04.25.26 POLICY PROPOSAL 1

Title: Supporting Patient-Owned, AI-Enabled Digital Health Data Organizers Based on Medical Cybernetics Principles for Clinician-Guided Lifestyle Change with Wearable Sensors

Full Name*

Zsolt Peter Ori, MD, MS, FACP

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

No

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

N/A

Submission / Idea*

This proposal recommends that SCMA adopt a policy supporting the development and clinical integration of patient-owned, AI-enabled Digital Health Data Organizers (DHDOs) grounded in medical cybernetics principles to enhance clinician-guided lifestyle change programs supported by wearable sensors. A DHDO built on medical cybernetics principles can securely integrate wearable sensor data, clinical records, and patient-reported information into a patient-owned, AI-searchable platform designed to support continuous monitoring and adaptive feedback. These systems generate personalized insights, dynamic risk assessments, and clinician-ready summaries that strengthen prevention-first care. By empowering patients with real-time understanding of their health patterns, DHDOs increase motivation, resilience, and adherence, ultimately improving the effectiveness of lifestyle-based interventions.

Evidence / Support for Proposal*

A growing body of research demonstrates that combining professional coaching, digital tools, structured data, and AI-enabled decision-making significantly improves lifestyle-related outcomes: Professional coaching improves engagement and cardiometabolic outcomes /1/. Hybrid models combining human coaching with digital e-coaching outperform digital-only approaches /2/. Fully automated, AI-led Diabetes Prevention

Programs perform comparably to human-led programs, demonstrating the viability of scalable, automated support /3/. AI-enabled systems that bundle sensors, coaching, and adaptive feedback improve glycemic control, reduce weight, enhance quality of life, and support the de-escalation of pharmacotherapy /4/. Expert consensus statements (e.g., GLP 1 supportive care) show how AI searchable platforms can operationalize expert guidance even when randomized trials are not yet available /5/. Together, these findings show that structured data, continuous monitoring, and AI-assisted interpretation meaningfully enhance lifestyle-based care. A patient-owned DHDO grounded in medical cybernetics principles would allow patients and clinicians to apply these insights in real time, creating a unified, adaptive, and prevention-focused system that strengthens clinical decision making and patient self-management. Collectively, these findings demonstrate that DHDO-enabled lifestyle care aligns with SCMA's goals of improving outcomes, reducing costs, and expanding equitable access to preventive services.

References to SCMA Policy Proposal 2026

/1/ https://www.acc.org/Latest-in-Cardiology/Articles/2025/02/01/42/Prioritizing- Health-Journey-of-the-Health-and-Well-Being-Coaching-Profession#:~:text=Research%20has%20shown%20that%20HWC,Encourage%20behavior%20change

/2/ Spring B, Pfammatter AF, Scanlan L, et al. An Adaptive Behavioral Intervention for Weight Loss Management: A Randomized Clinical Trial. JAMA. 2024;332(1):21–30. doi:10.1001/jama.2024.0821

/3/ Mathioudakis, N., Lalani, B., Abusamaan, M.S., Alderfer, M., Alver, D., Dobs, A., Kane, B., McGready, J., Riekert, K., Ringham, B. and Shehadeh, A., 2025. An AI-Powered Lifestyle Intervention vs Human Coaching in the Diabetes Prevention Program: A Randomized Clinical Trial. Jama, 334(23), pp.2079-2089.

/4/ Pantalone, K.M., Xiao, H., Bena, J., Morrison, S., Downie, S., Boyd, A.M., Shah, L., Willis, B., Beharry-Diaz, J., Milinovich, A. and Joshi, S., 2025. Type 2 diabetes pharmacotherapy de-escalation through ai-enabled lifestyle modifications: a randomized clinical trial. NEJM Catalyst Innovations in Care Delivery, 6(9), pp.CAT-25.

