, and

Whereas, the American Medical Association unsuccessfully advocated for the inclusion of a "common sense exception" to the 21st Century Cures Act and failed to gain the support of the National Coordinator for Health Information Technology for such an exemption, and

Whereas, there is a provision in the 21st Century Cures Act that provides an exception to the Act’s immediate release of information requirement for physicians and other clinicians who are in a state with a state law that requires a delay on release of certain information, and

Whereas, legislation instituting reasonable timelines for the release of certain sensitive information has been passed in California, Kentucky, and Texas; therefore be it

RESOLVED: That MSMS supports the imposition of a reasonable time period before certain sensitive health information is required to be released to patients to prevent unnecessary emotional and physical harm or stress to patients from receiving such information without the benefit of a discussion with their physician or other health care practitioner; and be it further;
RESOLVED: That MSMS actively identify and work with partners to draft legislation that establishes a reasonable (e.g., 72 hours) window before certain sensitive health information is released in order to 1) protect patients from harm, and 2) avoid potential for federally stipulated monetary penalties to providers who are considered to be in violation of the information blocking provision of the 21st Century Cures Act; and be it further

RESOLVED: That MSMS continue to update and provide educational resources for physicians and their practices to help them maintain compliance with the 21st Century Cures Act.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy - None

Relevant AMA Policy

Redefining the Definition of Harm D-315.972
Our AMA will: (1) advocate to the Office for Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient; (2) advocate that the Office for Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health; (3) continue to urge the Department of Health and Human Services (HHS)'s Office of the National Coordinator for Health Information Technology (ONC) and its Office of Inspector General (OIG) to leverage their enforcement discretion that would afford medical practices additional compliance flexibilities; and (4) urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.

Sources:
Title: Physician Rights and Responsibilities Regarding Collaboration with Non-Physician Practitioners

Introduced by: Viktoria Koskenoja, MD, for the Marquette-Alger County Delegation

Original Author: Viktoria Koskenoja, MD

Referred To: Reference Committee B

House Action:

Whereas, employed physicians generally have no control over the hiring, evaluation, or firing processes for nonphysician practitioners at their workplace, nor access to the record of training, experience, and competencies, nor access to details of their collaborative practice agreement(s), and

Whereas, employed physicians are generally not offered the choice of whether and to what extent they must work with nonphysician practitioners, regardless of whether a physician holds a collaborative practice agreement; therefore be it

RESOLVED: That MSMS update existing policy, “Standards for Collaborative Agreements,” to recognize that physician collaboration with nonphysician practitioners and the delegation of tasks that fall within the practice medicine is not a usual nor customary duty of a physician and, as such, the decision to collaborate must be made voluntarily, not as a condition of employment, and with a formal collaborative practice agreement; and be it further

RESOLVED: That MSMS support legislation or regulation to ensure that the employers of nonphysician practitioners have the financial and administrative responsibility to provide work and staffing conditions that offer (1) a safe level of collaboration in the independent medical judgment of the collaborative physician and (2) timely and safe level of oversight in the independent medical judgment of on-site physicians who may be asked to verify with or without attestation to medical acts of the nonphysician practitioner; and be it further

RESOLVED: That MSMS seek and support legislation regarding physicians with no active collaborative agreement(s), regardless of employment arrangement, that requires the following:

1. That on-site physicians may verify a medical task performed by a nonphysician practitioner provided that the verifying physician is present for key portions of any patient care task or procedure verified (similar to the standards for the verification of resident physician care).

2. That on-site physicians may only attest, through signature or other written documentation, to tasks, procedures, and elements of patient care that they have verified.

3. That the attestation of tasks, procedures, and patient care notes for patients whom the physician has not seen is not within the usual and customary duty of a physician in the course of employment and a request from the employer that a physician attest to care that the physician has not participated in may constitute a breach of ethics or contract on the part of the employer.

4. That, to ensure a safe level of patient care provided by nonphysician practitioners, on-site physicians who formally agree to be available for verification or attestation of medical acts by
nonphysician practitioners (1) have adequate time set aside from other professional responsibilities and duties to perform the verification and attestation function as determined by the respective physician’s independent medical judgment and (2) receive adequate compensation to account for the loss of individual productivity and lost revenue due to the verification and attestation functions; and be it further

RESOLVED: That MSMS seek and support legislation on behalf of physicians with one or more active collaborative agreements, regardless of employment arrangement, requires the following:

1. That physicians be allowed to fully participate in the recruitment, selection, hiring, performance evaluation and firing decisions regarding the nonphysician practitioner.
2. That, to ensure a safe level of patient care provided by nonphysician practitioners, physicians engaged in collaborative agreement (1) have adequate time set aside from other professional responsibilities and duties to perform the collaborative function as determined by the respective physician’s independent medical judgment and (2) receive adequate compensation to account for the loss of individual productivity and lost revenue due to the collaborative function.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy

Standards for Collaborative Agreements
MSMS affirms the urgency of defining standards for “collaborative agreements” with advanced practice registered nurses (APRNs) and that MSMS seek and support legislation that would require APRNs to work in a setting and perform tasks and procedures that are within the collaborating physician’s particular field of medicine, as qualified by residency training and/or board certification to perform.

MSMS believes physicians who enter into collaborative or practice agreements with APRNs or physician assistants (PAs) from a location outside of Michigan must be available to answer questions and directly collaborate with the non-physician practitioners (NPPs), or to examine the patient, during a majority of the hours of activity of the APRN and/or PA via video conferencing.

Safe Collaborative Medical Practice
MSMS supports the appropriate licensing Boards and agency investigating and censuring physicians who deliberately violate the spirit of safe collaborative medical practice with NPPs by (1) engaging in a pattern of negligent delegation to, supervision of, or collaboration with NPPs; (2) supervising activities for which the physician is not formally trained and/or board certified; (3) not being promptly available to communicate with the NPP and/or patient; and, (4) disregarding collaborative practice agreement requirements by aiding and abetting the unlicensed practice of medicine.

Physician Antiretaliation, Due Process, and Indemnification Rights
MSMS shall: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care; (3)
advocate for the rights of physicians against employer retaliation, including unfair or discriminatory termination of employment or contractual obligation for conscious objection and/or conscious refusal to participate in any activity that the physician judges to be unethical or unsafe for patients; (4) advocate for the physician’s authority to practice medicine based on medical judgment, conscience, ethics, morals, or good faith obligation toward patients to a non-physician or corporate entity; (5) advocate for the following: (a) that physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (b) that physician supervision should be explicitly defined and mutually agreed upon; (c) that advanced notice and disclosure be provided to physicians 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; (d) 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; (e) that physicians have the right to object to or refuse to allow their license to be used to document supervision of non-physician practitioners without fear of retaliation; (f) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation; and (g) that physicians be indemnified at the organizations’ and institutions’ expense from malpractice claims and other litigation arising out of the supervision function.

**Transparency of Practice Agreements Between Physicians and Non-Physicians**

MSMS supports public transparency of practice agreements, or lack of such agreements, between physicians and non-physician providers (such as nurse practitioners and physician assistants), as a reflection of our professionalism and commitment to patient safety in a physician-led care model.

**Relevant AMA Policy** - None

**Source:**
1. Credit to Mercy M. Hylton, MD, for introducing this original resolution to the Indiana State Medical Association.
Whereas, the Michigan Legislature is interested in exploring alternative pathways to
physician licensure for medical school graduates who have not matched to a residency position, as
well as for physicians and other health professionals who are foreign-trained and licensed and
practicing their respective professions in a country other than the United States, and

Whereas, the Michigan Task Force on Foreign Trained Medical Professional Licensing, which
was charged with identifying strategies to reduce licensure barriers for medical professionals who
were trained, licensed, and practicing outside of the United States, issued a Final report that
included a recommendation for alternate pathways to licensure, and

Whereas, this is an issue on which MSMS was being asked to engage, even before the
release of the Task Force’s final report, and

Whereas, legislators are seeking input on a variety of proposals ranging from legislation
modeling recently passed laws in Tennessee and Illinois permitting foreign-trained and licensed
practicing physicians who now reside in the United States to begin practicing with a temporary or
limited license under the supervision of a physician for a specified time period to proposals
creating a new medical position as “associate physicians” for graduate physicians who have not
found a residency position, and

Whereas, MSMS has current policy that opposes the “assistant physician” licensing pathway,
as well as a directive telling MSMS to look at various proposals that would result in a primary care
advanced practice licensing pathway, and

Whereas, since the adoption of MSMS policy the landscape around scope of practice has
changed, with non-physician providers using the shortage of physicians, especially in health
professions shortage areas, as an argument in support of their requests for expanded scope and/or
independent practice, and

Whereas, there is an immediate opportunity for MSMS to be a resource to legislators by
helping them to evaluate the pros and cons of various proposals and identify alternative licensing
pathways that can provide patients with access to physician-led and supervised care; therefore be it

RESOLVED: That MSMS consider innovative proposals with adequate training, supervision,
and external funding to establish a pathway for unmatched medical school graduates from
Michigan Department of Licensing and Regulatory Affairs-approved medical schools to obtain a limited educational license to practice under the direct supervision of a fully licensed physician with a goal of successfully matching into a residency program; and be it further

RESOLVED: That MSMS consider innovative proposals with adequate training, supervision, and external funding to establish a pathway for physicians who have previously practiced independently abroad to obtain an academic educational license to practice under the direct supervision of a fully licensed physician in their specialty for a specified time period before applying for full licensure; and be it further

RESOLVED: That MSMS consider innovative proposals with adequate training, supervision, and external funding to establish a pathway for physicians who have previously practiced independently in the United States to obtain an academic educational license to practice under the direct supervision of a fully licensed physician their specialty with a goal of successfully re-entering practice.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

**Relevant MSMS Policy**

**Board Action Report 34-14 (Adopted)**
RESOLVED: That MSMS consider innovative proposals with adequate training and supervision to assimilate USMLE-certified but unmatched U.S. citizen international medical graduates as advanced practice providers in primary care.

**Opposing the Establishment of an Assistant Physician Program**
MSMS opposes special licensing pathways, including the “assistant physician” pathway, for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or who have not completed at least one year of accredited post-graduate U.S. medical education.

**Automatic Eligibility for Licensure Limited to Graduates from Medical Schools which Meet LCME Standards**
Only graduates from medical schools which meet standards established by the Liaison Committee on Medical Education should be automatically eligible for licensure as medical doctors in Michigan.

**Relevant AMA Policy**

**Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977**
Our AMA will advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow: (1) completion of medical school and residency training outside the U.S.; (2) extensive U.S. medical practice; and (3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification.
Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950

Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialing bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.

Practicing Medicine by Non-Physicians H-160.949

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).

Medical Licensure H-275.978

Our AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for “assistant physicians.” It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician’s current ability to practice medicine;
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician’s knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United States Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement;
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license;
(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration;
(24) supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards;
(25) urges that the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams; and
(26) urges that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances.
Title: Addressing the Unregulated Body Brokerage Industry

Introduced by: Nicolas Fletcher, MD, MHSA, for the Wayne County Delegation

Original Author: Nicolas Fletcher, MD, MHSA

Referred To: Reference Committee B

House Action:

Whereas, the for-profit body broker industry’s (a.k.a., non-transplant tissue banks) lack of regulation gives rise to significant ethical dilemmas and public health hazards, and

Whereas, body brokers are firms or individuals that acquire whole bodies/cadavers donated to science, for the purpose of dissecting them to sell or lease the parts for profit, and

Whereas, brokers make money - anywhere from $5,000 to $10,000 - by providing bodies and dissected parts to companies and institutions that specialize in advancing medicine and other trades through training, education, and research, and

Whereas, a Reuters review of court, police, and internal broker records and interviews identified more than 2,357 body parts obtained by brokers from at least 1,638 people that were misused, abused, or defiled, and

Whereas, in 2017, a Midwest couple was charged with defrauding customers by selling body parts infected with hepatitis and HIV, and

Whereas, in 2016, more than 20 bodies donated to an Arizona broker were used in United States Army blast experiments, without the consent of the deceased or next of kin, and

Whereas, body brokers are known to prey on underserved and minoritized populations, profiting on exploitation while demand for organs, skeletons, and tissues unceasingly rise., and

Whereas, the Uniform Anatomical Gift Act (1967) is a federal framework that specifies how organ donations can be made and aims to maintain the current organ donation and transplantation systems in the U.S., and

Whereas, current regulations only cover body parts intended for transplant, such as hearts, livers, tissue; no such regulatory body exists for the body broker industry., and

Whereas, only ten states provide any oversight, and only some require licensing or disclosure of body brokers.; therefore be it

RESOLVED: That MSMS support federal and state legislation aimed at tracking what becomes of donors’ bodies or body parts within the body broker industry to ensure they are handled with dignity and returned to their loved ones after cremation.; and be it further
RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to collaborate with appropriate stakeholders, including but not limited to government agencies and professional organizations, to advocate for state and federal legislation that will provide the oversight and authority over body broker entities that receive donated human bodies and body parts for education and research.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy - None

Relevant AMA Policy

Improving Body Donation Regulation H-460.890
Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

Sources:
1. In a warehouse of horrors, a body broker allegedly stacked human heads (reuters.com)
2. Murphy, Tillis, Bilirakis, Fletcher Introduce Bipartisan, Bicameral Bill To Stop The Brokering Of Body Parts, Preserve Integrity Of Organ Donation Process (senate.gov)
3. Body Broker Bill Introduced in the Senate > National Funeral Directors Association (NFDA)
4. For Congress - CDRI Info 12-6-2023.pdf (nfda.org) 5) uaga_final_aug09.pdf (pitt.edu)
RESOLUTION 20-24

Title: Repeal Laws and Mandates Related to Breast Cancer Management

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Original Author: Richard E. Burney, MD

Referred To: Reference Committee B

House Action:

Whereas, over 30 years ago, when controversies over the treatment of breast cancer attracted the attention of the press, specialists in Radiation Oncology and some surgeons began questioning the value of mastectomy and publicizing the results of treatment by lumpectomy and radiation, and

Whereas, this led to the passage of MCL 333.17013, “Alternative methods of treatment of breast cancer; duty of physician to inform patient; standardized written summary or brochure; form; civil action,” in 1986, which mandates the distribution of information on alternative methods of treatment to patients with breast cancer and requires patients to sign a form acknowledging they have received the standardized written summary created or approved by the Michigan Department of Public Health, and

Whereas, this mandate is now widely ignored as badly outdated and obsolete, it nevertheless remains law, and is an example of why the Legislature should not attempt to practice medicine; therefore be it

RESOLVED: That MSMS work to repeal of MCL 333.17013, “Alternative methods of treatment of breast cancer; duty of physician to inform patient; standardized written summary or brochure; form; civil action.”

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy

Physician-Patient Relationship and Health Care Decisions
MSMS believes: 1) the physician-patient relationship is deeply personal and must be respected and protected at all costs; 2) physicians and their patients should be free to consider, discuss, and pursue medical procedures guided by a physician’s best medical judgment and a patient’s physical health and safety; and 3) as a Society, MSMS has always been and continues to be opposed to the potential criminalization of physicians and their patients in making health care decisions.

Mammography Screening
MSMS endorses baseline mammography screening and women talking with their doctor about when to start breast cancer screening with mammograms and how often to be screened. Decisions should be based a variety of considerations including national guidelines, benefits and harms of
mammography, and risk factors such as family history, radiation therapy to the chest between the ages of 10 and 30 years, and having or at high risk for mutations in certain genes that greatly increase the risk of breast cancer.

Relevant AMA Policy

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959
1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
   A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
   B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
   C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
   D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

Freedom of Communication Between Physicians and Patients H-5.989
It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;
(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;
(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and
(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Mammography Screening for Breast Cancer D-525.998
In order to assure timely access to breast cancer screening for all women, our AMA shall advocate for legislation that ensures adequate funding for mammography services.
Title: Modernize Requirements for Unrestricted Licensure in Michigan

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Original Author: Richard E. Burney, MD

Referred To: Reference Committee B

House Action:

Whereas, the public health of the citizens of the state of Michigan and the quality of patient care available to them depends on the quality and training of physicians licensed to practice in the state, and

Whereas, at present, the only requirement for the granting of a new, unrestricted license to practice medicine in Michigan is graduation from medical school and two years of post-graduate training, whether in the same or different specialties, and

Whereas, times have changed, this requirement originated decades ago when more than one or two years of post-graduate training was thought unnecessary and many physicians went into general practice, and

Whereas, recent research has shown that physicians with fewer than three years of post-graduate training are four times as likely to be subject to disciplinary action by a state medical board for substandard practice, and

Whereas, the Federation of State Medical Boards policy since 1998 has called for three years of post-graduate training as a prerequisite for obtaining a medical license, and

Whereas, it is now the public’s expectation that physicians will have completed residency training in a chosen field before being licensed to practice; therefore be it

RESOLVED: That MSMS should endorse the concept of requiring a physician to have completed either an Accreditation Council for Graduate Medical or American Osteopathic Association approved residency program or at least three years of post-graduate training in a single field of medicine as a prerequisite for the granting of a new, unrestricted medical license to practice medicine in the state of Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
Relevant MSMS Policy:

**Automatic Eligibility for Licensure Limited to Graduates from Medical Schools which Meet LCME Standards**

Only graduates from medical schools which meet standards established by the Liaison Committee on Medical Education should be automatically eligible for licensure as medical doctors in Michigan.

Relevant AMA Policy:

**Funding to Support Training of the Health Care Workforce H-310.916**

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.