/5/ Sievenpiper, J.L., Ard, J., Blüher, M., Chen, W., Dixon, J.B., Fitch, A., Gigliotti, L., Khunti, K., Lecube, A., Lean, M.E.J. and Mittendorfer, B., 2025. Nutritional and lifestyle supportive care recommendations for management of obesity with GLP-1-based therapies: An expert consensus statement using a modified Delphi approach. Obesity pillars, p.100228.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

SCMA is encouraged to enact a formal policy statement supporting the development, evaluation, and clinical integration of patient-owned, AI-enabled Digital Health Data Organizers (DHDOs) grounded in medical cybernetics principles, to enhance clinician-guided lifestyle change programs supported by wearable sensors. This action positions South Carolina to respond proactively to federal programs such as MAHA and the Rural Health Transformation Program, which increasingly tie funding to rapid adoption of technology-enabled preventive care. As recent NEJM analyses note /6, 7/, states that fail to articulate clear policies risk losing future federal funding and ceding control to politically driven priorities. This policy should:

- Affirm the role of patient-owned health data platforms in prevention-focused care
- Encourage voluntary clinical use of DHDOs to support lifestyle change, chronic disease prevention, and metabolic health
- Promote collaboration with academic, community, and industry partners to pilot DHDO-enabled care models
- Support exploration of reimbursement pathways for digital lifestyle support systems
- Align SCMA with emerging federal initiatives (MAHA, CMS Digital Health Ecosystem, RHTP)
- Ensure that South Carolina physicians have a unified, clinically grounded stance before future federal funding cycles require rapid policy decisions A review of SCMA's existing policy documents shows no current policies addressing patient-owned data platforms, wearable-supported lifestyle change, digital behavioral counseling, or continuous monitoring for prevention. This proposal fills a clear policy gap and positions SCMA to lead in modern, data-empowered preventive care. References to SCMA Policy Proposal 2026 /6/ Heather Howard, J.D., and Carmel Shachar, J.D., M.P.H. https://orcid.org/0000-0002-4517-6363 Author Info & Affiliations, Published February 7, 2026, N Engl J Med 2026;394:625-627, DOI: 10.1056/NEJMp2515454, VOL. 394 NO. 7 /7/ John D. Halamka, M.D., and Micky Tripathi, Ph.D. The Next Chapter in Health Care Interoperability. Published February 7, 2026, N Engl J Med 2026;394:628-630. DOI: 10.1056/NEJMp2511798, VOL. 394 NO. 7

Why is the Requested Action important?*

Lifestyle-related chronic diseases remain the primary drivers of morbidity, mortality, and healthcare spending in South Carolina. At the same time, federal initiatives such as Make

America Healthy Again (MAHA) and the CMS Rural Health Transformation Program are accelerating the shift toward prevention, digital health integration, and patient-generated data. SCMA needs a forward-looking policy to ensure that South Carolina physicians—not political or commercial forces—shape how these technologies are adopted. A patient-owned DHDO grounded in medical cybernetics principles directly advances MAHA's core priorities:

1. Whole-Person, Lifestyle-Based Interventions DHDOs integrate nutrition, physical activity, sleep, stress, and metabolic data into a unified, patient-owned platform that supports sustainable behavior change.
2. Prevention Over Treatment Continuous monitoring and AI-assisted interpretation allow earlier detection of risk trajectories, reducing downstream costs and improving long-term outcomes.
3. Data-Driven Evaluation of Preventive Models DHDOs generate structured, real-world data that can be used to evaluate lifestyle interventions, support reimbursement decisions, and strengthen South Carolina's competitiveness for federal demonstration funding.
4. Rural and Underserved Community Support Wearable-enabled, patient-owned platforms extend preventive care beyond clinic walls, reducing access barriers and supporting self-management in areas with limited clinical resources.
5. Physician Leadership in a Rapidly Changing Policy Environment Recent federal programs have required states to make rapid decisions with limited stakeholder input. A standing SCMA policy ensures that South Carolina physicians have a unified, evidence-based position before the next federal funding cycle demands accelerated action.

By adopting this policy, SCMA positions itself as a national leader in prevention-first, data-empowered care. It also strengthens South Carolina's ability to compete for substantial federal and philanthropic funding while ensuring that digital health innovation remains clinically grounded, equitable, and aligned with long-term public health needs. Without a proactive SCMA policy, South Carolina risks falling behind in federal scoring, funding opportunities, and the adoption of clinically grounded digital prevention models.

If there are additional details not addressed above that you would like to share, please provide them here.

Additional Context and Opportunities for SCMA Leadership South Carolina is uniquely positioned to demonstrate how patient owned, AI enabled health data platforms can strengthen prevention focused care in real communities. A concrete opportunity already exists through the emerging Hartsville Heart Health (HHH) community pilot /8-11/, which

applies the same medical cybernetics principles described in this proposal. The HHH project integrates wearable sensors, patient generated data, and clinician guided lifestyle change into a unified, patient owned Digital Health Data Organizer (DHDO) framework. Early design work suggests that this model could serve as a practical demonstration site for evaluating DHDO enabled preventive care in a rural setting. A formal SCMA policy supporting patient owned DHDOs would provide the professional foundation needed for South Carolina clinicians to participate in such pilots and to compete for federal and philanthropic funding streams that prioritize digital prevention, including MAHA ELEVATE, CMMI demonstration projects, and state level public health innovation grants. SCMA's endorsement would not commit the organization to any specific program; rather, it would ensure that South Carolina physicians have a unified, evidence based stance as communities explore DHDO enabled care models. By articulating this policy now, SCMA can help position South Carolina as a national leader in clinically grounded, prevention first digital health innovation—while supporting real world evaluation efforts such as the HHH pilot that reflect the needs of rural and underserved populations. SCMA's adoption of this policy would affirm that South Carolina's physicians are prepared to lead the evaluation and responsible implementation of DHDO enabled preventive care models—including emerging community pilots such as Hartsville Heart Health—ensuring that innovation in our state remains clinically grounded, equitable, and guided by physician expertise.

References to SCMA Policy Proposal 2026

/8/ Ori, Z: The Hartsville Heart Health Community Prevention Project. (unpublished, created for the Byerly foundation – available upon request)

/9/ Ori Z (2022) Wearable Sensors for Monitoring Personal Health and Supporting Recognition of Medical Urgencies. Curr Res Emerg Med, Volume 2, Issue 4: 1032. DOI:10.54026/CREM/1032, ISSN: 2832-5699

/10/ Ori Z (2024) Reaching for Cardio-Metabolic Fitness and Resilience through Self-Healing and Guided Individualized Cyber-Therapy: An Opportunity to Reenergize Primary Care. Quality in Primary Care ISSN: 1479-1064, Volume 32 • Issue 03 • 012, https://www.primescholars.com/archive/ipqpc-volume-32-issue-3-year- 2024.html, 10.36648/1479-1064.32.3.14

/11/ Ori Zs: Tracking Cardio-Metabolic Health with Biosensors for Improving Insulin Resistance in Primary Care. (A Holistic Approach Using Principles of Medical Cybernetics, Mathematics, and Measurement Science.) Poster Session 2 #25, Building Bridges Across NIH and the Broader Engineering Community, Tuesday, October 22, 2024 Masur

Auditorium Building 10 – NIH Campus Bethesda, MD, https://www.nibib.nih.gov/news-events/meetings-events/building-bridges-across-nih-and-broader-engineering-community

04.25.26 POLICY PROPOSAL 2

Title: Regulatory Considerations for 7-Hydroxymitragynine (7-OH): Addressing Emerging Opioid-Like Products in South Carolina

Full Name*

Lianna Perazzo

Designation*

Medical Student

Are you submitting on behalf of a county medical society, specialty society, or other member?*

Yes

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

Paige Gosewisch, Hannah Casper, Jake Larsen

Submission / Idea*

To address the growing availability of concentrated and synthetic 7-hydroxymitragynine (7-OH) products in South Carolina retail markets and their emerging clinical impact as opioid-active substances. This proposal seeks SCMA review and formal policy consideration regarding the regulation of high-potency 7-OH formulations due to their opioid receptor activity, addiction potential, and increasing need for medical management of withdrawal.