2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

**Sources:**

1. Susan H. Allen, DrPH, MBA; Robert L. Marier, MD, MHA; Cecilia Mouton, MD; Arti Shankar, PhD. Training Matters: A Retrospective Study of Physician Disciplinary Actions by the Louisiana State Board of Medical Examiners, 1990â€“2010. JOURNAL of MEDICAL REGULATION 2016; 102 (4): 7-1
Title: Change to Regulations of Botulinum Toxin Usage

Introduced by: Ali Moiin, MD, for the Michigan Dermatological Society

Original Author: Ali Moiin, MD

Referred To: Reference Committee B

House Action:

Whereas, current botulinum toxin regulations dictate that individual vials can only be used on a single patient, and

Whereas, multiple studies have found that this regulation is outdated and that the use of botulinum toxin more than 24 hours after reconstitution and in more than one patient per vial is appropriate and consistent with the safe and effective practice of medicine, and

Whereas, physicians using vials of botulism toxin on more than a single patient are currently subject to disciplinary action by the Michigan Board of Medicine; therefore be it

RESOLVED: That MSMS advocate for a change to current regulations to reflect the standard of care that allows for the use of botulinum toxin more than 24 hours if refrigerated after reconstitution with bacteriostatic saline and in more than one patient per vial.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy - None

Relevant AMA Policy - None

Sources:
2. Consensus Statement Regarding Storage and Reuse of Previously Reconstituted Neuromodulators, American Society for Dermatologic Surgery
ACTION REPORT #01-24 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 08-23
Credential, Supervision, and Outcomes Transparency

REFERRED TO: Reference Committee B

HOUSE ACTION:

RECOMMENDATION: THAT THE 2024 HOUSE OF DELEGATES DISAPPROVE RESOLUTION 08-23, “CREDENTIAL, SUPERVISION, AND OUTCOMES TRANSPARENCY.”

The MSMS Committee on State Legislation and Regulations reviewed Resolution 08-23 at its meeting on October 18, 2023. The Resolution author, Donald Tynes, MD, attended the committee meeting and spoke to his resolution. Committee members discussed redrafting the Resolution for clarity, but then arrived on simply disapproving the proposal, which would still provide the author with the opportunity to bring clarified language forward at a future House of Delegates. Doctor Tynes agreed to this plan and the Committee unanimously voted to recommend disapproval.

The Legislative Policy Committee reviewed the recommendation from the MSMS Committee on State Legislation and Regulations and recommends the following motion:

MOTION: THAT THE MSMS BOARD OF DIRECTORS RECOMMENDS TO THE 2024 HOUSE OF DELEGATES THAT IT DISAPPROVE RESOLUTION 08-23, “CREDENTIAL, SUPERVISION, AND OUTCOMES TRANSPARENCY.”

At its meeting on March 20, 2024, the MSMS Board of Directors approved the recommendation of the Legislative Committee to disapprove Resolution 08-23.

Attachment
Resolution 08-23
Title: Credential, Supervision, and Outcomes Transparency

Introduced by: Rev. Don H. Tynes, MD, for the Wayne County Delegation

Original Authors: Holly S. Gilmer, MD, Anita V. Moncrease, MD, MPH, and Rev. Don H. Tynes, MD

Referred To: Reference Committee B

House Action: **REferred to the MSMS Board of Directors for Study**

Whereas, the term “physician” refers specifically to a health care practitioner who has successfully matriculated and graduated from an allopathic or an osteopathic school of medicine, and

Whereas, the term health care practitioner refers to anyone who provides health care services, and

Whereas, some health care practitioners are misleading patients when they introduce themselves, implying they are physicians, and

Whereas, some health care practitioners are performing procedures and delivering treatments while allowing patients to believe they are physicians, and

Whereas, some non-physician health care practitioners are performing treatments and procedures unsupervised by physicians, and

Whereas, insurance companies are paying less for procedures and treatments that are delivered by non-physician health care practitioners, and

Whereas, patient care is potentially compromised by medical procedures and treatments delivered by unsupervised non-physician health care practitioners, and

Whereas, physicians are more likely to be sued for incorrect treatments and procedures performed by non-physician health care practitioners than the practitioners themselves, and

Whereas, health center and hospital Chief Executive Officers are directing their facilities to hire non-physician health care practitioners to deliver treatment and procedures instead of physicians because this practice saves their facilities money; therefore be it

RESOLVED: That MSMS believes all health care practitioners must clearly identify themselves as a physician or as a non-physician practitioner, including their credentials and field of specialty; and be it further

RESOLVED: That MSMS believes that a physician must directly supervise all non-physician practitioners. In cases where a non-physician practitioner is practicing unsupervised in a health
care facility, the health care facility must acknowledge in writing that the facility is directly responsible for patient care provided by the non-physician practitioners; and be it further

RESOLVED: That MSMS supports all insurance companies annually reporting outcomes for all health care practitioners against whom they have taken corrective action to the health care facilities where they have privileges and their respective licensing Boards. Additionally, health care practitioners shall self-report any corrective actions to the health care facilities where they have privileges and their respective licensing Boards; and be it further

RESOLVED: That MSMS supports all hospitals and health care facilities reporting any outcomes of health care practitioners that have led to a corrective action to the health practitioner’s respective licensing Boards.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy:

Clear Identification of Health Worker Position/Title with ID Tags
MSMS supports that physicians, nurses and other health providers wear a clearly visible photo identification badge that states their credentials in large block letters with descriptions such as “physician,” “nurse,” “physician assistant,” “nurse practitioner,” and that the badges be worn at all times when in contact with patients.

Non-Physician Practitioner Use Rules
MSMS supports daily physician supervision of all non-physician practitioners who provide care to hospitalized patients as documented by a signature.

Relevant AMA Policy:

Clarification of Healthcare Physician Identification: Consumer Truth & Transparency D-405.974
Our AMA will advocate for: (1) legislation that would establish clear legal definitions for use of words or terms “physician,” “surgeon,” “medical doctor,” “doctor of osteopathy,” “M.D.,” “D.O.,” or any other allopathic or osteopathic medical specialist; and (2) “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and board licensure in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. -ologist) that can mislead the public.

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.
**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.

**Scopes of Practice of Physician Extenders H-35.973**

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

**Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation Manual for Hospitals" H-220.990**

The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.

**Sources:**

# RESOLUTIONS BY COMMITTEE

## REFERENCE COMMITTEE C – INTERNAL AFFAIRS, BYLAWS, AND RULES

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<td>30-24</td>
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<td>Expand Medicaid For All Undocumented Persons</td>
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<th>BOARD ACTION REPORTS</th>
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<td>#2-24</td>
<td>Resolution 38-23 – “Free Digital CME for MSMS Members to Promote Membership Growth”</td>
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<td>#5-24</td>
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<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>42-23</td>
<td>Upper Peninsula Regional Director Constitution and Bylaws Amendment</td>
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</table>
Title: Medical Student Section Representation

Introduced by: Robert Levine, MD, for the Oakland County Delegation

Original Author: Robert Levine, MD

Referred To: Reference Committee C

House Action:

Whereas, Section 12.10 of the MSMS Bylaws currently states, “one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section,” and

Whereas, this has seemingly given the Medical Student Section an unfair representation compared to other specialty sections; therefore be it

RESOLVED: That Section 12.10 of the MSMS Bylaws be amended as follows:

12.10 COMPOSITION—The House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by a delegate from the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Bylaws:

12.10 COMPOSITION—The House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by a delegate from the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section. All other delegates and alternate delegates must be voting members of MSMS.

Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life, and active emeritus) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate.
Title: Restructure Student Dues Assessment

Introduced by: Steven Daveluy, MD, FAAD, for the Genesee, Ingham, Saginaw, Washtenaw, and Wayne County Delegations

Original Author: Steven Daveluy, MD, FAAD

Referred To: Reference Committee C

House Action:

Whereas, this resolution is introduced by the Genesee, Ingham, Saginaw, Washtenaw, and Wayne County Medical Societies, and

Whereas, the MSMS Bylaws state that one of its purposes is to encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians, and

Whereas, the MSMS Board of Directors now has the authority to set student dues pursuant to the MSMS Bylaws, and

Whereas, at their July 2023 meeting, the MSMS Board of Directors voted to increase student dues from $5 for four years to $300 for four years, and

Whereas, this makes Michigan dues rate for students one of the highest in the nation, as many states either charge no students dues or charge a very nominal amount, and

Whereas, at that same meeting, the MSMS Board of Directors voted to assess a $100 fee to existing student members in order to maintain their current membership, even if they are in their last year of medical school, and

Whereas, the county medical societies will be negatively impacted by loss of student memberships that this dues increase, and mandated administrative fee, will lead to, and

Whereas, the county medical societies and the House of Delegates have no input into student dues or student assessments; therefore be it

RESOLVED: That the MSMS Bylaws be amended as follows:

2.60 STUDENTS (MEDICAL STUDENT SECTION) - Medical students may become members of the State Medical Society through a component society or directly through the MSMS Medical Students Section. Except as provided in Section 12.10 of these Bylaws, they may not vote or hold office. They may be appointed to MSMS committees as student members. State Society dues shall be set proposed by the Board of Directors to cover administrative costs of membership except in the first year of membership and approved by the House of Delegates. Component dues for students shall be determined at the local level.
WAYS AND MEANS COMMITTEE FISCAL NOTE: See below.

Fiscal Note 1: Revenue Loss: Undetermined.
- The resolution asserts that the dues rate is too high but does not state what that rate should be. If the dues rate was reduced from $300 to $5, the annual revenue loss would range between $22,000 and $35,000. However, any reduction in the current $300 dues rate would result in further increasing the loss on student memberships (see below).

Fiscal Note 2: Reducing the dues rate for students would increase the loss realized on student memberships
- Student Resolutions Fiscal Note Costs: Estimated fiscal note costs for student resolutions have averaged between $120,000 and $241,000 over the past 5 years (see the HOD Handbook for a more detailed description of how fiscal notes are calculated).
- Student Resolutions: Students have submitted an average of 17 resolutions per year over the past 5 years making up 31% of all resolutions and 28% of all resolution fiscal note costs.
- Total Estimated Student Costs: Total estimated costs for the students are between $134,000 and $255,000 which include the cost of resolutions and another $14,000 for other administrative costs based on estimated staff time.
- # of Student Memberships Needed to Breakeven on Costs at Current $300 4 Year Rate: 1,797 – 3,409
- Student Memberships Over Past 5 Years When Dues Rate was $5 for 4 Year Membership: High (1,122); Low (482); Avg (854); Mean (918)

Fiscal Note 3: Board and House of Delegates Fiscal Responsibility
- Budget Challenges: The Board reduced expenses over the past year by 36% or almost $2 million. The pain of the expense reductions have been felt throughout the organization including reducing the staff by 26%. To position MSMS for a positive operating surplus in 2024, additional steps were needed and involved increasing revenue by not only expanding memberships, but also in adjusting pricing to sustainable levels. The old $5 for 4 year dues rate for students was not sustainable.
- Fiscal Responsibility: The Board and House of Delegates both have a fiduciary duty to operate the organization in fiscally responsible ways. Considering the low dues revenue and high administrative costs, it was clear to the Board that a significant increase in student dues is both fiscally responsible and necessary.

Relevant MSMS Policy – None

Relevant AMA Policy - None

Source:
1. National student and resident dues rate spreadsheet: https://docs.google.com/spreadsheets/d/1V38rod7mZNZRJ8bhA04LiBeeDjqwZZW2e_KxFdyfqY/edit?usp=sharing
**Student Costs - Other**: Includes Governing Council, meetings, membership, communications, questions. Based on staff estimate of their time spent.

**Student Costs - HOD Resolutions**: Includes time a resolution comes in to when it exits the HOD approved, disapproved or referred. Also includes the time it takes after approval/referred to accomplish the resolution. This is all built into the cost ranges of the resolutions by type. This analysis is based on the last few years resolutions submitted by the students. (see HOD Handbook for a more detailed description of how fiscal notes are calculated).

**Board and House of Delegates Fiscal Responsibility**

**Budget Challenges**: The Board reduced expenses over the past year by 36% or almost $2 million. The pain of the expense reductions have been felt throughout the organization including reducing the staff by 26%. To position MSMS for a positive operating surplus in 2024, additional steps were needed and involved increasing revenue by not only expanding memberships, but also in adjusting pricing to sustainable levels. The old $5 for 4 year dues rate for students was simply not sustainable.

**Fiscal Responsibility**: The Board and House of Delegates both have a fiduciary duty to operate the organization in fiscally responsible ways. Considering the low dues revenue and high administrative costs, it was clear to the Board that a significant increase in student dues is both fiscally responsible and necessary.

<table>
<thead>
<tr>
<th><strong>Student Costs - Other</strong></th>
<th>Total Staff Hours</th>
<th><strong>Low Cost Estimate</strong></th>
<th><strong>High Cost Estimate</strong></th>
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</thead>
<tbody>
<tr>
<td>Total - Other</td>
<td>108</td>
<td>13,895</td>
<td>13,895</td>
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<tr>
<th><strong>Student Costs - HOD Resolutions - Fiscal Note Costs</strong></th>
<th><strong>Low Estimate</strong></th>
<th><strong>High Estimate</strong></th>
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<tbody>
<tr>
<td>Year 2023</td>
<td>98,000</td>
<td>196,000</td>
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<tr>
<td>Year 2022</td>
<td>100,000</td>
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<td>Year 2021</td>
<td>23,000</td>
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<tr>
<td>Year 2020</td>
<td>201,000</td>
<td>402,000</td>
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<tr>
<td>Year 2019</td>
<td>182,500</td>
<td>365,000</td>
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Average Per Year - 5 Year Average

<table>
<thead>
<tr>
<th><strong>Total Estimated Costs for Students</strong></th>
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<tbody>
<tr>
<td>134,795</td>
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<tr>
<td>255,695</td>
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Total Student Memberships Needed to Breakeven on Annual Costs at Current $300 4 Year Rate

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<tr>
<td>1,797</td>
<td>3,409</td>
</tr>
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</table>

Student Memberships Over Past 5 Years When Dues Rate was $5 for 4 Year Membership: High (1,122), Low (482), Avg (854); Mean (918)
Whereas, since October 7, 2023, the ongoing bombardment of the Gaza Strip, home to over 2.3 million civilians with half being children, has led to the loss of civilian life surpassing that of any conflict in this region in the past 17 years, and

Whereas, attacks have resulted in the tragic deaths of over 25,000 civilians and 63,000 injuries, of which two-thirds are women and children, and

Whereas, The Geneva Conventions protect journalists, refugees, children, pregnant women and mothers with infants, civilians, patients, physicians, and other medical personnel during times of conflict, and

Whereas, over 1.93 million civilians have been displaced in Gaza, leading to severe overcrowding in refugee camps, which, coupled with loss of access to clean water and adequate medical care, has lead to a sharp increase in the prevalence of preventable and epidemic diarrheal, respiratory, and dermatologic diseases in a population facing synchronous severe food shortages, creating catastrophic health effects, and

Whereas, United Nations (UN) officials proclaim there is “no safe place in Gaza,” as shelters, refugee camps, hospitals, ambulances, homes, bakeries, mosques, toy stores, and UN-funded schools, clinics and shelters have faced airstrike, shootings, and have been flooded with poisonous white phosphorous gases, and

Whereas, 318 unprecedented attacks on healthcare facilities have tragically resulted in 615 deaths, including 250 healthcare workers, and 778 injuries, affecting 95 health facilities and 85 ambulances, and

Whereas, physicians and other medical personnel are forced to perform surgeries in corridors and waiting rooms, conserve supplies due to a lack of basic medical supplies, anesthetics or pain killers, and use vinegar instead of antibiotics on open wounds, and

Whereas, the destruction of homes and vital infrastructure, targeting of hospitals and refugee camps, and depletion of medical resources in the setting of a complete blockade have led to a critical humanitarian crisis and near complete collapse of the Gazan healthcare system, with only 22 percent of hospitals and 25 percent of health facilities in (partially) functional condition, and
Whereas, the head of the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) informed a UN emergency meeting on Monday October 30, 2023, that “an immediate humanitarian cease-fire has become a matter of life and death for millions,” and

Whereas, a humanitarian ceasefire is defined as a long-term suspension of fighting in the entire geographic area that is agreed upon by all involved parties, and would allow for the continuous flow of humanitarian aid, with safe passage for aid workers into and civilians out of Gaza, and

Whereas, a multitude of other international health care and humanitarian organizations recognize the dire situation in Gaza, issuing statements in support of a humanitarian cease-fire allowing for safe transit of aid, and the protection of Gaza’s civilian population and civilian infrastructure, and

Whereas, many organizations are diligently recruiting volunteers to aid the civilian population in Gaza; however, are unable to enter due to the increasingly unsafe conditions, and

Whereas, health care professionals and organizations are responsible for upholding medical neutrality and condemning violence against healthcare infrastructure, hospitals, first responders, patients, children, refugees, and the blockade of essential health supplies, water, food and fuel including in times of war and siege; and

Whereas, past AMA president Gerald E. Harmon, MD wrote, “targeting civilians and health care in war is unconscionable;” therefore be it

RESOLVED: That MSMS supports efforts to ensure the prompt delivery of humanitarian aid and medical supplies to civilians affected by the humanitarian crisis in Gaza; and be it further

RESOLVED: That MSMS advocates for the protection of hospitals, shelters, refugee camps, and other safety zones in Gaza; and be it further

RESOLVED: That MSMS supports a humanitarian cease-fire in Palestine and Israel in order to protect civilian lives and health care personnel.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy - None

Relevant AMA Policy - None

Sources:


Title: Expand AMA’s Position on Health Care Reform Options

Introduced by: Nicklas Bara for the Medical Student Section

Original Author: Eric Bui, Norah Fanning, Rohith Kesaraju, and Grace Tremonti

Referred To: Reference Committee C

House Action:

Whereas, American Medical Association (AMA) policy states that “health care is a basic human right” and that “the provision of health care services... is an ethical obligation of a civil society, and

Whereas, AMA Principles of Medical Ethics states that “physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means,” and

Whereas, AMA policy establishes “a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans,” and

Whereas, AMA policy supports streamlining the prior authorization process and reducing the overall volume of prior authorizations for physician practices, and

Whereas, AMA policy supports comprehensive reforms to reduce administrative inefficiencies, costs, and burdens, and

Whereas, AMA policy states that “Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians,” and

Whereas, evidence suggests that a single-payer health insurance system has the potential to address the above AMA policies via: elimination of uninsurance and underinsurance through universal coverage; improved health insurance affordability and elimination of surprise bills through no out-of-pocket payments; improved financing for physicians in rural areas through the removal of systemic biases; improved health equity through reduced disparities in health insurance coverage and health care access, with the greatest relief to lower-income households; improved prescription drug costs through drug price negotiations; reduced tort claims because medical expenses would no longer be a major concern; reduced prior authorization burden; reduced administrative expenses; expanded patient choice to choose any physician, and

Whereas, evidence suggests that a single-payer health insurance system has potential added benefits such as saving over 68,000 lives and 1.73 million life-years every year, saving the
health system billions annually, having positive effects on the economy, lowering the cost burden for lower-and middle-income households, and even leading to increased physician wages, and

Whereas, our AMA is limited in its ability to meaningfully contribute to the design and implementation of any potential single-payer proposals due to its blanket opposition to single-payer financing mechanisms, and

Whereas, other physician groups affiliated with the AMA such as the American College of Physicians, American Medical Women’s Association, Hawaii Medical Society, New Hampshire Medical Society, Vermont Medical Society, and Washington State Medical Association, endorse a single-payer financing approach as an option to achieve universal coverage, and

Whereas, evidence suggests that our AMA’s stance against single-payer does not currently represent the majority of physicians, with surveys by Merritt Hawkins (56 percent either strongly support or somewhat support a single-payer system), The Physicians Foundation (67 percent rate a two-tiered system featuring a single-payer option plus private pay insurance as the best or next-best direction for the U.S. health care system), and the Chicago Medical Society (66.8 percent have a “generally favorable” view of a single-payer financing health care system), demonstrating broad support for single-payer health insurance, and

Whereas, resolutions supporting Medicare for All have been passed in Detroit, MI (March 2019), Ann Arbor, MI (May 2020), Pittsfield Township, MI (June 2020), Kalamazoo County, MI (June 2020), Ypsilanti, MI (March 2021), And Kalamazoo, MI (July 2022) which combined are home to over 1 million Michigan residents, and

Whereas, MSMS supports access to comprehensive, affordable, high-quality health care, in support of universal health coverage; and

Whereas, MSMS supports affordable health insurance coverage for all Americans, and

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) to adopt a neutral stance on single payer health care reform and evaluate single payer proposals by the extent to which they align with the AMA’s policy on healthcare reform.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

National Health Care
MSMS supports free-choice methods of medical and health care, providing universal health coverage for all as an evidence-based policy informed by the latest in economic and healthcare policy research that continues to fairly fund all physician practices.

Universal Coverage
MSMS supports comprehensive health system reform described in the MSMS Future of Medicine Report. (See Addendum P in website version)
ACA Reform Principles
MSMS supports the AMA’s “core principles” for reform of the Affordable Care Act (ACA) as follows: “In considering opportunities to make coverage more affordable and accessible to all Americans, it is essential that gains in the number of Americans with health insurance coverage be maintained. Consistent with this core principle, we believe that before any action is taken through reconciliation or other means that would potentially alter coverage, policymakers should lay out for the American people, in reasonable detail, what will replace current policies. Patients and other stakeholders should be able to clearly compare current policy to new proposals so they can make informed decisions about whether it represents a step forward in the ongoing process of health reform.”

Automatic and Affordable Health Insurance Coverage for All
MSMS supports affordable health insurance coverage for Americans.

Relevant AMA Policy

National Healthcare Finance Reform: Single Payer Solution 165.020MSS
(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS.

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.

Opposition to Nationalized Health Care H-165.985
Our AMA reaffirms the following statement of principles as a positive articulation of the Association’s opposition to socialized or nationalized health care: (1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.

(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service.

(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.

(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.

(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.

(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

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.

**Health System Reform Legislation H-165.838**

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans; b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; d. Investments and incentives for quality improvement and prevention and wellness initiatives; e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; f. Implementation of medical liability reforms to reduce the cost of defensive medicine; g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
   c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
   d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
   e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
   f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA’s position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Sources:
Title: MSMS Medical Student Section Membership Dues

Introduced By: Nicklas Bara for the Medical Student Section

Original Authors: Vivienne Acuña, Nicklas Bara, Remonda Khalil-Moawad, and Susanna Wang

Referred To: Reference Committee C

House Action:

Whereas, the MSMS Constitution Section 2.6 states “Medical students may become members of the State Medical Society through a component society or directly through the MSMS Medical Students Section,” and

Whereas, the MSMS Constitution Section 12.6 states House of Delegates shall include “one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section,” and

Whereas, MSMS policy 45-22, “MSMS Committee on Membership Recruitment and Retention,” approves the re-establishment of the Member Committee to report and restructure dues for state society membership, and

Whereas, the current cost of MSMS membership for a new medical student member has been raised from $5 to $300 for 4 years as of 2023, a 5,900 percent increase, and

Whereas, the current cost of MSMS membership for a recurring medical student member has been raised from $5 to $100 as of 2023, a 2,566.67 percent to 7,900 percent increase depending on medical school graduation year, and

Whereas, medical students must increasingly rely on loans and scholarships to counter progressively rising tuition, cost of living, and other expenses, and

Whereas, the median education debt for indebted medical students as of 2019 was $200,000, with 73 percent of graduates reported having educational debt, and

Whereas, medical school debt interest rates currently outpace inflation, and

Whereas, MSMS policy 46-08A, “Michigan Medical Student Debt Crisis,” resolves that the MSMS pursue venues to actively decrease the medical student debt burden, and

Whereas, MSMS policy 46-08A “Michigan Medical Student Debt Crisis” references policy stating adequate financial aid systems should be readily available for financially needy medical students, and
Whereas, AMA policy H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt,” advocates for reduction of additional expense burden upon medical students regarding non-educational debt, and

Whereas, drastically increased dues costs have resulted in widespread aversion from future physicians towards the MSMS; therefore be it

RESOLVED: That MSMS reduce the financial burden on medical students while ensuring continued access to the benefits and resources by reducing the student membership dues to $30 for 4 years, with a $10 fee for pre-existing members (which is a 600 percent increase and 100 percent increase from the original due rate).

WAYS AND MEANS COMMITTEE FISCAL NOTE: See below.

Fiscal Note 1: Revenue Loss (reducing student dues from $300 to $30 for 4 year membership): $20,000 - $32,000 per year based on student memberships over past 2 years

Fiscal Note 2: Revenue Loss (reducing one-time fee for pre-existing members from $100 to $10): $43,000 based on prior year student memberships who need to pay to retain membership

Fiscal Note 3: Reducing the dues rate for students would increase the loss realized on student memberships
- Student Resolutions Fiscal Note Costs: Estimated fiscal note costs for student resolutions have averaged between $120,000 and $241,000 over the past 5 years (see the HOD Handbook for a more detailed description of how fiscal notes are calculated).
- Student Resolutions: Students have submitted an average of 17 resolutions per year over the past 5 years making up 31% of all resolutions and 28% of all resolution fiscal note costs.
- Total Estimated Student Costs: Total estimated costs for the students are between $134,000 and $255,000 which include the cost of resolutions and another $14,000 for other administrative costs based on estimated staff time.
- # of Student Memberships Needed to Breakeven on Costs at Current $300 4 Year Rate: 1,797–3,409
- Student Memberships Over Past 5 Years When Dues Rate was $5 for 4 Year Membership: High (1,122); Low (482); Avg (854); Mean (918)

Fiscal Note 4: Board and House of Delegates Fiscal Responsibility
- Budget Challenges: The Board reduced expenses over the past year by 36% or almost $2 million. The pain of the expense reductions have been felt throughout the organization including reducing the staff by 26%. To position MSMS for a positive operating surplus in 2024, additional steps were needed and involved increasing revenue by not only expanding memberships, but also in adjusting pricing to sustainable levels. The old $5 for 4 year dues rate for students was not sustainable.
- Fiscal Responsibility: The Board and House of Delegates both have a fiduciary duty to operate the organization in fiscally responsible ways. Considering the low dues revenue and high administrative costs, it was clear to the Board that a significant increase in student dues is both fiscally responsible and necessary.

Relevant MSMS Policy - None
Relevant AMA Policy - None

Sources:
MSMS
Students Membership Cost Analysis

**Student Costs - Other**: Includes Governing Council, meetings, membership, communications, questions. Based on staff estimate of their time spent.

**Student Costs - HOD Resolutions**: Includes time a resolution comes in to when it exits the HOD approved, disapproved or referred. Also includes the time it takes after approval/referred to accomplish the resolution. This is all built into the cost ranges of the resolutions by type. This analysis is based on the last few years resolutions submitted by the students. (see HOD Handbook for a more detailed description of how fiscal notes are calculated).

**Board and House of Delegates Fiscal Responsibility**

**Budget Challenges**: The Board reduced expenses over the past year by 36% or almost $2 million. The pain of the expense reductions have been felt throughout the organization including reducing the staff by 26%. To position MSMS for a positive operating surplus in 2024, additional steps were needed and involved increasing revenue by not only expanding memberships, but also in adjusting pricing to sustainable levels. The old $5 for 4 year dues rate for students was simply not sustainable.

**Fiscal Responsibility**: The Board and House of Delegates both have a fiduciary duty to operate the organization in fiscally responsible ways. Considering the low dues revenue and high administrative costs, it was clear to the Board that a significant increase in student dues is both fiscally responsible and necessary.

### Student Costs - Other

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Staff Hours</th>
<th>Low Cost Estimate</th>
<th>High Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total - Other Governing Council, meetings, membership, communications, questions</td>
<td>108</td>
<td>13,895</td>
<td>13,895</td>
</tr>
</tbody>
</table>

### Student Costs - HOD Resolutions - Fiscal Note Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2023 Fiscal note estimated costs for all student resolutions</td>
<td>98,000</td>
<td>196,000</td>
</tr>
<tr>
<td>Year 2022 Fiscal note estimated costs for all student resolutions</td>
<td>100,000</td>
<td>200,000</td>
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<tr>
<td>Year 2021 Fiscal note estimated costs for all student resolutions</td>
<td>23,000</td>
<td>46,000</td>
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<tr>
<td>Year 2020 Fiscal note estimated costs for all student resolutions</td>
<td>201,000</td>
<td>402,000</td>
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<tr>
<td>Year 2019 Fiscal note estimated costs for all student resolutions</td>
<td>182,500</td>
<td>365,000</td>
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</table>

**Average Per Year - 5 Year Average**

<table>
<thead>
<tr>
<th>Description</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Per Year - 5 Year Average</td>
<td>120,900</td>
<td>241,800</td>
</tr>
</tbody>
</table>

**Total Estimated Costs for Students**

<table>
<thead>
<tr>
<th>Description</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Estimated Costs for Students</td>
<td>134,795</td>
<td>255,695</td>
</tr>
</tbody>
</table>

**Total Student Memberships Needed to Breakeven on Annual Costs at Current $300 4 Year Rate**

<table>
<thead>
<tr>
<th>Description</th>
<th>Low Estimate</th>
<th>High Estimate</th>
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<tbody>
<tr>
<td>Total Student Memberships Needed to Breakeven on Annual Costs at Current $300 4 Year Rate</td>
<td>1,797</td>
<td>3,409</td>
</tr>
</tbody>
</table>

**Student Memberships Over Past 5 Years When Dues Rate was $5 for 4 Year Membership**: High (1,122), Low (482), Avg (854); Mean (918)
Title: Expand Medicaid For All Undocumented Persons

Introduced By: Nicklas Bara for the Medical Student Section

Original Author: Manasi Desai

Referred To: Reference Committee C

House Action:

Whereas, the United States is currently facing record levels of migration upwards of 300,000 a month (as of December 2023) at the Southern border, spurred by political instability and environmental collapse in multiple regions of the world, and

Whereas, Michigan is home to 91,000 undocumented people, 73 percent of whom have resided in Michigan for five years or longer, and

Whereas, being undocumented results in lack of access to healthcare, with 37 percent of Michigan’s undocumented lacking health insurance, compared to only 7.8 percent of Michigan’s total population, and

Whereas, undocumented individuals largely seek care from emergency departments and wait to receive care until their health has deteriorated significantly resulting in higher expenses and serves as a greater threat to life, with 38 percent of them reporting no other source of care other than the emergency department, and

Whereas, lack of access to preventative services leads to higher overall health costs, with state coverage existing only for emergency department hemodialysis services resulting in higher overall costs on hospital systems and higher mortality rates for undocumented individuals when compared to standard outpatient hemodialysis services, and

Whereas, data from Medicaid/Medicare shows that undocumented immigrant coverage costs the American healthcare system approximately $974 million, which is only 0.2 percent of annual federally funded health care costs, and

Whereas, the challenges that undocumented individuals face while searching for reliable and high-quality health care poses as a social determinant of health and is perpetuating “explicit and invisible” violence against undocumented individuals, and

Whereas, discrimination from providers and required documentation processes can lead to internalized oppression, negatively affecting quality of life and overall well-being, despite having access to health care under the Affordable Care Act (ACA), and

Whereas, undocumented individuals are currently eligible to purchase health insurance in the marketplace under the ACA, but this option proves inadequate to cover the health needs of the undocumented population, and
Whereas, California, Colorado, Illinois, New York, Oregon, and Washington DC have all expanded Medicaid to cover some or all parts of their eligible undocumented populations, with California’s program offering the most robust coverage by expansion of state level Medicaid (Medi-Cal) to all eligible Californians, regardless of immigration status, and

Whereas, previous expansions of health care coverage have been associated with reduced death rates, greater financial security, and improved worker productivity, and

Whereas, in states with expansion of Medicaid pregnancy coverage to include undocumented peoples, access to healthcare was associated with improved health outcomes of increased average birth weight and gestation length, and

Whereas, Michigan already has a history of expanding coverage to undocumented people through their expansion of Children’s Health Insurance Program (CHIP) coverage to all pregnant people regardless of immigration status, and

Whereas, the American Medical Association (AMA) has a history of supporting insurance coverage to support the health care of undocumented people, as evidenced by its numerous reaffirmed policies; and

Whereas, the AMA collaborated with stakeholders to advocate for life-saving medical care coverage for undocumented immigrants including, “at the state and federal level, for extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy, expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants and financially cover outpatient dialysis for undocumented immigrants with end stage kidney disease under Emergency Medicaid,” and

Whereas, the AMA committed to actively “lobby Congress to adequately and appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented” immigrants, while also committing to states to address the “lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level,” and

Whereas, the AMA specifically advocated to extend “eligibility to purchase ACA marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients,” guaranteeing that immigration status data will not be collected or reported, and

Whereas, the AMA “recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status;” therefore be it

RESOLVED: That MSMS advocate for continuation of the AMA’s legacy in recognizing health care as a fundamental human right for undocumented individuals in America; and be it further

RESOLVED: That MSMS acknowledge the long-term fiscal benefits and improved health outcomes associated with providing health care access to undocumented immigrants, as demonstrated by the success of Medi-Cal in California; and be it further
RESOLVED: That MSMS advocates for health insurance coverage through Medicaid expansion for all undocumented people residing in the state of Michigan, with guarantee that immigration status will not be collected or reported.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy

**Medicaid Dialysis Policy for Undocumented Patients**
MSMS encourages the state of Michigan to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid.

**Medicaid Expansion**
MSMS supports the expansion of Medicaid under the Affordable Care Act.

Relevant AMA Policy

**D-440.985 Health Care Payment for Undocumented Persons**
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

**H-130.967 Action Regarding Illegal Aliens**
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available.

**H-160.956 Federal Funding for Safety Net Care for Undocumented Aliens**
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.

**Medicaid Dialysis Policy for Undocumented Patients H-290.957**
Our AMA will work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid. [Res. 121, A-21] D-290.974

**Extending Medicaid Coverage for One Year Postpartum D-290.974**
Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children’s Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants.

Sources:


4. Overuse of Hospital EDs for Primary Care High Cost of Primary Care in Hospital EDs.; 2019. https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf


Title: Single Payer Health Care System

Introduced by: Nicklas Bara for the Medical Student Section

Original Author: Brandon Leung

Referred to: Reference Committee C

Whereas, access to affordable health care is a fundamental human right, and

Whereas, the current fragmented health care system in the United States has resulted in disparities in health care access and outcomes, disproportionately affecting marginalized and vulnerable populations, and

Whereas, administrative costs associated with the current multi-payer health care system in the United States are excessive, diverting resources away from patient care, and contributing to poorer patient outcomes, and

Whereas, a single payer health care system has been proven to reduce overall health care spending while improving health outcomes and patient satisfaction in countries around the world, and

Whereas, a single payer health care system would promote preventive care, early intervention, and disease management, leading to healthier populations and reduced long-term health care costs, and

Whereas, health care should be based on medical need rather than the ability to pay, and a single payer system would ensure that all individuals receive necessary medical treatment regardless of their financial status; therefore be it

RESOLVED: That MSMS support federal efforts to implement a single payer health care system, and be it further;

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA support federal efforts to implement a single payer health care system.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy

Universal Coverage
MSMS supports comprehensive health system reform described in the MSMS Future of Medicine
ACA Reform Principles
MSMS supports the AMA’s “core principles” for reform of the Affordable Care Act (ACA) as follows: “In considering opportunities to make coverage more affordable and accessible to all Americans, it is essential that gains in the number of Americans with health insurance coverage be maintained. Consistent with this core principle, we believe that before any action is taken through reconciliation or other means that would potentially alter coverage, policymakers should lay out for the American people, in reasonable detail, what will replace current policies. Patients and other stakeholders should be able to clearly compare current policy to new proposals so they can make informed decisions about whether it represents a step forward in the ongoing process of health reform.”

Automatic and Affordable Health Insurance Coverage for All
MSMS supports affordable health insurance coverage for Americans.