Evidence / Support for Proposal*

7-Hydroxymitragynine (7-OH) is an alkaloid derived from Mitragyna speciosa (kratom) that functions as a potent μ-opioid receptor agonist. Although it occurs naturally in very small amounts in raw kratom leaf, commercially available products now contain concentrated or synthetic formulations that dramatically increase its potency and opioid-like effects. This proposal does not seek to ban traditional kratom leaf products; rather, it addresses the growing availability of high-potency 7-OH formulations that pharmacologically function as opioid agonists. Clinically, providers are increasingly observing opioid-like tolerance and dependence, withdrawal syndromes consistent with opioid withdrawal, escalating use patterns, and a rising need for buprenorphine initiation for cessation. These concentrated products are widely accessible in gas stations, vape shops, smoke shops, and convenience stores across South Carolina, often marketed as “natural” supplements without clear disclosure of opioid receptor activity or addiction risk. Despite its clear opioid

pharmacodynamics, 7-OH remains unscheduled at the federal level, creating a regulatory gap that allows a highly potent opioid-active compound to be sold with minimal oversight. The widespread retail accessibility of concentrated 7-OH products presents a growing public health concern in a state already significantly burdened by opioid-related morbidity and mortality.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

The requested action is for the South Carolina Medical Association to adopt a formal policy statement recognizing concentrated 7-hydroxymitragynine (7-OH) as an opioid-active substance with significant abuse and dependence potential, and to advocate for legislative review at the state level. Legislative consideration should include scheduling or restricting high-concentration and synthetic 7-OH products, prohibiting fortified retail formulations, implementing enhanced labeling requirements that clearly disclose opioid receptor activity and addiction risk, and limiting retail distribution channels to prevent unrestricted sale in gas stations, smoke shops, and convenience stores.

Importantly, regulatory language should extend beyond 7-OH specifically to include synthetic analogs, structural derivatives, and compounds with substantially similar chemical structure or μ-opioid receptor agonist activity derived from kratom alkaloids. This broader, pharmacology-based approach would prevent minor molecular modifications from circumventing regulation and ensure policy addresses opioid-like effect rather than a single named compound.

Additionally, collaboration with appropriate state agencies to evaluate surveillance and reporting of 7-OH–related adverse events should be considered to inform ongoing evidence-based policymaking.

Why is the Requested Action important?*

South Carolina continues to face significant opioid-related morbidity and mortality. The increasing retail availability of concentrated 7-hydroxymitragynine (7-OH) products introduces an opioid-active compound into the marketplace without safeguards consistent with its pharmacologic profile. Unlike traditional kratom leaf, these high-potency formulations function as direct μ-opioid receptor agonists and are capable of producing tolerance, dependence, and withdrawal syndromes that increasingly require medical management, including buprenorphine initiation.

Because these products are marketed as “natural” supplements and are readily accessible in gas stations, vape shops, and convenience stores, many consumers may be unaware of

their opioid receptor activity and addiction risk. Without proactive regulatory clarification, minor chemical modifications could allow similar opioid-active derivatives to enter the market unchecked, perpetuating a cycle of reactive enforcement rather than preventative policy.

Addressing this issue now would align regulation with pharmacologic reality, support clinicians managing emerging cases of dependence, and help prevent the expansion of another opioid-adjacent public health crisis in a state already deeply affected by substance use disorders.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

The evolution of concentrated 7-hydroxymitragynine products represents a significant increase in both potency and clinical severity compared to traditional kratom leaf use. While kratom has historically been used in low doses in Southeast Asia, modern commercial formulations frequently contain concentrated or synthetic 7-OH in amounts that far exceed natural plant exposure. These high-potency products function as μ-opioid receptor agonists and are capable of producing tolerance, dependence, and withdrawal syndromes consistent with other opioid substances.

Clinicians are increasingly observing that cessation no longer requires only symptomatic “comfort” management, but instead necessitates initiation of buprenorphine for safe withdrawal and stabilization. This shift reflects a meaningful escalation in physiologic dependence and treatment complexity. Compounding this concern is the manner in which these products are marketed and distributed. Concentrated 7-OH formulations are widely available in gas stations, vape shops, and convenience stores and are frequently promoted as “natural” remedies for anxiety or pain. Consumers seeking non-opioid or plant-based alternatives may unknowingly initiate use of a potent opioid receptor agonist without clear disclosure of addiction risk. This lack of consumer transparency, combined with high retail accessibility and increasing clinical severity, underscores the need for proactive, pharmacology-based regulatory action.