Relevant AMA Policy

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans; b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine; g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services; b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system; c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted; d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate; e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA’s position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Sources:
Whereas, MSMS seems to no longer be able to identify its primary goals, and this has resulted in it losing its way, and

Whereas, in contrast, the Oakland County Medical Society (OCMS) in their logo implies that “Empowering physicians and Advancing medicine” is their primary goal; therefore be it

RESOLVED: That MSMS clearly state that its goals are to enhance physician’s well-being both personally and professionally, to improve the physician’s ability to provide health care, to counter threats that interfere with a physician’s ability to provide patient care, and to help advance medicine and medical care; and be it further

RESOLVED: That prior to each MSMS House of Delegates meeting, the MSMS Board of Directors or an appropriate committee thereof review and rate all upcoming resolutions on a 1-5 scale where 5 is fully congruent with the goals of MSMS and 1 is unrelated to the goals of MSMS.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy

MSMS Mission Statement:
The mission of the Michigan State Medical Society is to improve the lives of physicians so they may best care for the people they serve.

Core Values:
- Advocate on behalf of physicians and their patients
- Provide leadership
- Promote quality health care
- Demonstrate ethical behavior

Relevant AMA Policy - None
ACTION REPORT #02-24 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 38-23
Free Digital CME for MSMS Members to Promote Membership Growth

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: THAT THE 2024 MSMS HOUSE OF DELEGATES APPROVE RESOLUTION 38-23, "FREE DIGITAL CME FOR MSMS MEMBERS TO PROMOTE MEMBERSHIP GROWTH," AS AMENDED TO READ:

RESOLVED: That the MSMS Board of Directors offer as many free online CME for state mandated content (pain, ethics, implicit bias, human trafficking, and any future requirement) as the budget allows to promote retention and recruitment of membership; and be it further

RESOLVED: That MSMS find a respectful and appropriate way to honor Venkat Rao, MD, for his tireless advocacy of MSMS through naming a conference, lecture series, or program in his honor.

Resolution 38-23 was introduced by Venkat Rao, MD. It asked that the MSMS Board of Directors study the possibility of offering free online CME for state mandated content (pain, ethics, implicit bias, human trafficking, and any future requirement) to promote retention and recruitment of membership for the purposes of growing membership revenue.

As the Board is aware, MSMS is not in a financial position to offer all required credit as a member benefit. This is a reasonable and long-term goal of the association. However, with the current but improving financial situation of MSMS, some classes are being offered to members for free. The MSMS Foundation is currently offering the Human Trafficking requirement at no cost for members. In addition, another 2.25 hours is available for free on opioids. These classes meet the pain and opioid requirements for the one-time state-controlled substance requirement, the 3-hour every 3-year state medical license requirement and for the one-time federal DEA MATE act requirement. MSMS also provides the monthly Grand Rounds and Practice Management series for no cost. This provides members with 24 hours of free CME per year.
For all of these complex and important reasons, the MSMS Board of Directors recommends amending Resolution 38-23, “Free Digital CME for MSMS Members to Promote Membership Growth” to offer some CME for no cost as the budget allows and to recognize Doctor Rao for his dedication and commitment to MSMS through a future educational activity.

Attachment
Resolution 38-23
RESOLUTION 38-23

Title: Free Digital CME for MSMS Members to Promote Membership Growth

Introduced by: Venkat Rao, MD

Original Author: Venkat Rao, MD

Referred To: Reference Committee C

House Action: APPROVED AS AMENDED

Whereas, MSMS awards continuing medical education (CME) through in-person and online, on-demand programming, and

Whereas, many organizations in Michigan and nationally (i.e., the American Medical Association, specialty organizations, and state specialty societies) provide CME to their members free of charge, and

Whereas, some CME is required for state of Michigan licensure, and

Whereas, this CME programming can be hard to find from other sources, and

Whereas there was an increase in new membership when free CME was provided by some county medical societies,

Whereas, providing CME credits free of charge or at a significant discount is a valuable membership benefit, and

Whereas loss of any revenue could be offset by retention of current members and recruitment of new members; therefore be it

RESOLVED: That the MSMS Board of Directors study the possibility of offering free online CME for state mandated content (pain, ethics, implicit bias, human trafficking, and any future requirement) to MSMS members to promote retention and recruitment of membership for the purposes of growing membership revenue.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy:

Mission Statement of MSMS CME Program
Purpose: The purpose of the Michigan State Medical Society (MSMS) Continuing Medical Education (CME) Program is to help Michigan physicians meet their continuing medical education needs through the sponsorship of quality Category I CME activities.
Content Areas: The Committee will address educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to
provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public. All continuing educational activities which assist physicians in carrying out their professional responsibilities more effectively and efficiently are CME.

Target Audience: The CME activities will address the needs of Michigan Physicians.

Types of Activities Provided: The MSMS Committee on CME Programming serves the CME needs of MSMS and of noncommercial, health related organizations that are not accredited to offer Category I credit. Jointly sponsored programs must comply with the MSMS CME Programming Committee’s policies and meet its programming criteria in order to receive approval for Category I credit. The Committee on CME Programming shall assure proper needs assessment, development, conduct and supervision of MSMS sponsored CME activities.

Expected Results of Program: The Committee expects that the programs will contribute to cost effective care for the well-being of patients and the public; stimulate clinical competency; and provide quality Category I CME activities that give practicing physicians educational opportunities which contribute significantly to the continuum of professional learning.

**Opposition to Compulsory Content of Mandated Continuing Medical Education**

MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan.

**Relevant AMA Policy:**

**Reduced Continuing Medical Education (CME) Fees for Retired Physicians D-300.994**

Our AMA supports reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians.
ACTION REPORT #05-24 OF THE BOARD OF DIRECTORS

SUBJECT: Revisions to the MSMS Policy Manual and the 2024 Sunset Report

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the 2024 MSMS House of Delegates approve the attached additions to the MSMS Policy Manual and the 2024 Sunset Report. Upon House approval, the updates will be placed in the Policy Manual on the MSMS website.

The MSMS Policy Manual Review Committee met virtually on February 21, 2024, to review existing policy slated for review pursuant to the MSMS sunset policy; reviewed the 2023 House of Delegates Resolutions and Board Action Reports, as well as the MSMS Board Actions from January through October 2023. Following its review, the Committee voted to recommend that the MSMS Board of Directors recommend approval of the updates to the MSMS Policy and 2024 Sunset Report.

At its meeting on March 20, 2024, the MSMS Board of Directors approved the updates to the MSMS Policy Manual and the 2024 Sunset Report and that upon House approval, the updates will be placed in the Policy Manual on the MSMS website.

Attachments
  MSMS Policy Manual Updates
  2024 Sunset Report
COMMUNICATIONS

Adopting Standard Language for Discussions Regarding Scope of Practice
MSMS shall use the terms “unsupervised practice of medicine” in place of “independent practice of medicine” when referring to the activities of nurse practitioners, certified registered nurse anesthetists, and physician assistants; “non physician practitioner” (NPP) to describe physician assistants, nurse practitioners, and clinical nurse specialists; and “residency,” “resident,” “fellowship,” and “fellow” in discussions regarding physicians only. (Res21-23)

CONTINUING MEDICAL EDUCATION

Continuing Medical Education for Controlled Substance Prescribing
MSMS supports the alignment of state and federal training requirements related to the prescribing of controlled substances to ensure training received counts for both sets of requirements. MSMS also supports education to encourage physicians and other health care providers to co-prescribe naloxone when prescribing opiates. (Res51-16)
- Amended (Res22-23)

END OF LIFE CARE

Importance of Palliative Care
MSMS encourages the usage of palliative care and will work to identify and mitigate barriers to the provision of palliative care. (Res11-23)

ETHICS

Practice of Medicine and Workplace

Physician’s Rights in Treatment Decisions
Neither physicians, hospitals nor hospital personnel shall be required to perform any act that violates good medical judgment or is contrary to moral principles of the individual. In such circumstances, the physician or other professional may withdraw from the case as long as the withdrawal is consistent with good medical practice. (Prior to 1990)
- Reaffirmed (Sunset Report 2021)
- Reaffirmed (37-23)
- Reaffirmed (39-23)
GOVERNMENT PROGRAMS AND REGULATORY OVERSIGHT

Protect Patients with Medical Debt Burden
MSMS believes in the adoption of state and federal policies that prevent medical debt, help individuals avoid court involvement, and ensure that court involved cases do not result in devastating consequences on individuals' employment, physical health, mental wellbeing, housing, and economic stability. Such policies include garnishment protections to protect assets needed to pay down medical debt (i.e., wages or property) and capping the maximum interest rate on medical debt at 5 percent. (Res04-23)

National Health Care
MSMS supports free-choice methods of medical and health care, providing universal health coverage for all as an evidence-based policy informed by the latest in economic and healthcare policy research that continues to fairly fund all physician practices. (Prior to 1990) - Edited 1998 - Reaffirmed (Sunset Report 2021) - Amended (Res10-23)

HEALTH CARE DELIVERY

Access
Access to Emergency Contraception
MSMS: (1) supports efforts to increase access to emergency contraception in various medical settings including ambulatory offices, pharmacies, emergency departments, and hospital; and, (2) encourages physicians to provide patients with evidence-based information about emergency contraception as part of the counseling and informed consent process provided to any patient requesting emergency contraception. (Res29-23)

Access to Gender-Affirming Care
MSMS: (1) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender, and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth; (2) supports access to and health insurance coverage of gender-affirming care including the spectrum of behavioral, psychological, medical, and surgical interventions for the treatment of gender dysphoria or gender incongruence; (3) opposes criminalization and legislative interference in the provision of gender-affirming care as outlined by generally-accepted standards of medical and surgical practice; (4) supports education on gender diversity and gender-affirming care at all levels of medical education, including medical school, residency, and continuing professional development; and (5) affirms that physicians should assist in transferring and referring transgender patients to the appropriate health care when they are unable to provide the gender-affirming services the patient needs. (Res35-23)

Hormonal Contraceptives Available Over-the-Counter
MSMS supports the American College of Obstetricians and Gynecologists' Committee Opinion 788 which supports access to over-the-counter contraception including oral pills, vaginal rings, contraceptive patches, and depot medroxyprogesterone acetate. (Res31-23)
**Over-The-Counter Contraception as a Qualified Medical Expense**

MSMS supports inclusion of over-the-counter contraception as a qualified medical expense under tax-advantaged accounts including but not limited to health savings accounts and flexible spending accounts. (Res31-23)

**Protecting Access to Gender-Affirming Care**

MSMS supports patient access to gender affirming care and opposes efforts to ban or restrict patient access to such care. MSMS also opposes punishing, imprisoning, or fining health care providers for providing gender-affirming care as recommended by established medical guidelines. (Res02-23)

**Universal Coverage**

MSMS supports comprehensive health system reform described in the MSMS Future of Medicine Report. (Res81-06A)

*(See Addendum P in website version)*

- Reaffirmed (Sunset Report 2021)
- Reaffirmed (Res10-23)

**Economics**

**Unnecessary Charges for Ophthalmic Medications**

MSMS encourages Health Institution Pharmacies (HIP) to review their current practices and modify their inpatient recommendations for eye medication dispensed in multi-use containers to be consistent with HIP outpatient practices for ophthalmic medication. MSMS supports the ability of patients who receive therapeutic ophthalmic medicine, to be used after discharge or operation, to take this medication (along with prescriptive instructions) with them when discharged from the hospital. (Res26-23)

**Emergency Care**

**Dedicated On-Site Physician Requirement for Emergency Departments**

MSMS believes that all facilities in the state of Michigan that imply the provision of emergency medical care should have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., APRNs, PAs, and CRNAs, as defined by CMS) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Res20-23)

**Guidelines**

**Moving Beyond the BMI**

MSMS recognizes that the BMI is a limited metric and acknowledges that weight bias is a pervasive problem in medicine which actively harms patients. (Res14-23)

**General Care Delivery**

**Availability of Unused Medication Following Surgery**

MSMS believes that any unused portion of a facility-provided drug that is dispensed for an ophthalmic surgical procedure performed in a hospital or freestanding surgical
outpatient facility should be offered to the patient at discharge if all of the following apply:
1. The hospital or freestanding surgical outpatient facility orders the facility-provided drug not less than 24 hours in advance before the surgical procedure.
2. The facility-provided drug is administered to the patient at the hospital or freestanding surgical outpatient facility.
3. The unused portion of the facility-provided drug is required for the patient’s continued treatment. (Board-July2023)

**Physician-Patient Relationship and Health Care Decisions**
MSMS believes: 1) the physician-patient relationship is deeply personal and must be respected and protected at all costs; 2) physicians and their patients should be free to consider, discuss, and pursue medical procedures guided by a physician's best medical judgment and a patient's physical health and safety; and 3) as a Society, MSMS has always been and continues to be opposed to the potential criminalization of physicians and their patients in making health care decisions. (Board Action Report #1, 2023 HOD, re: Res33-22)

**Translated Procedural Consent Forms**
MSMS encourages its members to use translated procedural consent forms in their practice. (Res06-23)

**Medical Necessity**

**Determination of Medical Necessity of Medical Case Management**
The treating physician shall be the sole determinant of medical case management and medical necessity. MSMS believes that an insurer, a health care corporation or a government agency may not interfere with the patient/physician relationship by determining medical necessity or medical case management without a fair and reasonable appeals process and independent binding arbitration in a timely fashion. (Board Action Report #14, 1994 HOD, re Res121-93A)
– Reaffirmed (Sunset Report 2021)
  - Reaffirmed (37-23)

**HEALTH CARE INSURANCE**

**Annual Deductible Payment Options**
MSMS affirms the need for viable payment options for the purchase of health care insurance, as well as for affording annual deductible amounts and shall work with the Michigan Department of Insurance and Financial Services and third-party payers to explore options that will benefit the people of the state of Michigan. (Res25-23)

**Enacting Change for Social Determinants of Health**
MSMS supports adequate reimbursement to screen for, and intervene on, identified social determinants of health. (Res30-23)
**Equitable Interpreter Services and Fair Reimbursement**
MSMS supports efforts to ensure payers, including Medicaid programs and Medicaid managed care plans, relieve the financial burden of medical interpretive services from physicians by covering and directly paying for such services. (15-23)

**Evidence-based Treatment for Obesity as a Covered Benefit**
MSMS supports evidence-based, medically necessary treatments for obesity as a benefit covered by health insurance plans without undue prerequisites on the part of the patient. (Res36-23)

**Out-of-Pocket Insulin Cap**
MSMS supports an out-of-pocket cap for insulin not to exceed $35.00. (Board-July2023)

**HEALTH CLINICIANS OTHER THAN PHYSICIANS**

**Standards for Collaborative Agreements**
MSMS affirms the urgency of defining standards for “collaborative agreements” with advanced practice registered nurses (APRN)s and that MSMS seek and support legislation that would require APRNs to work in a setting and perform tasks and procedures that are within the collaborating physician’s particular field of medicine, as qualified by residency training and/or board certification to perform.

MSMS believes physicians who enter into collaborative or practice agreements with APRNs or physician assistants (PAs) from a location outside of Michigan must be available to answer questions and directly collaborate with the non-physician practitioners (NPPs), or to examine the patient, during a majority of the hours of activity of the APRN and/or PA via video conferencing. (Res19-23)

**HEALTH INFORMATION TECHNOLOGY**

**Access to Telemedicine Health Care Delivery System**
MSMS adopts AMA policy, Coverage of and Payment for Telemedicine H 480.946, to ensure patients’ access to care and improved health outcomes. (Res33-23)

**HOSPITAL BOARDS**

**Transparency Requirement For Hospital Requested Exemption Filing from ACA Categorical Discrimination**
MSMS believes all health care facilities should make their filings for religious or other exemptions accessible to the public without requiring individuals to file a Freedom of Information Act request to access such data. (Res07-23)

**LICENSEURE**

**Safe Collaborative Medical Practice**
MSMS supports the appropriate licensing Boards and agency investigating and censuring physicians who deliberately violate the spirit of safe collaborative medical practice with NPPs by (1) engaging in a pattern of negligent delegation to, supervision of, or
collaboration with NPPs; (2) supervising activities for which the physician is not formally trained and/or board certified; (3) not being promptly available to communicate with the NPP and/or patient; and, (4) disregarding collaborative practice agreement requirements by aiding and abetting the unlicensed practice of medicine. (Res19-23)

MATERNAL AND INFANT HEALTH

Michigan Maternal Health, Safety, and Quality Care Initiatives
MSMS shall participate with other stakeholders involved in the care of pregnant women to advance statewide initiatives to improve maternal health outcomes including, but not limited to, Maternal Levels of care at birthing centers. (Res24-14)
- Reaffirmed (Res06-21)
- Reaffirmed (Res32-23)

Newborn Screening for Urea Cycle Disorder
MSMS supports newborn screenings including the screening of urea cycle disorders specifically OTC and CPS1 deficiency through blood nitrogen level or other similar tests. (Res03-23)

Reimbursement for Postpartum Depression Prevention
MSMS shall advocate for the following:
1. State Medicaid programs to reimburse applicable CPT codes that can be used for postpartum depression prevention by a broad range of health workers, with services currently covered under the Affordable Care Act.
2. An initiative to allow all qualified health care professionals to bill under a “pregnancy” diagnosis code, so that they can deliver perinatal and postnatal mental health preventive interventions.
3. State Medicaid programs to provide avenues for nurses, doulas, community health workers, and health educators trained in these programs as part of physician led health care teams to deliver these primary prevention interventions and be reimbursed.
4. States, payers, and health systems to make evidence-based postpartum depression prevention services the official standard of care and increase bundle payments accordingly statewide.