04.25.26 POLICY PROPOSAL 3

Title: Preventing overcharging copays greater than the cash price of generic medications

Full Name*

Ryan Garbalosa

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

No

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

N/A

Submission / Idea*

Insurance companies and pharmacy benefit managers have been overcharging beneficiaries for covered generic medications more than they would have paid if they if bought the medications without insurance.

Evidence / Support for Proposal*

A study in JAMA showed that 28% of generic prescriptions had copays higher than the "cash price" of the medication.

JAMA
Published Online: March 13, 2018
2018;319;(10):1045-1047. doi:10.1001/jama.2018.0102

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

Enact legislation to prevent insurance companies for charging a copay that exceeds the cash price of the drug. Some other states such as Kentucky currently have a pending bill relating to this issue. 2026 KY H 453

Why is the Requested Action important?*

Drug cost is a common reason for medication noncompliance and in turn poor outcomes particularly in a lower income patient population. Many of the generic medications the insurance companies have been price gouging are essential medications as identified by the World Health Organization.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

04.25.26 POLICY PROPOSAL 4

Title: Prevention of Violence in Hospitals and Health Care Facilities

Full Name*

Barbara E Magera, MD, PharmD, MMM

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

No

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

N/A

Submission / Idea*

H3480 known as the "Health Care Workplace Security Act" passed the SC legislature in 2025. Violence against health care workers (HCW) in the hospital and health care facilities (HCF) has markedly increased. This bill establishes criminal penalties against perpetrators who commit violent physical acts against any HCW working in a hospital or HCF; however, the employer should institute policies to prevent potential violence in their facilities to extend to patients, families and visitors.

Gun and weapon violence are increasing common in our society. Patients, employees and visitors to hospitals and HCF are recently targets of gun violence particularly in the Emergency Department (ED). Installation of metal devices have shown to identify persons carrying lethal weapons into the ED. Screening of potential violent offenders carrying guns or metal weapons is a recognized measure to at least identify and remove perpetrators attempting to enter the ED with a lethal weapon.

Evidence / Support for Proposal*

In the ED, several hospitals including MUSC, Charleston; Spartanburg General, Spartanburg and Self Memorial Hospital, Greenwood have adopted the use of metal detector equipment to screen persons carrying a gun or metal weapons. These persons are immediately removed from the facility by security/police.

In 2024, the California Assembly bill 2975 (AB2975) passed that mandates that all California hospitals install weapons detection systems (i.e. metal detectors) at main public, emergency and labor and delivery entrances by March 1, 2027. This bill requires trained staff to operate the metal detectors to prevent armed threats from perpetrators from entering the healthcare workplace.

The University Hospital in Orlando Florida has a similar program where all persons entering the ED must go through a metal detection device. Additionally, all visitors/family accompanying a patient in the ED routinely undergo an identity screening and are issued a photo identification badge which they must wear while in the hospital facility. A map is provided that clearly identifies which areas the visitor/family member may safely access and which areas are 'off limits'. Failure to comply with these instructions risks immediately bodily removal from the ED by security and/ or police.

The SC Hospital Association (SCHA) workplace violence collaboration released their 2nd annual report in 2024. By their estimation, at least 7 HCW daily face assault or aggressive behavior in the workplace. Of the participating hospitals, 2,646 incidents were reported in 2024. Although this is a reported decrease from previous years, data indicates that through proactive measures, violent incidents could markedly improve. MUSC and other academic and community hospitals have instituted a HCW tutorial and poster campaign focusing on how HCW may identify and attempt to de-escalate an aggressive individual; however, measures to prevent potentially violent individuals from access to the hospital, particularly the ED have largely been ignored.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

To ensure the safety of their employees, patients and visitors, the SCMA is called to endorse the following preventative measures in all South Carolina hospitals and HCFs:

1. Restrict access of all nonemployees to ONE entrance and ONE exit into the hospital or HCF. Access to all other doors/entrances to the hospital or facility is gained using a use a keyless/computer coded access code.
2. All people (ie hcw and nonemployees) and packages must pass through a METAL DETECTOR devices located in the ED or HCF entrance to identify potential weapons that include but are not limited to firearms, knives, box cutters or other dangerous items that are known to be used to harm, hurt humans.

3. Require mandate and established training and education of staff that are responsible for screening all persons and objects through the metal detector devices.

Why is the Requested Action important?*

The frequency of violence against HCWs, particularly against nurses, has markedly increased nationally. Bill 3480 focuses on the threat of criminal consequences of physical altercation of a HCW however; a prevention program should be instituted by hospitals and HCF to eliminate or curtail violent persons from entering the ED or HCF. HCWs, patients and visitors deserve a safe working environment. Hospitals and HCFs are obligated to provide a safe health care environment for their patients, families and visitors. Examples of recent HCW workplace violence include:

1. On Apri 10, 2019, a nurse was critically injured after suffering gunshots inflicted by a patient who returned to the Orangeburg Regional Medical Center with an AR-15 rifle.
2. A staff member suffered a traumatic (undisclosed) injury at a McLeod Health facility that prompted a new safety partnership with local law enforcement.
3. In 2018 at Baptist Hospital, Prisma Health, Columbia SC, a radiology technician identified a loaded gun in the pants pocket of an ER patient undergoing a CT scan.
4. In 2019, at a Prisma Hospital in Irmo SC, a physician was attacked in the hospital parking lot while attempting to enter the hospital ED. The attacker announced he had a loaded gun.
5. In a NYC hospital, a disgruntle HCW entered the front door of the hospital with a loaded rifle and proceeded to a hospital floor where he shot and killed several HCWs, a patient and visitor.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

Review of bill H3480 indicates that grant funds are available for security projects to be used in hospitals or HCFs. To lessen the financial burden of installing metal detectors and the training of personnel in the use of these devices, hospitals and HCFs are urged to apply for grant monies available from the state.

Hospital administrators may not be aware of the routine pressures faced by health care workers. Training of HCWs on how to de-escalate an agitated or violent person is often ineffective and has resulted in needless bodily harm to many HCWs.

Administrators can no longer claim immunity as to ‘not knowing’ which prevention measures routinely have proven effective to protect HCW’s patients and visitors in the

hospital or HCF. At the very least, a hand-held wand to detect metal devices (i.e. available from Amazon for $75.00) is a simple option to immediately identify guns, knives and other metal weapons from entering the ED. No one can enter any court facility in South Carolina without first going through a metal detector device system. Security are consistently trained in the detection of potentially lethal weapons and how to effectively detain any person carrying a known weapon.

Metrics will be developed to rank each institution's commitment to proactive safety measures. Independent patient advocacy groups will score those institutions which aggressively implement prevention safety measures. A score to access the "proactive measures to prevent violence in health care institutions" will be publicly available for patients, HCWs, insurers and other hospital systems. Patients and third party payers will then have another choice of which hospital or HCF facility to patronize based upon 'prevention safety scores'.

04.25.26 POLICY PROPOSAL 5

Title: SCMA Statement supporting the AAP evidence-based vaccine schedule

Full Name*

Martha Edwards, MD, FAAP

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

Yes

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

SC Chapter of the AAP

Submission / Idea*

SCMA Statement Supporting the evidence-based vaccine schedule recommended by the American Academy of Pediatrics

Evidence / Support for Proposal*

The new CDC vaccine schedule is confusing to both parents and providers and is based on arbitrary changes, not on data or evidence. In particular, it changes multiple vaccines to "shared decision making" or "high risk" when there is no evidence or data to back up any change from the "recommended" status. Pediatricians follow evidence-based guidelines in caring for their patients and practice according to the guidelines established by the American Academy of Pediatrics. The following vaccines have been affected by this change. These links can be reviewed to explore the well-reasoned and researched AAP policy statements explaining the reasons and benefits of these four vaccines:

COVID: https://doi.org/10.1542/peds.2025-073924

RSV: https://doi.org/10.1542/peds.2025-073923

Influenza: https://doi.org/10.1542/peds.2025-073620 & https://doi.org/10.1542/peds.2024-068508