MSMS believes evidence-based postpartum depression prevention services should be the official standard of care for all federally-funded health care programs for pregnant women federally. (Res12-23)

MEDICAID

Suspend Waiting Period
MSMS supports suspending the 5-year waiting period for children who are immigrants and people who are pregnant who are otherwise eligible to enroll in Medicaid or the MI Child program. (Board-July2023)
MEDICAL EDUCATION AND TRAINING

Climate Change Education
MSMS supports efforts to educate physicians and other health care workers about climate change including its health consequences; air pollution and its health consequences; approaches to mitigating climate changes, air pollution, and their health consequences; and approaches to resilience from the effects of climate change and air pollution. (Res46-23)

Medical Education for Medication Reconciliation
MSMS supports education for relevant health care providers to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care. (Res51-23)

Oppose Discriminatory ERAS® Filters In NRMP Match
MSMS recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates, and opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system. (Res52-23)

Paternal and Maternal Leave for Medical Students, Residents, and Physicians
MSMS encourages the development of policies to allow up to 12-weeks paternal and maternal leave for medical students, residents, and attending physicians in accordance with recommendations from the American Academy of Pediatrics, while ensuring that individuals understand the consequences such leave may impact graduation date and board eligibility. (Res01-23)

Pain Management, Palliative Care, and Hospice Education
MSMS recommends and promotes effective education in pain management, opioid tapering, referral best practices, palliative care, and/or hospice care for physicians and medical students. (Res69-93A)
- Edited 2017
- Amended (Res11-23)

The Designation of Descendants of Enslaved Africans in America
MSMS supports:
1. Defining and adding the term “Descendants of Enslaved Africans in America” to the glossary of the Association of American Medical Colleges and medical school applications.
2. Working with organized medicine and medical schools to accurately separate Descendants of Enslaved Africans in America from the generic terms African American and Black. (Res17-23)
MEMBERSHIP

Dissemination of Information to the County Medical Societies
MSMS affirms the provision of regular and monthly membership database updates to all county medical society chapters electronically. (Board Action Report #4, 2023 HOD, re: Res04-21)

PEER REVIEW

Accountability of Utilization Review Firms
Utilization review firms employed by insurance companies should be held accountable for medical decisions based on their review. (Res14-92A)
– Reaffirmed (Sunset Report 2022)
- Reaffirmed (39-23)

PHYSICIAN BUSINESS AND LEGAL RELATIONS

Physician Antiretaliation, Due Process, and Indemnification Rights
MSMS shall: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care; (3) advocate for the rights of physicians against employer retaliation, including unfair or discriminatory termination of employment or contractual obligation for conscious objection and/or conscious refusal to participate in any activity that the physician judges to be unethical or unsafe for patients; (4) advocate for the physician’s authority to practice medicine based on medical judgment, conscience, ethics, morals, or good faith obligation toward patients to a non-physician or corporate entity; (5) advocate for the following: (a) that physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (b) that physician supervision should be explicitly defined and mutually agreed upon; (c) that advanced notice and disclosure be provided to physicians 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; (d) 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; (e) that physicians have the right to object to or refuse to allow their license to be used to document supervision of non-physician practitioners without fear of retaliation; (f) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation; and (g) that physicians be indemnified at the organizations’ and institutions’ expense from malpractice claims and other litigation arising out of the supervision function. (16-23)
PUBLIC HEALTH

Environmental Health Issues

Decarbonization of Health Care Facilities
MSMS supports the reduction of the greenhouse gas profile of health care facilities and the involvement of physicians in this effort including the following:

A. Reduction in the release of CO2 and methane related to building electricity, building heating and cooling, water heating, vehicle use, components of buildings, and other sources.
B. MSMS supports the exploration of limiting and/or removing deslurane and nitrous in operating rooms within hospitals, private facilities and offices providing anesthesia to patients for surgeries and for procedures.
C. Reduction in greenhouse gas release related to products used in health care, employee and patient travel, and other sources.
D. Electrification of appliances to enable future powering by electricity from sustainable sources, replacing use of fossil fuels.
E. Signing of the HHS pledge form by health care systems in Michigan.
F. Development and participation in climate resilience plans by health care systems. (Res45-23)

General

Well Trained County Health Officers and Leadership
County public health departments should be staffed with highly qualified individuals who have been hired by utilizing processes outlined by the Michigan Department of Health and Human Services and formal hiring procedures and protocols to ensure the selection of qualified candidates for permanent positions. (Res18-23)

QUALITY ASSURANCE AND PATIENT SAFETY

Medication Reconciliation Processes
MSMS encourages the study of current medication-reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training to reduce medical errors and ensure patient safety and quality of care. (Res51-23)

SAFETY AND ACCIDENT PREVENTION

Firearm Safety

Guiding Principles for Reforms to Reduce Violence and Improve Firearm Safety
The principles listed in Addendum T, in addition to existing MSMS policy, shall assist MSMS in evaluating legislative and regulatory proposals related to firearms, as well as opportunities to engage with other organizations on this issue. (Board-March2023)
SUBSTANCE USE AND ADDICTION

Address Disproportionate Sentencing for Drug Offenses
MSMS supports federal and state efforts to eliminate the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply them retroactively to those already convicted or sentenced. (Res41-23)

Eliminate Barriers and Stigma to Treatment for Substance Use Disorder
MSMS supports increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders. MSMS opposes Medicaid and Medicare transportation “carve out” policies that disadvantage beneficiaries diagnosed with a substance use disorder who are being treated with medication for opioid use disorder. (Res24-23)

WOMEN’S HEALTH

Repeal of Michigan’s Abortion Law
MSMS supports the repeal of Michigan Compiled Laws 750.14 and 750.15, due to the criminalization of physicians. (Board Action Report #1, 2023 HOD, re: Res33-22)
Sunset Report to 2024 MSMS House of Delegates

At its 2018 Annual Meeting, the Michigan State Medical Society (MSMS) House of Delegates (HOD) established a sunset mechanism for House policies (Resolution 14-18, “Sunset Mechanism MSMS Policy”). Pursuant to this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure the MSMS Policy Manual is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of MSMS to communicate and promote its policy positions, as well as contributes to the efficiency and effectiveness of HOD deliberations.

The MSMS Committee to Review the MSMS Policy Manual recommends that the House of Delegates policies listed in this report be acted upon in the manner indicated and the remainder of the report be filed.

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| CONTINUING MEDICAL EDUCATION (p. 5) | Maintenance of Certification versus CME and Lifelong Commitment to Learning
MSMS opposes discrimination by hospitals and any employer, the Michigan Board of Medicine, insurers, Medicare, Medicaid, and other entities, which might restrict a physician’s right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of participation in prescribed corporate programs including Maintenance of Certification or expiration of time limited board certification. | Res85-13 | Retain, policy is still relevant. |
| END OF LIFE CARE (p. 7) | Declaring a Patient Dead/End-of-Life Care Training
MSMS supports implementation of curricula in end-of-life care, hospice, and declaration of patient death in residency training programs where appropriate and the development of continuing medical education programs in end-of-life care and sensitivity/communication training for physicians. | Res34-13 | Retain, policy is still relevant. |
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<td>END OF LIFE CARE (p. 8)</td>
<td>Position on Physician Assisted Suicide</td>
<td>Res68-97A; AMA Current Opinions-98; Edited 2016</td>
<td>Retain, policy is still relevant, but update to reflect current AMA Code of Ethics formatting.</td>
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MSMS adopts the following position of the American Medical Association on physician assisted suicide:

“Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

“It is understandable, though tragic, that some patients in extreme duress---such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

“Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including special consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.”

Code of Medical Ethics Opinion 5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress---such as those suffering from a terminal, painful, debilitating illness---may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.
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<td>ETHICS (p. 8)</td>
<td><strong>AMA Principles of Medical Ethics</strong>&lt;br&gt;MSMS supports the AMA Principles of Medical Ethics:&lt;br&gt;“PREAMBLE: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, but also as well as to society, to other health professionals, and to self.&lt;br&gt;“The following Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.&lt;br&gt; I. A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.&lt;br&gt; II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.&lt;br&gt; III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.&lt;br&gt; IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.&lt;br&gt; V. A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.&lt;br&gt; VI. A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.&lt;br&gt; VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and society.&lt;br&gt;</td>
<td><strong>AMA Current Opinions, 2001; Prior to 1990; Reaffirmed 1998; Reaffirmed (Res30-14); Edited 2016</strong></td>
<td>Retain, policy is still relevant, but some technical updates are necessary to be consistent with the current AMA Code of Ethics.</td>
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<td>Patient Centered Medical Home</td>
<td>MSMS presently accepts the Joint Principles and footnotes as originally proposed while working within the Michigan Primary Care Consortium to assure appropriate physician oversight of nurse practitioners and physician assistants is maintained as the Patient Centered Medical Home is promoted.</td>
<td>Board-April09; Reaffirmed (Res30-14)</td>
<td>Retain, policy is still relevant. (See Addendum Q)</td>
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<tr>
<td>Physician Leadership Role in Health Care</td>
<td>MSMS accepts its role as an advocate of quality health care for all patients. In order to ensure the quality of care given to patients,</td>
<td>Prior to 1990; Reaffirmed (Res30-14)</td>
<td>Retain, policy is still relevant.</td>
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<td>physicians must maintain overall responsibility and leadership in decisions affecting the health care received by the public. Physicians should be encouraged to strive for unity of purpose in this area of responsibility and leadership and participate in activities, both public and professional, that will serve to advance this goal.</td>
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<td>HEALTH CARE DELIVERY/MEDICAL NECESSITY (p. 13)</td>
<td>Quality of Patient Care Medical services to the patient should be allocated based upon the physician's best medical judgment with regard to the patient's health and welfare. Financial consideration shall not alter the physician's best medical judgment and treatment of that patient.</td>
<td>Prior to 1990; Edited 1998; Reaffirmed (Res30-14)</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>HEALTH CARE INSURANCE (p. 15)</td>
<td>Genetic Information Non-Discrimination in Insurance Coverage MSMS encourages physicians to inform patients that their genetic test results may not be currently protected from discrimination by long-term care, disability, or life insurance providers and opposes the use of genetic information in decision-making for not only health insurance policies, but also long-term care, disability, and life insurance policies.</td>
<td>Res46-13</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>HEALTH INFORMATION TECHNOLOGY (p. 18)</td>
<td>Barriers to Connectivity MSMS supports governmental authorities and purchasers of care to compel health systems to cooperate by developing electronic interfaces with physician offices and supports the Centers for Medicare and Medicaid Services to compel and/or incentivize health systems to work with physician practices to achieve interconnectivity through interfaces.</td>
<td>Res18-13</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>HOSPITAL-PHYSICIAN RELATIONS</td>
<td>Physician Rights Regarding Performance-Based Reporting MSMS supports a physician's right to prompt notification, review, and comment regarding any complaint made to a hospital pertaining to the physician's professional behavior; that a physician shall be given an adequate opportunity to provide written comment in response to the specific complaint; and that a physician's comments shall be included adjacent to the specific complaint in any hospital-generated report. MSMS supports a fair process of physician collaboration in the development of professional behavior programs or reporting by hospitals.</td>
<td>Res7-14</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>LICENSURE (p. 23)</td>
<td>Transparency Within the Board of Medicine MSMS support efforts to protect the citizens of Michigan by assuring transparency within the Michigan Board of Medicine by strengthening policies against conflicts of interest by requiring attestation of the lack of any conflict on a case by case basis, and other efforts to assure that conflicts of interest of this nature do not occur.</td>
<td>Board-April13</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>MEDICAID (p. 25)</td>
<td>Medicaid Coverage for Women with Molar Pregnancy MSMS supports administrative and legislative remedies to require Medicaid in Michigan to cover the surveillance and treatment of women with newly diagnosed gestational trophoblastic disease.</td>
<td>Res27-13</td>
<td>Retain, policy is still relevant, but amend to read as follows: Medicaid Coverage for Women with Molar Pregnancy MSMS supports Medicaid coverage of the surveillance and treatment of women with newly diagnosed gestational trophoblastic disease.</td>
</tr>
<tr>
<td>MEDICAID (p. 25)</td>
<td>Tuberculosis as Qualifying Condition for Medicaid MSMS supports making tuberculosis a qualifying condition for Medicaid and other health care coverage in the state of Michigan and supports requiring the Michigan Department of</td>
<td>Res16-13</td>
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<td>Community Health to support the financial costs of treating tuberculosis in each county and advocate for the availability of negative pressure rooms in non-hospital settings for persons with infectious tuberculosis.</td>
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<td>Retain, policy is still relevant, but replace “Community Health” with “Health and Human Services”.</td>
</tr>
<tr>
<td>MEDICAL EDUCATION AND TRAINING (p. 26)</td>
<td>Increase Funding for Post-Graduate Education</td>
<td>Res67-13</td>
<td>Retain, policy is still relevant, but combine to read as follows:</td>
</tr>
<tr>
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<td>MSMS supports increased federal funding for post graduate medical education, nationwide.</td>
<td>Res66-13</td>
<td>Funding for Post-Graduate Medical Education MSMS supports increased funding from private, state, and federal sources for post-graduate residency training in the state of Michigan.</td>
</tr>
<tr>
<td>MEDICAL EDUCATION AND TRAINING (p. 26)</td>
<td>Increasing Post-Graduate Medical Education Slots in the State of Michigan</td>
<td>Prior to 1990; Edited 1998; Edited 2012 (Res22-12)</td>
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<tr>
<td></td>
<td>MSMS supports increased funding from private and federal sources for post-graduate residency training in the state of Michigan.</td>
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<tr>
<td>MEDICAL EDUCATION AND TRAINING (p. 27)</td>
<td>Medicaid Funding for Graduate Medical Education</td>
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<td></td>
<td>MSMS supports increased funding for graduate medical education by Medicaid.</td>
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<tr>
<td>MEDICAL EDUCATION AND TRAINING (p. 27)</td>
<td>Mental Health Support and Medical Students</td>
<td>Res48-14</td>
<td>Retain, policy is still relevant.</td>
</tr>
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<td></td>
<td>MSMS supports medical students seeking assistance for mental health issues during their medical school years without fear that it will jeopardize consideration for residency match.</td>
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<tr>
<td>MEDICAL EDUCATION AND TRAINING (p. 27)</td>
<td>Residency Selection</td>
<td>Res47-97A; Reaffirmed (Res24-04A); Edited (Res28-14)</td>
<td>Retain, policy is still relevant.</td>
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<td>Admission to residency training shall be based upon the merit of the applicant without regard to race, color, creed, gender, *gender identity, sexual orientation, and country of original medical training when such an applicant has satisfied all current legal and regulatory requirements for medical practice in the United States of America.</td>
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<tr>
<td>MEDICAL EDUCATION AND TRAINING (p. 27)</td>
<td>State Medicaid GME Funding for New GME Slots</td>
<td>Board Action Report #8, 2013 HOD, re Res70-12</td>
<td>Retain, policy is still relevant, but replace “Community Health” with “Health and Human Services”.</td>
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<tr>
<td>NUTRITION (p. 32)</td>
<td>Genetically Modified Organisms Labeling</td>
<td>Res45-14</td>
<td>Retain, policy is still relevant.</td>
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<td>PHARMACY AND PHARMACEUTICALS (p. 35)</td>
<td>Pharmacy: Halt Pharmacy Solicitation of Prescriptions from Physicians Offices</td>
<td>Res5-13</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>PHARMACY AND PHARMACEUTICALS (p. 36)</td>
<td>Remove Inpatient Pharmacy Requirements of Labeling/Dispensing Sparsely Used Meds to Patients at Discharge</td>
<td>Board Action Report #3, 2013 HOD, re Res43-12</td>
<td>Retain, policy is still relevant.</td>
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<tr>
<td>PUBLIC HEALTH/HEALTHY CHOICES (p. 41)</td>
<td>Support of Healthy Lifestyle</td>
<td>Res36-93A; Reaffirmed (Res34-14)</td>
<td>Retain, policy is still relevant.</td>
</tr>
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*LGBTQIA (lesbian; gay; bisexual; transgender; queer; intersex; asexual/ally) ally—a person who does not identify as LGBTQIA, but supports the rights and safety of those who do*
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<tr>
<td>QUALITY ASSURANCE AND PATIENT SAFETY (p. 41)</td>
<td>Hyperbaric Oxygen Chamber Accreditation MSMS supports all hyperbaric oxygen chambers in the state of Michigan be fully accredited on a regular basis to improve patient and staff safety.</td>
<td>Board Action Report #9, 2013 HOD, re Res65-13</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>SCOPE OF PRACTICE (p. 44)</td>
<td>Oppose Rapid Diagnosis Testing Program in Pharmacies MSMS opposes the existing Rapid Diagnostic Testing (RDT) program in Michigan pharmacies, as well as any future expansion or creation of similar programs that may result in a diagnosis of illness or initiation of a prescription medication treatment plan by a pharmacist in the state of Michigan.</td>
<td>Res67-14</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>TOBACCO AND SMOKING (p. 46)</td>
<td>Ban e-Cigarettes from Public Venues MSMS supports banning the use of e-cigarettes and any nicotine delivery devices in public places.</td>
<td>Res66-11; Edited (Board-April14)</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>TOBACCO AND SMOKING (p. 46)</td>
<td>Ban on Dissolvable Tobacco Products MSMS opposes the distribution and sale of dissolvable tobacco products in Michigan.</td>
<td>Res18-09A; Reaffirmed (Res34-14)</td>
<td>Retain, policy is still relevant.</td>
</tr>
<tr>
<td>TOBACCO AND SMOKING (p. 46)</td>
<td>Ban on Smoking in Public Places MSMS supports seeking legislation at the state level calling for a ban on smoking in all public places including parks and beaches. Ban Smoking in All Areas of Employment, Restaurants and Malls MSMS opposes smoking in all enclosed areas of employment and all areas where second hand smoke compromises the air quality, including restaurants and malls.</td>
<td>Res93-06A; Edited 2013 (Res49-13); Reaffirmed (Res34-14) Res53-94A &amp; Res54-94A; Reaffirmed (Res116-98A); Reaffirmed (Res36-01A); Reaffirmed (Res34-14)</td>
<td>Retain, policy is still relevant, but combine to read as follows: Smoking Bans MSMS supports a ban on smoking in enclosed areas of employment, in all areas where second hand smoke compromises the air quality, and in all public places including, but not limited to, malls, restaurants, parks, and beaches.</td>
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<td>TOBACCO AND SMOKING (p. 46)</td>
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<tr>
<td><strong>TOBACCO AND SMOKING (p. 46)</strong></td>
<td>Ban Smoking in Cars with Children</td>
<td>Res34-14</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td></td>
<td>MSMS supports banning smoking in cars and other vehicles containing children. (Res4-10A) – Reaffirmed</td>
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<tr>
<td><strong>TOBACCO AND SMOKING (p. 47)</strong></td>
<td><strong>Minors Purchasing Tobacco Products</strong></td>
<td>Res1-94A; Reaffirmed (Res116-98A); Reaffirmed (Res34-14)</td>
<td><strong>Retain, policy is still relevant.</strong></td>
</tr>
<tr>
<td></td>
<td>MSMS is opposed to allowing the sale of tobacco to minors. MSMS opposes the use of vending machines for the sale of tobacco.</td>
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<tr>
<td><strong>WOMEN’S HEALTH/ PREVENTION AND SCREENING (p. 48)</strong></td>
<td><strong>Opposition to Government Regulations Limiting Scope of Women’s Health Coverage</strong></td>
<td>Board Action Report #6, 2015 HOD, re Res15-14</td>
<td><strong>Retain, policy is still relevant.</strong></td>
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<td>MSMS supports maintaining the privacy and confidentiality of anyone who purchases additional coverage riders for any benefits including abortion and opposes any limitations on the scope of health care coverage that private insurance companies can offer in a comprehensive health plan.</td>
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RESOLUTION 42-23

Title: Upper Peninsula Regional Director Constitution and Bylaws Amendment

Introduced by: David Whalen, MD, for the Grand Traverse-Leelanau-Benzie County Delegation

Original Author: Bradley P. Goodwin, MD

Referred To: Reference Committee C

House Action:

Whereas, as a result of the most recent reorganization of the MSMS Board of Directors there are only two geographic board positions for a vast, diverse portion of the state of Michigan where only one position has been routinely filled, and

Whereas, it is currently stated in the MSMS Constitution that “one Regional Director must hold membership in a county located in the upper peninsula” (Article IX, Section 1), and

Whereas, for a variety of reasons it is not always possible to recruit active participation of MSMS member physicians from the upper peninsula willing to serve as a Regional Director, and

Whereas, no other Region has such specific exclusionary geographic requirements stated in the Bylaws regarding the selection of Regional Director; therefore be it

RESOLVED: That the MSMS Constitution Article IX, Section 1(a) be amended by addition to read as follows:

a) Two Directors (the “Regional Directors”) from each of the nine regions depicted on Exhibit A to the Bylaws (each a “Region” and collectively the “Regions”). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula unless no such member is available in which case, the two Regional Directors from Region 9 may come from the northern lower peninsula of the state.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Bylaws:

ARTICLE IX—THE BOARD OF DIRECTORS
Section 1. - COMPOSITION—The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:

a) Two Directors (the “Regional Directors”) from each of the nine regions depicted on Exhibit A to the Bylaws (each a “Region” and collectively the “Regions”). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula unless no such member is available in which case, the two Regional Directors from Region 9 may come from the northern lower peninsula of the state.

b) The President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice Speaker of the House of Delegates.

c) One Director elected by those members in each of the membership classifications defined in Sections 2.50 and 2.60 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in
Section 20.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.

d) The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.

e) Up to six Directors elected by the House of Delegates representing those constituencies deemed from time to time the most relevant to the current health care marketplace to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates (the “Designated Directors”). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.

MSMS Bylaws - 13.20 ELECTION OF REGIONAL DIRECTORS—
Regional Directors shall be elected as provided in Article IX, Section 1(a) of the Constitution. Each component society in a Region shall be notified in writing by the Secretary of the Society at least sixty days in advance of the Annual Session when a Regional Director is to be elected from that Region. If, by reason of death or resignation, a vacancy in the office of Regional Director occurs at any time other than during an Annual Session, each component society in that Region shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Region may caucus, and if a majority of the seated delegates from such Region shall submit a nomination to the Board of Directors to fill such vacancy, the Board of Directors shall appoint such nominee to serve as interim Regional Director of such Region until a successor is elected in accordance with Article IX, Section 1(e) of the Constitution.

If a vacancy in the office of Regional Director occurs during an Annual Session of the Society, the delegates of the component societies in the Region affected shall be given notice thereof and afforded time to caucus and consider nominations to fill such vacancy.
## RESOLUTIONS BY COMMITTEE

### REFERENCE COMMITTEE D – PUBLIC HEALTH

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<td>#3-24</td>
<td>Resolution 47-23 - “Support for Climate Plans for the State of Michigan, Counties, Townships and Municipalities, School Districts and Other Governmental Entities in Michigan”</td>
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</table>
Title: Partnership with Mental Health Providers and Law Enforcement

Introduced by: Kai Anderson, MD, for the Saginaw County Delegation

Original Author: Kai Anderson, MD, and Anushree Jagtap

Referred To: Reference Committee D

House Action:

Whereas, law enforcement officers are becoming increasingly tasked with responding to calls outside of enforcing the law, including but not limited to de-escalating behavioral health crises and reversing overdoses, and

Whereas, at least 20 percent of calls received by 911 are related to mental health concerns, and

Whereas, 80 percent of Americans have never heard of the 988 Suicide and Crisis Lifeline, and

Whereas, although Michigan law enforcement officers are required to undergo training in de-escalation techniques, people with mental health issues continue to be arrested or harmed in situations where violence and force may not be warranted, and

Whereas, de-escalation training is not enough to prevent mental health crises from escalating as the presence of armed law enforcement officials can exacerbate feelings of distress, and behavioral or cognitive impairment increases the risk of escalation to using force, and

Whereas, studies have shown that four out of five Americans think mental health professionals should be the first responders when someone is having a mental health or suicide crisis, and

Whereas, a mental health provider accompanying law enforcement on calls responding to mental health crises may assist in de-escalating the situation and avoiding unnecessary violence or arrest; therefore be it

RESOLVED: That MSMS provide education to the public on the importance of mental health providers accompanying law enforcement officers on calls responding to mental health crises; and be it further

RESOLVED: That MSMS work with law enforcement agencies in the state of Michigan to incorporate mental health providers on calls regarding mental health crises.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,500-$9,000
Relevant MSMS Policy

Support for Mental Health Reform in Michigan
MSMS supports efforts to improve mental health services in Michigan, including those that address mental health disparities, promote interdepartmental coordination and shared accountability, and provide greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

Relevant AMA Policy

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities; and (5) supports: (a) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and (b) research of fatal encounters with law enforcement and the prevention thereof.

Mental Health Crisis D-345.972
1. Our AMA will work expeditiously with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to:
   a) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;
   b) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;
   c) Expand research into the disparities in youth suicide prevention;
   d) Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;
   e) Develop and support resources and programs that foster and strengthen healthy mental health development; and
   f) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.
2. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.
3. Our AMA along with other interested parties will advocate that children’s mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties.
4. Our AMA will join with other interested parties to advocate for efforts to increase the mental health workforce to address the increasing shortfall in access to appropriate mental health care for children.

Sources:
RESOLUTION 04-24

Title: Plastic Surgery Medical Tourism

Introduced by: Anthony M. Zacharek, MD, for the Michigan Academy of Plastic Surgeons, Michigan College of Emergency Physicians, and Saginaw County Delegation

Original Author: Magdalena Iannello, Alexia Lucas and Anthony M. Zacharek, MD

Referred To: Reference Committee D

House Action:

Whereas, medical tourism is an increasing phenomenon with over 1.3 million Americans undergoing procedures abroad annually, and the most common international destinations being India, Mexico, Brazil, Thailand, South Korea, Dominican Republic and Turkey, and the most common domestic destinations being Miami, Los Angeles, Atlanta, and New York City, and

Whereas, the most common procedures received via medical tourism are breast augmentation, liposuction, blepharoplasty, breast reduction, rhinoplasty, abdominoplasty, and injections, and

Whereas, patients may opt for medical tourism due to lower costs of procedures, increased levels of privacy, allure of vacation packages, shorter wait times, getting treatments that are illegal in the United States, and receiving care from a provider with similar cultural background, and

Whereas, an estimated $1.3 billion dollars was spent in 2012 on treating complications for medical tourism, with the most common complications being infection, wound breakdown, pain, implant rupture, aesthetic dissatisfaction, capsular contracture, and hematoma following abdominoplasty and breast augmentation procedures, and

Whereas, medical tourism has had negative impacts on the American healthcare system and physicians, with an increase in medical tourists from 750,000 to 15.75 million people from 2007-2017, and an estimated $80 billion dollars spent on medical care overseas in this time, representing a lost opportunity cost to domestic healthcare providers of approximately $600 billion dollars, and

Whereas, medical tourism impacts physicians directly, as 80 percent of American plastic surgeons report experience with patients who traveled abroad for cosmetic procedures, and further impacts them by imposing the need for treatment of complications, decreasing time physicians can spend with other patients, and decreasing the amount of payment they receive overall; therefore be it

RESOLVED: That MSMS recognizes that medical tourism for plastic surgery is an increasingly popular phenomenon amongst Michigan residents and is associated with both risks and complications for the patient; and be it further

RESOLVED: That MSMS make a concerted effort to inform the Michigan public about the dangers and risks of medical tourism for cosmetic surgery.
Relevant MSMS Policy

Resolution 06-07: Support Ethical Procurement of Transplant Organs
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with The World Medical Association to provide ethical guidelines regarding “transplant tourism,” the traveling to another country for the purposes of organ transplantation, thereby increasing the possibility of exploitation of donors through coercive practices including paid donation.

Relevant AMA Policy

Code of Ethics - 1.2.13 Medical Tourism
Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient’s decision to seek health care abroad. (IV, V, VI)

Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.
(b) Advocate for education for health care professionals about medical tourism.
(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.
(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:
(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual’s concerns and wishes about care.
(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.
(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.

(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.
(i) Offer their best professional guidance about a patient’s decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patient's best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.
(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician’s prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:
   (i) the nature and duration of the patient-physician relationship;
   (ii) the likely impact on the individual patient’s well-being;
   (iii) the burden declining to provide follow-up care may impose on fellow professionals;
   (iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.

**Stem Cell Tourism H-460.896**

Our AMA (a) encourages the study of appropriate guidance for physicians to use when advising patients who seek to engage in stem cell tourism and how to guide them in risk assessment, (b) encourages further research on stem cell tourism, and (c) urges physicians to educate themselves on these issues.

**Sources:**


Title: Universal Newborn Eye Screening

Introduced by: Patrick Droste MD, for the MI Society of Eye Physicians & Surgeons

Original Author: Patrick Droste MD

Referred To: Reference Committee D

House Action:

Whereas, Red Reflex Testing (RRT) is the current standard of care for newborn eye screening in the United States, and

Whereas, there are approximately 3.7 million live births in the United States per year and the American Academy of Pediatrics recommends that newborn infants be screened prior to discharge from the hospital, and

Whereas, RRT is simple and inexpensive, it only evaluates approximately 6.5 percent of the retina (i.e., the optic disc and posterior pole) and leaves 95 percent of the retina unexamined, and

Whereas, four prospective studies of RRT versus fundus imaging via Fundus Camera have demonstrated sensitivity of RRT to be 0-10 percent, and

Whereas, camera based photographic screening for Retinopathy of Prematurity has been studied and found effective in telemedicine examinations for Retinopathy of Prematurity, and

Whereas, wide-angle camera imaging covers 181 degrees of retina (six field, wide angle imaging per eye) and RRT covers approximately five degrees of retina, and

Whereas, twenty papers have been published throughout the world that have shown that wide angle imaging studies performed within 72 hours of birth are much more sensitive and specific than RRT in detecting retinal/macular hemorrhages, and

Whereas, multiple studies have been performed with wide-angle fundus imaging and have revealed that approximately 4.5 – 8 percent of all newborn eyes studied had some form of referral warranted abnormality including, foveal hemorrhages, retinoblastoma, optic nerve abnormalities, retinal detachments, cataract, developmental abnormalities, inherited retinal dystrophies and infectious chorioretinitis, and

Whereas, the yield of positive results for referral warranted newborn eye screening (4.5-8 percent) is greater than newborn screening for hearing deficits (1.6/1000 or 0.16 percent of live births, and

Whereas, the Universal Photographic Newborn Eye Screening (U.N.E.S.) workflow consent protocol requires pharmacologic dilation, nursing and or technician photographers, six field, wide-angle imaging per eye, image interpretation and decision for follow up (U.N.E.S. taskforce), and
Whereas, the safety summary data has been published and shows “No ocular or systemic complications during or after eye examination;” therefore be it

RESOLVED: That MSMS support initiatives for Universal Photographic Newborn Eye Screening in the State of Michigan; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) encourage our AMA to endorse Universal Photographic Newborn Screening as a national practice for newborn children.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

Children’s Vision Screening
MSMS supports vision screening by primary care physicians pursuant to guidelines supported by scientific evidence and the establishment of vision screening programs.

Conditions for Mandatory Vision Screening
MSMS supports the current state of Michigan Vision Screening Program (VSP) for infants and children which ensures follow-up and collaboration with local health departments, primary care physicians, schools, and the Michigan Department of Health and Human Services and opposes any changes to the current VSP process that do not demonstrate added value.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)
MSMS supports Early and Periodic Screening, Diagnosis and Treatment Programs to reach as many eligible children as possible. All qualified providers should have equal opportunities to participate in the program.

Relevant AMA Policy

Standardization of Newborn Screening Programs H-245.973
Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; and (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

Sources:


Title: Support for Water Safety

Introduced by: Bryan Huffman, MD, for the Ottawa County Delegation

Original Author: Bryan Huffman, MD

Referred To: Reference Committee D

House Action:

Whereas, Michigan has the longest shoreline of any state in the continental United States, and

Whereas, according to the Centers for Disease Control and Prevention’s statistics, drowning is the leading cause of death in the USA in children aged 1-4, and the second leading cause of death in children 5-15 behind auto accidents, and

Whereas, a session of swim lessons given between the ages of 1-4 has been shown to decrease the risk of drowning by 88 percent, and

Whereas, Michigan prides itself in being the “Great Lakes State,” and

Whereas, every child in Michigan will encounter multiple situations with the risk of drowning every year, and

Whereas, 1,155 people drowned in the Great Lakes between 2010 and 2022, with Lake Michigan being the deadliest Great Lake, accounting for over half of all the Great Lakes drownings each year, and

Whereas, Michigan does not have lifeguards at the vast majority of its waterfront state parks and most state parks lack basic rescue equipment. Michigan also does not require swim lessons as part of k-12 education, and

Whereas, several groups, including the Great Lakes Surf Rescue Project and the Michigan Drowning Prevention Alliance, are already working to improve water safety in Michigan through increasing availability of swim lessons, promoting lifeguards at state and county parks, providing community lifejackets at swimming areas, training surf lifeguards, and lobbying for increased state support for drowning prevention, and

Whereas, Medicine should have a vocal supportive role in preventing the number one cause of childhood death, and

Whereas, several other groups have this objective as their main mission. Therefore, MSMS does not need to lead this charge, but should be supportive of their efforts, and

Whereas, MSMS currently has no official policy on drowning prevention; therefore be it
RESOLVED: That MSMS adopt the following policy supporting water safety in Michigan:

MSMS supports (1) early childhood swim lessons for every child in Michigan with the goal of “drown-proofing” the children of our state; (2) the availability of basic water rescue equipment at all public beaches including throw rings and lifejackets; (3) the presence of lifeguards at public beaches in Michigan; and (4) legislative efforts to protect entities that hire lifeguards from liability in a manner similar to good Samaritan laws; and be it further

RESOLVED: That MSMS provide visible support to the efforts of other groups that are working to further MSMS stated policy on water safety issues in Michigan. This support would include vocal support of efforts to improve water safety, and adding our support to these groups at legislative hearings in Lansing regarding water safety.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy - None

Relevant AMA Policy

Swimming Safety H-10.983
Our AMA (1) strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs and (2) encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety.

Sources:
1. CDC drowning statistics: http://www.cdc.gov/drowning/facts
Title: Perinatal Mental Health and Substance Use Disorder Services

Introduced by: Sara Jaber, MD, for the Michigan Section of the American College of Obstetricians and Gynecologists

Original Author: Sara Jaber, MD

Referred To: Reference Committee D

House Action:

Whereas, one in five women experience mental health or substance use disorders in the United States during pregnancy and the postpartum period, and

Whereas, 96 maternal deaths from 2012-2016 in Michigan were the result of substance use overdose, accounting for 26.1 percent of maternal deaths, and

Whereas, Michigan’s rates of postpartum depression have been persistently higher than the national rate over the past few years, with the gap further widening in 2021 with postpartum depression in Michigan reported at 16.5 percent compared with 12.7 percent nationally, and

Whereas, untreated maternal mental health conditions result in annual cost of $14 billion or $32,000 per mother and infant, and

Whereas, mental health conditions during pregnancy and postpartum are associated with significant adverse outcomes including stillbirth, preterm birth, fetal growth restriction, low birth weight, impaired bonding, poor infant neurodevelopment, and higher rates of long-term health problems after delivery, and

Whereas, screening for mental health and substance use disorders are recommended at the first prenatal visit and then periodically during pregnancy and postpartum visits, and

Whereas, evidence shows that both non-pharmacological and pharmacological interventions are effective for preventing and treating perinatal mental health conditions, and

Whereas, the inpatient psychiatric admission of pregnant adolescents with suicidal ideation, or to provide more adequate psychiatric care, can lead to improved pregnancy outcomes, and

Whereas, only one intensive outpatient and partial hospitalization perinatal psychiatry program has been registered in Michigan, and

Whereas, although obstetric care providers play a critical role in the screening of mental health and substance use disorders in pregnancy and postpartum, most obstetric providers are not reimbursed for the time spent providing maternal mental healthcare services, and
Whereas, most states consider screening for mental health and substance use disorders as part of the "global obstetric code" rather than being reimbursed additionally for this service, and this was particularly correct if the physician screened every patient routinely, and

Whereas, some insurance payers provide reimbursement for services linked to a maternal mental health service only if the services are provided by psychologists and/or psychiatrists, and

Whereas, only California, Colorado, and Tennessee have addressed and implemented Medicaid-related screening and billing/reimbursement protocols for obstetric care providers attending to pregnant and postpartum women; therefore be it

RESOLVED: That MSMS will (1) support improvements in mental health and substance use disorder services during the pregnancy and postpartum period including access to non-pharmacotherapy, pharmacotherapy, outpatient services and inpatient psychiatric and medical services; (2) will advocate for inclusive private and public insurance coverage of, and sufficient payment for, all mental health services during pregnancy and the postpartum period; (3) will advocate for evidence-based, non-punitive, screening and treatment of mental health and substance use disorders as the standard of care during pregnancy and the postpartum period; (4) will encourage the expansion of mental health and substance use disorder treatment facilities that provide care during pregnancy and the postpartum period for those in need of inpatient and intensive outpatient disease management, including facilities that enable them to bring their minor children.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $4,000-$8,000

Relevant MSMS Policy

Support for Mental Health Reform in Michigan
MSMS supports efforts to improve mental health services in Michigan, including those that address mental health disparities, promote interdepartmental coordination and shared accountability, and provide greater access to timely outpatient treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

Childcare Availability for Persons Receiving Substance Use Disorder Treatment
MSMS supports the development of childcare resources for existing substance use treatment facilities and believes childcare infrastructure and support should be a major priority in the development of new substance use programs.

Eliminate Barriers to Medication-Assisted Treatment
MSMS supports the elimination of insurance-related access barriers, including prior authorization requirements, to all forms of medication-assisted treatment for the medical treatment of substance use disorder.

Reimbursement for Postpartum Depression Prevention
MSMS shall advocate for the following:
1. State Medicaid programs to reimburse applicable CPT codes that can be used for postpartum depression prevention by a broad range of health workers, with services currently covered under the Affordable Care Act.

2. An initiative to allow all qualified health care professionals to bill under a “pregnancy” diagnosis code, so that they can deliver perinatal and postnatal mental health preventive interventions.

3. State Medicaid programs to provide avenues for nurses, doulas, community health workers, and health educators trained in these programs as part of physician led health care teams to deliver these primary prevention interventions and be reimbursed.

4. States, payers, and health systems to make evidence-based postpartum depression prevention services the official standard of care and increase bundle payments accordingly statewide.

MSMS believes evidence-based postpartum depression prevention services should be the official standard of care for all federally-funded health care programs for pregnant women federally.

**Relevant AMA Policy**

**Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953**

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

**Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991**

Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

**Sources:**


Title: No-cost Reproductive Planning For Michigan Users

Introduced by: Federico G. Mariona, MD, for the Wayne County Delegation

Original Author: Federico G. Mariona, MD

Referred To: Reference Committee D

House Action:

Whereas, under Section 2713 of the Public Health Service Act (PHS Act), added to the Patient Protection and Affordable Care Act, as amended, enacted March 23, 2010, requires coverage without cost sharing of certain preventive health services by group health plans and health insurance coverage, including all Food and Drug Administration (FDA)-approved contraceptives, sterilization procedures, and patient education and counseling for women with reproductive capacity, as published in the final regulations in August of 2014, including the steps to obtain accommodations to insurers with religious objections to contraception, and

Whereas, on June 23, 2023, President Biden issued an Executive Order directing the Secretaries of Treasury, Labor and Human Services to ensure that all FDA approved, granted, or cleared contraceptives be provided at no cost sharing, and

Whereas, the Governor of Michigan and the Michigan Department of Health and Human Services (MDHHS) reiterated their efforts to preserve and expand reproductive rights for females and males, making in-clinic induced abortion available along with items or services involving comprehensive contraception, emergency contraception and medication abortion to individuals regardless of their residency or immigration status, age, race, sexual orientation, gender identity, income, insurance status and more at low or no cost and based on the ability to pay, and

Whereas, only 45 percent of women in Michigan receive said care at no cost, 30 percent at discount, 15 percent at full fee and 10 percent unknown, and

Whereas, the FDA approved on July 13, 2023, the first over the counter daily oral hormonal contraceptive pill with no age restrictions and no prescription, which will increase the availability of contraception in areas with geographic or logistical barriers to health care facilities, and

Whereas, recent reports showed that the number of induced abortions in Michigan increased during 2023 by over 2850 in spite of existing restrictions, an indirect indication of suboptimal and inconsistent utilization of effective contraception as a preventive service, and Michigan providing an unknown number of induced abortions to non-Michigan residents;

therefore be it

RESOLVED: That MSMS seek the collaboration of the Michigan Department of Health and Human Services and all Michigan health care services and health insurers to comply with the requirements of the Affordable Care Act as amended and provide comprehensive contraceptive issues, processes, and products as approved by the United States Food and Drug Administration to
all pregnancy capable persons in Michigan at no cost, funded via the Title X funds available to the
state for this purpose and all other funds available for similar purpose.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Policy

Preserve Access to Contraceptives
MSMS supports the preservation of access to contraceptive services, including through Title X funds.

Relevant AMA Policy

Support for Medicare Coverage of Contraceptive Methods D-330.900
Our AMA will work with the Centers for Medicare and Medicaid Services and other stakeholders to
include coverage for all US Food and Drug Administration-approved contraceptive methods for
contraceptive and non-contraceptive use for all patients covered by Medicare, regardless of
eligibility pathway (age or disability).

Coverage of Contraceptives by Insurance H-180.958
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan
include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without
regard to prescription or over-the-counter utilization because all contraception is essential
preventive health care.

Sources:
Services Under the Affordable Care Act A Rule by the Internal Revenue Service, the Employee Benefits
Security Administration, and the Health and Human Services Department on 07/14/2015 Accessed Jan
31, 2024 Department of Labor website ( //www.dol.gov/ebsa).
2. U.S Food and Drug Administration. FDA approves first non-prescription daily oral contraceptive.
https://www.fda.gov/new-events/press-announcements/fda-approves-first-nonprescription-daily-oral-
contraceptive Accessed Jan 26, 2024
January 30, 2024.
5. Kavanaugh M.L et al. Where do reproductive-age women want to get contraception? J. Women’s Health
(Larchment) 2023,32 657-59. Recommended preventive services https://www.healthcare.gov/preventive-
care-benefits.
Jan. 2015 Allen R.H et al. Opill, the over-the-counter contraceptive pill. Ob-Gyn, 143. 2, Feb 2024. 184-
188.
8. MDHHS. Overview of telehealth contraceptive policies relevant to contraceptive access. Title X role in
Michigan. John Cleland 1The complex relationship between contraception and abortion Best Pract Res
9. HRSA. The complete list of recommendations and guidelines : https://www.healthcare.gov/preventive-
care-benefits. Guttmacher institute Monthly abortion provision study
Title: HPV Vaccination

Introduced by: Nicklas Bara for the Medical Student Section

Original Author: Christian R. Schaaff

Referred To: Reference Committee D

WHEREAS, infection by human papillomavirus (HPV) has been associated with an increased risk of cervical cancer and is now implicated in nearly 80 percent of all cases of oropharyngeal cancer in the United States, and

WHEREAS, cases of oropharyngeal cancer in the United States are rising annually by 2.7 percent, with the greatest increases seen across Midwestern and Southern states, and

WHEREAS, overall survival of Black populations HPV-associated head and neck cancer are disproportionately low compared to their White counterparts and have some of the lowest rates of HPV vaccination, and

WHEREAS, the Food and Drug Administration expanded approval of HPV vaccination for use in those 9 to 45 in 2018, and

WHEREAS, HPV vaccination has been shown to be safe and effective for those aged 9 through 26, as well as those aged 27 through 45 for the prevention of both cervical and oropharyngeal HPV-related malignancies, and

WHEREAS, HPV-associated sexual stigma among parents of adolescent patients represents a formidable barrier against HPV vaccination, and

WHEREAS, HPV vaccination rates remain low in males throughout the United States, with a pooled HPV vaccination coverage of 11 percentage in men aged 18-30, despite males being more frequently diagnosed with HPV-associated malignancies and presenting with higher mortality, and

WHEREAS, the HPV vaccination uptake rate among adolescent males aged 13 through 17 in Michigan lags behind that of the United States, with only 52.4 percentage completing the three-dose HPV vaccine schedule, and

WHEREAS, cervical cancer rates have decreased following the approval of the HPV vaccine, rates of HPV-related oropharyngeal cancer have been rising among younger adults (particularly men) who either have no history of tobacco-use or use tobacco infrequently, and be it further

RESOLVED: That MSMS encourage and support efforts by the Michigan Legislature, Michigan Department of Health and Human Services, and the Michigan State Board of Education.
bolster statewide public education on the benefits of HPV vaccine in reducing not only cervical cancer risk in females, but also oropharyngeal cancer risk in both females and males; and be it further

RESOLVED: That MSMS support efforts to increase the rate of HPV vaccination uptake among children and adults up to the age of 45 of all genders.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Policy

Support for Public Health Vaccine Initiatives

MSMS supports the broad authority of the Michigan Department of Health and Human Services to protect all Michigan citizens from vaccine-preventable disease using evidence-based policies for public health.

Universal Access to Child Immunizations

MSMS supports a policy of universal access to immunizations for all Michigan children. It further supports a strategy whereby the immunizations are purchased by the state at the lowest possible price and made available to all health care providers administering immunizations.

Relevant AMA Policy

HPV Associated Cancer Prevention H-440.872

Our American Medical Association: urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.

Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers. Our AMA: encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits, supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings. Our AMA will study requiring HPV vaccination for school attendance. Our AMA encourages collaboration with interested parties to make available human
papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.

Sources:
7. Su-Velez BM, St John MA. To Vaccinate or Not to Vaccinate: Should Adults Aged 26 to 45 Years Receive the Human Papillomavirus Vaccine?. Laryngoscope. 2021;131(1):1-2. doi:10.1002/lary.28666
Title: Free Menstrual Products in Public Schools

Introduced By: Nicklas Bara for the Medical Student Section

Original Authors: Hashim Aslam, Riya Chhabra, Shivapriya Chandu, Shreya Desai, Raywa Masti, Inderjeet Sahota, Merzia Subhan, and Deepali Tailor

Referred To: Reference Committee D

House Action:

Whereas, menstruation continues to be a highly stigmatizing issue for individuals with periods in the United States, and

Whereas, a lack of access to menstrual products adversely impacts the health, well-being, and academic performance of menstruating students, and

Whereas, a lack of access to menstrual products is associated with poor mental health outcomes, such as elevated anxiety, depression, and distress, and

Whereas, according to a 2019 article in Women's Reproductive Health, out of 693 19–25-year-old students, a lack of access to menstrual products resulted in 12.7 percent of students missing school, 15.01 percent of students being late to school, 23.91 percent leaving school early, and 17.6 percent of students reporting that it has a negative impact on their learning ability, and

Whereas, in a 2018 survey from the Society of Women's Health Research, 362 school nurses across elementary, middle, and high schools over the United States reported that 75 percent of bathrooms in schools were not well-stocked with menstrual products, and

Whereas, an organization advocating for menstrual products in school found that 23 percent of students ages 13-19 in 2021 said they struggled to afford menstrual products, with the COVID-19 pandemic severely impacting resources, and

Whereas, the government funded Supplemental Nutrition Assistance Program (food-stamps) does not allow individuals to buy menstrual products with these funds, and

Whereas, according to government programs like a Health Savings Account or Flexible Spending Account, funds like menstrual products are considered a qualified medical expense, and

Whereas, 25 states and the District of Columbia have passed legislation that helps provide free menstrual products in schools, and

Whereas, an advocacy group focused on getting period products in state budgets estimates that it costs $5-7 per year per student to supply period products, and
Whereas, providing free menstrual products in school restrooms can potentially decrease gender discrimination and help open conversations and decrease stigma surrounding menstrual health; and therefore be it

RESOLVED: That MSMS encourage all Michigan school districts, other public schools, and chartered nonpublic schools that enrolls girls in grades 6-12 to provide free tampon and pad products to those students; and be it further

RESOLVED: That MSMS encourage each district or school to provide tampon and pad products to students below grade 6 and to inform students where the products are kept in the school.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy - None

Relevant AMA Policy

Increasing Access to Hygiene and Menstrual Products H-525.973
Our AMA: (1) recognizes the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; (2) supports the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs; (3) will advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance; and (4) encourages public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students.

Sources:


Whereas, fentanyl overdoses make over 67 percent of overdoses in the United States, which is about 73,654 deaths in a year, and

Whereas, overall overdose deaths in Michigan have surged from 183 people in 2000 to 2,539 people in 2021, per state data, and

Whereas, as of May 2023 about 77 percent of drug supply in Michigan is tainted with fentanyl, and

Whereas, research indicates a 94 percent increase in fentanyl detection in drug overdose cases across 11 rural Michigan counties from 2018 to 2020, and

Whereas, two milligrams of fentanyl can prove fatal, underscoring the drug’s deadly potential, and

Whereas, para-fluorofentanyl (pFF) is a fentanyl analog on the rise in Michigan overdoses, and pFF is more potent than fentanyl, and

Whereas, fentanyl testing strips can detect fentanyl and most fentanyl analogs, and

Whereas, Michigan is one of 25 states where fentanyl testing strips are legal, and

Whereas, Oakland County’s Alliance of Coalitions for Healthy Communities set up save-a-life boxes, which include fentanyl testing strips and other substance testing supplies, which have seen 80 percent of supplies used and community requests for more supplies as of July 2023, and

Whereas, providing fentanyl test strips in a similar format to Oakland County is much less expensive than Narcan vending machines, costing the Oakland County’s Alliance of Coalitions for Healthy Communities $450 a unit rather than $6,500, and

Whereas, fentanyl testing strips cost $1 per strip versus $75 per dose of naloxone, making them more cost-efficient for being equitably funded across all Michigan counties, and

Whereas, providing testing strips can reduce stigma for people with substance use disorders in seeking support, and
Whereas, Harm Reduction Michigan has similar boxes to Oakland County’s Save-a-Life boxes set up in 28 Michigan counties as of July 2023; and be it further

RESOLVED: That MSMS support programs that work to increase access to fentanyl test strips; and be it further

RESOLVED: That MSMS encourage save-a-life/harm reduction boxes containing fentanyl testing strips and other harm reduction resources be available 24/7 in every Michigan county in accessible locations for individuals with substance use disorders to test their substances and make an informed decision about using that substance in order to reduce overdose deaths in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000 - $24,000

Relevant MSMS Policy

Addiction a Disease
MSMS recognizes drug addiction as a disease.

Addiction Treatment, Facilities, and Services
MSMS supports enhanced availability of and access to addiction treatment, facilities, and services within the State of Michigan.

Availability of Naloxone Boxes
MSMS supports the implementation of naloxone box stations in high-risk areas throughout the state.

Safe Consumption Sites for Opioids
MSMS supports the use of government funding in Michigan by clean syringe access programs for the purchase of syringes, needles and other equipment needed for safe consumption of opioids.

Relevant AMA Policy

Dispelling Myths of Bystander Opioid Overdose  D-95.965
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other safe and effective overdose reversal medications and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other safe and effective overdose reversal medications and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: advocate for the removal of fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia.

3. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) support the development of
adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; and (c) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

4. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

5. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

6. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

7. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Sources:
ACTION REPORT #03-24 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 47-23
        Support for Climate Plans for the State of Michigan

REFERRED TO: Reference Committee D

HOUSE ACTION:

RECOMMENDATION 1: THAT THE 2024 MSMS HOUSE OF DELEGATES APPROVE RESOLUTION 47-23, “SUPPORT FOR CLIMATE PLANS FOR THE STATE OF MICHIGAN, COUNTIES, TOWNSHIPS AND MUNICIPALITIES, SCHOOL DISTRICTS, AND OTHER GOVERNMENTAL ENTITIES IN MICHIGAN.”

RECOMMENDATION 2: THAT MSMS ADVOCATE FOR THE PASSAGE OF MEASURES TO FUND AND IMPLEMENT MICHIGAN’S HEALTHY CLIMATE PLAN.

The voting members of the Health Care Delivery Committee concurred with the recommendation of the MSMS Liaison Committee on Michigan’s Public Health to recommend approval of Resolution 47-23 as introduced. Additionally, because the Legislature is likely to take up legislation to implement various components of Michigan’s Healthy Climate Plan prior to the 2024 MSMS House of Delegates meeting, the Board has also requested to give direction to staff for engagement on this issue. In addition to the provision in the MSMS Bylaws below that permits the Board to act on timely issues when existing policy is not already in place, there is sound precedent.

12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

The Health Care Delivery Committee makes the following motion:

MOTION: That the MSMS Board of Directors recommend that the 2024 MSMS House of Delegates approve Resolution 47-23, “Support for Climate Plans for the State of Michigan, Counties, Townships and Municipalities, School Districts and Other Governmental Entities in Michigan.”
MOTION: THAT MSMS advocate for the passage of measures to fund and implement Michigan’s Healthy Climate Plan.

Attachment
Resolution 47-23
Title: Support for Climate Plans for the State of Michigan, Counties, Townships and Municipalities, School Districts and Other Governmental Entities in Michigan

Introduced by: James Mitchiner, MD, MPH, for the Washtenaw County Delegation

Original Author: James Mitchiner, MD, MPH

Referred To: Reference Committee D

House Action: REFERRED TO THE MSMS BOARD OF DIRECTORS FOR ACTION

Whereas, the climate crisis may be the greatest challenge facing humans, with important present and future health consequences for adults and children, and

Whereas, greenhouse gases and particulate air pollution caused by the burning of fossil fuels is the cause of common and important health consequences, including large numbers of deaths and large amounts of disability in adults and children, and

Whereas, Michigan has a Healthy Climate Plan that will help deal with climate change and air pollution, but substantial efforts and funding will be required over many years to successfully implement this plan, and

Whereas, some municipalities have active or proposed climate plans that will help to deal with climate change by reducing greenhouse gases and particulate air pollution, but substantial efforts and funding will be required over many years to successfully implement this plan, and

Whereas, local plans may encompass development of climate resilience plans by governmental agencies and health care systems; therefore be it

RESOLVED: That MSMS supports Michigan’s Healthy Climate Plan, including measures to fund and implement this plan; and be it further

RESOLVED: That MSMS supports development and implementation of climate plans for counties, townships, cities and other municipalities, school districts, and other governmental entities in Michigan; and be it further

RESOLVED: That MSMS urges physician involvement in developing, building support for, funding, and implementing climate plans for counties, townships, cities and other municipalities, school districts, and other governmental entities in Michigan.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000
Relevant MSMS Policy:

**Climate Change**
MSMS supports the American Medical Association policy, Global Climate Change and Human Health (H-135.938).

**Medical Society Consortium on Climate and Health**
MSMS endorses the Consensus Statement of the Medical Society Consortium on Climate and Health. (See Addendum R in website version)

Relevant AMA Policy:

**Stewardship of the Environment H-135.973**
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

**Global Climate Change and Human Health H-135.938**
Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.


7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

**Climate Change Education Across the Medical Education Continuum H-135.919**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

**Declaring Climate Change a Public Health Crisis D-135.966**

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.

2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

**Climate Change and Human Health D-135.963**

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.

2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.

4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.

5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

**AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

**Source:**

## RESOLUTIONS BY COMMITTEE

### REFERENCE COMMITTEE E – SCIENTIFIC AND EDUCATIONAL AFFAIRS

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RESOLUTION 02-24

Title: Anti-Racism Training for Medical Students and Medical Residents

Introduced by: Kai Anderson, MD, for the Saginaw County Delegation

Original Authors: Kai Anderson, MD, and Samantha Hess

Referred To: Reference Committee E

House Action:

Whereas, the Liaison Committee on Medical Education (LCME) stated that faculty must teach students to recognize bias “in themselves, in others, and in the health care delivery process,” but does not explicitly require accredited institutions to teach about systemic racism in healthcare, and

Whereas, medical students across the country wish to see this change, and

Whereas, the members of the Association of American Medical Colleges Medical Education Senior Leaders (AAMC MESL) “condemn the structures of racism that have allowed inequities in medicine and medical education to persist and are committed to combating racism in medical education by creating policies and changes that will support an antiracist learning environment and culture,” and

Whereas, one of the long-term goals of the AAMC MESL is the provision of antiracism faculty and trainee development at least annually, and

Whereas, medical students can recognize that racism has no place in healthcare, however, this knowledge does not translate to an understanding of how historical events, historical figures, and current events play a role in race in healthcare and how patient care and health equity efforts are impacted, and

Whereas, further educating students with the knowledge of why inequalities and inequities exist in the modern day and modern medicine will allow them to speak out against structural issues and better treat their future patients, and

Whereas, a significant amount of medical distrust exists amongst minorities due to a long history of mistreatment and health disparities, and

Whereas, medical distrust cannot be combated if future healthcare professionals are not properly trained in anti-racism and the root causes of existing race-based health disparities, and

Whereas, despite a widespread denouncement of racism and reexamining of their diversity and inclusion efforts, academic medical institutions have remained stagnant in their abilities to recruit, retain, and support ethnic minorities. A strong recommendation of investing funding and resources into anti-racism initiatives takes the burden off trainees and faculty of color to provide their talents and time for free to educate their peers, and
Whereas, “racial and ethnic minorities experience a lower quality of health services and are less likely to receive even routine medical procedures than are White Americans,” and

Whereas, involvement of anti-racism in medical school curriculum encourages students to be aware of their own biases and implement strategies to actively work against their biases for the betterment of patient care, and

Whereas, racial discrimination has been linked to mental health issues (e.g., depression, substance use, PTSD), a variety of medical conditions (e.g., diabetes, hypertension, obesity) and dementia. It is common for minoritized individuals to experience racism in their daily lives and health care settings. Experiencing racism has also been shown to accelerate aging and affect brain circuitry that plays a role in regulating emotions and cognition. These have been found to come from the social burdens placed on racial groups, rather than any biological or genetic factor, and

Whereas, the Michigan State Medical Society recognizes that structural racism is a major factor that contributes to health disparities in marginalized populations; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to make a concerted effort to require that the Liaison Committee on Medical Education and Association of American Medical Colleges mandate, rather than encourage, anti-racism training for medical students and medical residents.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy

Standards in Cultural Humility Training within Medical Education
MSMS supports initiatives by Michigan medical schools to include cultural humility training for medical students as part of their cultural competency curricula; including but not limited to integrating cultural humility within didactic and experiential learning across medical school curricula.

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.

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Healthcare organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:
• Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
• Ensure the policy is prominently displayed and easily accessible.
• Describe the management’s commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
• Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
• Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
• Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
• These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.
In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
  - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
  - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

Sources:
2. January 2021, Creating Action to Eliminate Racism in Medical Education Medical Education Senior Leaders’ Rapid Action Team to Combat Racism in Medical Education. Available at: https://www.aamc.org/media/50581/download (Accessed: 18 February 2024).
4. In medical schools, students seek robust and mandatory anti-racist ... Available at: https://www.washingtonpost.com/health/racism-medical-school-health-disparity/2020/11/06/6608aa7c-1d1f-11eb-90dd-abd0f7086a91_story.html (Accessed: 18 February 2024).
7. How racism affects the brain and mental health, according to science ... Available at: https://www.washingtonpost.com/wellness/2023/02/16/racism-brain-mental-health-impact/ (Accessed: 18 February 2024).
Whereas, during the COVID-19 pandemic, federal and state governments issued waiver flexibilities that allowed hospitals to provide advanced level services to patients at home under certain circumstances, and

Whereas, the waiver flexibilities built on the success of previous acute care at home models that have been tested over decades, showing that advanced care at home can be a safe, effective way to provide care to patients that is associated with lower costs and better patient outcomes and satisfaction compared with inpatient hospitalization, and

Whereas, as part of the omnibus spending bill that became law December 29, 2022, the Centers for Medicare & Medicaid Services (CMS) extended, through December 31, 2024, the Acute Hospital Care at Home initiative whereby individual hospitals may seek waivers to operate acute care at home programs, and

Whereas, the many state and federal laws/regulations conflict making implementation of acute care at home more difficult than CMS likely anticipated, and

Whereas, currently, advocacy groups such as Advanced Care at Home and AmediSys are actively lobbying CMS and the legislature to extend the Hospital at Home Waiver to a permanent CMS program. MSMS could work in partnership with these and other key stakeholders on addressing state regulatory barriers, and

Whereas, there has been opposition by nursing unions engendered by perceived or real changes in work requirements, patient safety and job security concern, and

Whereas, it is recognized that Emergency Department overcrowding and boarding due to hospital beds being full has reached a critical point, and hospital at home provides a relief valve in this regard, and

Whereas, the American Medical Association (AMA) report, “Financing of Home and Community-Based Services,” recommended CMS and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria; therefore be it

RESOLVED: That MSMS advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model; and be it further
RESOLVED: That MSMS identify state-level barriers to implementing and expanding acute care at home including: health and safety regulation applicability to services in the home, union opposition to acute care at home, and Mobile Integrated Health/Community Paramedicine limitations in state; and be it further

RESOLVED: That MSMS, in coordination with other acute care at home advocacy groups, work to address any concerns of state regulators; and be it further

RESOLVED: That MSMS engage with nursing organizations to share perspectives and address concerns about the benefits and challenges of acute care at home.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

**Relevant MSMS Policy** - None

**Relevant AMA Policy**

**Advancing Acute Care at Home D-160.910**

Our AMA will:
1. Advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model; and
2. Work with interested state medical associations to identify state-level barriers to implementing and sustainably funding acute care at home; and
3. In coordination with other acute care at home advocacy groups, identify avenues for addressing state regulatory concerns; and
4. Engage with allied health professional organizations to share perspectives and address concerns about the benefits and challenges of acute care at home.

**Source:**
1. Federman, A.D. et al. (2018) Association of a bundled hospital-at-home and 30-day postacute transitional care program with clinical outcomes and patient experiences; JAMA Internal Medicine; 178(8); p. 1033-1040.
Title: Make Implicit Bias Training One Time Only

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Original Author: Richard E. Burney, MD

Referred To: Reference Committee E

House Action:

Whereas, the Michigan Department of Licensing and Regulatory Affairs (LARA) now requires implicit bias training for physicians (and other health care professionals). The requirements apply to both new applicants as well as those renewing their existing licenses or registrations starting on June 1, 2022, and

Whereas, new applicants for licensure are required to have completed two hours of implicit bias training within the five years immediately preceding issuance of the license or registration, and

Whereas, renewing licensees are required to complete one hour of implicit bias training for each year of their license or registration cycle. For fully licensed physicians, this will be three hours for their three-year license cycle, and

Whereas, a commentary that appeared in the Journal of the American Medical Association Health Forum in August 2022, while lauding the mandated implicit bias training nevertheless calls attention to the fact that it does not address the specific clinical areas and populations most affected by implicit bias and experiencing inequities in health care, and

Whereas, it is unlikely that there will be anything new in implicit bias training year after year, the requirement for annual training will become a meaningless, repetitive exercise, of no incremental benefit to population health; therefore be it

RESOLVED: That MSMS petition the Michigan Department of Licensing and Regulatory Affairs and any other oversight body to make the requirement for implicit bias training a one-time requirement for licensees and licensure applicants.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy

Opposition to Compulsory Content of Mandated Continuing Medical Education
MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan. (Res67-07A) – Reaffirmed (Sunset Report 2020) – Reaffirmed (Res01-21)

Relevant AMA Policy
Support for Continuing Medical Education H-300.958

Our AMA:

(1) supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education;

(2) encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform;

(3) assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies;

(4) encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education;

(5) supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians;

(6) supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location; and

(7) affirms that lifelong learning is a fundamental obligation of our profession and recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education appropriate to that physician’s medical practice as determined by the relevant specialty society.

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA
supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Whereas, on August 28 2023, a new United States Drug Enforcement Administration (DEA) regulation went into effect, allowing patients to request electronic transfer of controlled substance prescriptions to another pharmacy on a one-time basis, and

Whereas, ongoing and unpredictable drug shortages of basic generic medications have been plaguing patients and physicians for years, without any relief in sight, and

Whereas, Michigan law requiring electronic prescriptions has added to patient and physician burden, as patients are not allowed to easily choose pharmacies based on cost or drug availability and multiple new prescriptions must be issued by the physician for controlled substances, and

Whereas, drug shortages and pharmacy decisions to not carry generic options for patients has created a crisis for those treated for ADHD and other conditions requiring controlled substances, as patients and physicians call multiple pharmacies daily to determine drug availability and physicians have to issue multiple new prescriptions based on availability, and

Whereas, multiple active prescriptions between pharmacies creates confusion and error as patients can fill multiple prescriptions for controlled substances either intentionally or unintentionally, and

Whereas, this DEA rule has the potential to alleviate this burden and potential for error, allowing electronic transfer of controlled substance prescriptions to another pharmacy utilizing existing SCRIPT Standard Version 2017071 protocol, just like any other prescription, and

Whereas, most Michigan pharmacies are simply ignoring the DEA rule, and not offering this option to patients, and

Whereas, some Michigan pharmacies only allow transfer within their chain network, claiming computer issues prevent transfer to another chain or independent pharmacy; however the DEA specifically debunked this excuse in the federal register comment section, citing that SCRIPT Standard Version 2017071 is available to independent and chain pharmacies and has been required since 2018 to participate in filling and transferring Medicare Part D drugs between pharmacies; therefore be it
RESOLVED: That MSMS work with interested organizations within Michigan to assure pharmacy compliance with the United States Drug Enforcement Administration’s regulations regarding transfer of electronic prescriptions for controlled substances between pharmacies.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

**Relevant MSMS Policy** - None

**Relevant AMA Policy**

**Access to Medication H-120.920**
Our AMA will advocate against pharmacy practices that interfere with patient access to medications by refusing or discouraging legitimate requests to transfer prescriptions to a new pharmacy, to include transfer of prescriptions from mail-order to local retail pharmacies.

**Source:**
Whereas, cannabis use is legal in the state of Michigan on a recreational basis, and

Whereas, the medical use of cannabis is protected in the state of Michigan, and

Whereas, AMA H-95.981 emphasizes protection in employment protocols for “drug abusers,” and

Whereas, recreational cannabis use away from the workplace is not associated with increased risk of occupational injury, and

Whereas, the Michigan Civil Service commission unanimously agreed to remove cannabis testing from pre-employment drug testing protocols, and

Whereas, other states with medical and recreational cannabis permissions have passed statutory language prohibiting cannabis-related employment discrimination, and

Whereas, there are no best practices or evidence-based recommendations supporting the use of one-time cannabis screening for employment in healthcare because of limitations in Tetrahydrocannabinol (THC) urinalysis; therefore be it

RESOLVED: That MSMS support policies making it unlawful for health care employers to discriminate in hiring, termination, or any term or condition of employment if the discrimination is based upon the person’s use of cannabis off the job and away from the workplace; and be it further

RESOLVED: That MSMS oppose one-time Tetrahydrocannabinol (THC) screening for employment in health care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy - None

Relevant AMA Policy

Federal Drug Policy in the United States H-95.981
“The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal
government and the nation should: . . .(6) extend greater protection against discrimination in the employment and provision of services to drug abusers. . .”

Sources:


Title: Language Modules for Medical Students in Michigan

Introduced By: Nicklas Bara for the Medical Student Section

Original Authors: Riya Chhabra, Patrick Gabriel, Zaheen Hossain, Tai Metzger, and Deepali Tailor

Referred To: Reference Committee E

House Action:

Whereas, Spanish is the second most common language after English in Michigan and Arabic is the third, with a high concentration of Arabic speakers in Southeast Michigan, and

Whereas, tens of thousands of patients in Michigan do not speak English. In 2021, 38.2 percent of the 679,402 foreign-born residents of Michigan and 0.7 percent of the 8,825,430 U.S.-born residents of Michigan—a total of 321,309 people—speak English less than “very well” according to a self-report, and

Whereas, patients with language barriers experience poorer health outcomes including medical errors, increased wait times, higher charges, larger workups, and vision impairment with type II diabetes, and

Whereas, language barriers inhibit patients from seeking medical care, and

Whereas, some patients are not even being matched with a doctor if they don’t speak English. Researchers found that the Spanish-speaking callers were provided with next steps to access cancer care only 38 percent of the time, significantly less than the 94 percent of English-speaking patient callers who were provided with next steps to access cancer care, and

Whereas, Arab, Middle Eastern, and North African Americans have been shown to have poor health outcomes relative to non-Hispanic Whites, including metabolic disorders, cardiovascular disease, low birth weight, and depressive symptoms, and

Whereas, language barriers are responsible for lower overall satisfaction rates from both the medical providers and the patients, and

Whereas, language barriers create the need for interpreters which increases time to receive care, added expenses, and risks for miscommunication and errors in understanding; and

Whereas, members of immigrant communities who have limited English abilities, such as recent immigrants, refugees and the elderly, oftentimes find themselves unable to access resources, and

Whereas, Michigan law currently requires that hospitals provide a certified interpreter for low English proficiency (LEP), deaf, deaf-blind, or hard of hearing patients at no cost to the
Whereas, by Michigan Law, providers may have a legal obligation to provide accommodations such as sign language interpreters in specific settings. This is so that effective communication between the consumer who is deaf, deafblind, or hard of hearing and the provider. Both parties must engage in an interactive process, and

Whereas, medical students are not required to have any language proficiency outside English nor are they required to interact with LEP patients or standardized patients during their training, and

Whereas, the prevailing knowledge suggests that medical professionals who are officially recognized and familiar with a second language contribute to the development of more robust patient-physician connections, particularly regarding the trust patients place in their doctors, and

Whereas, as the United States population is becoming more diverse, nursing students need enhanced clinical experiences to become proficient in patient-centered, culturally appropriate nursing care, and

RESOLVED: That MSMS recommend medical schools in Michigan include a Spanish language module in their curriculum for interested students so that they are able to recognize the language and request an appropriate interpreter as well as to be familiar with common phrases; and be it further

RESOLVED: That MSMS recommend medical schools in Southeast Michigan include an Arabic language module in their curriculum for students so that they are able to recognize the language and request an appropriate translator as well as to be familiar with common phrases;

RESOLVED: That MSMS recommend medical schools in Michigan expose students to patients and standardized patients who do not speak English well during the pre-clinical and clinical training and teach students about the importance of removing linguistic barriers in their curriculum.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $12,000-$24,000

Relevant MSMS Policy - None

Relevant AMA Policy - None

Sources:


Instructions for Accessing the Annual Financial Report

The Annual Financial Report is a separate document. The report is password protected. The password for delegates and alternates is included in the delegate email from March 29, 2024. If you need assistance, please email Rebecca Blake at rblake@msms.org or 517-336-5729.

Message from Ways and Means Committee Chair, Edward Rutkowski, MD

The Ways and Means Committee discusses financial “policy” of MSMS at the annual House of Delegates meeting. If anyone has “bookkeeping” type questions on the MSMS Annual Financial Report, please email your questions prior to the meeting to Lauchlin MacGregor, Chief Financial Officer, at Imacgregor@msms.org. Responses to these questions will be given prior to the meeting. This will allow the Ways and Means Committee meeting to be more efficient and effective with its time by focusing its discussion on the financial policy of MSMS. Thank you.