Hep B birth dose: https://doi.org/10.1542/peds.2017-1870

https://www.healthychildren.org/English/tips-tools/ask-the-pediatrician/Pages/what-is-the-difference-between-the-AAP-recommended-immunization-schedule-and-other-vaccine-schedules.aspx

Key points on the 2026 AAP immunization schedule and why it is important:

Pediatric researchers continually study new and existing vaccines to make sure they are safe for children's developing bodies and brains — and that they effectively build kids' immune systems to resist diseases. These experts review data from clinical trials and real-world settings. For almost 90 years their recommendations have been compiled into the American Academy of Pediatrics' vaccine guidelines — which are reviewed regularly by scientists. The AAP recommendations did not change for 2026. That's because there's no new evidence suggesting that changes are needed to keep kids healthy and thriving. If you have questions about the ideal timing and pacing for vaccinations, talk with your pediatrician.

The American Academy of Pediatrics continually reviews its recommendations for childhood vaccines. The guidelines are thoroughly researched and rooted in science — and they are based on what kids in the United States need to build resistance to serious childhood illnesses. The AAP recommendations protect children against 18 serious diseases and have not changed for 2026. That's because there's no new evidence suggesting that changes are needed to keep kids healthy and thriving. If you have questions about the optimal timing and pacing for vaccines, talk with your pediatrician. They have medical training and specialized knowledge to help you sort through all of the information out there.

Parents and pediatricians share a common goal: the healthy development of children. The American Academy of Pediatrics' vaccination recommendations are based on what kids in the United States need to build immune systems that can resist serious diseases. The guidelines, which have saved millions of lives, are constantly reviewed and frequently updated to reflect the latest scientific research. This January, the AAP stayed the course on its recommendations for routine immunizations against 18 serious childhood illnesses. That's because there's no new evidence suggesting that changes are needed to keep kids healthy and thriving. Parents can be confident in the vaccine recommendations from the AAP because they are consistent, based on science, and carefully reviewed each year.

Parents and pediatricians share a common goal: seeing children healthy, developing, and thriving. The American Academy of Pediatrics' vaccination recommendations are based on what kids in the United States need to build immune systems that can resist serious diseases. The guidelines reflect the latest scientific research and evidence and are

carefully reviewed each year by panels of respected leaders in infectious disease, immunology, and other scientific disciplines. This January, the AAP maintained their existing recommendations for routine immunizations. In contrast, federal officials rolled back the recommendations for several important vaccines without independent review. The AAP schedule is endorsed by all of the nation's major medical organizations. It's the plan that America's doctors, nurses, and pharmacists trust.

The following societies have formally endorsed this schedule:

For the 2026 AAP Recommended Child and Adolescent Immunization Schedule, at least 12 national medical and health professional organizations have formally endorsed the schedule:

American Academy of Family Physicians (AAFP)
American College of Nurse Midwives (ACNM)
American College of Obstetricians and Gynecologists (ACOG)
American Medical Association (AMA) American Pharmacists Association (APhA)
Council of Medical Specialty Societies (CMSS)
Infectious Diseases Society of America (IDSA)
National Association of Pediatric Nurse Practitioners (NAPNAP)
National Medical Association (NMA)
Pediatric Infectious Diseases Society (PIDS)
Pediatric Pharmacy Association (PPA)
Society for Adolescent Health and Medicine (SAHM)

Beyond the 12 formal endorsers, broader coalitions and statements of support include 230+ organizations (such as regional, specialty, advocacy, and public health groups) that have signed joint statements endorsing the AAP's vaccine recommendations and schedule.

SCMA should be on that list.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

SCMA Policy Statement

Why is the Requested Action important?*

Parents express confusion about vaccine schedules and question recommendations that pediatricians know to be safest for their patients. This is leading to burnout for pediatric

providers and moral injury for pediatricians who understand the importance and science behind the evidence-based vaccine schedule in protecting children and their communities.

Furthermore, HRSA has kept in place its requirements for primary care providers to achieve high rates of completed vaccinations in their practices. These standards have not changed, and are used to determine reimbursement for physicians.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

I will email a copy of the 230 organizations supporting the AAP's schedule. Please look for that.

04.25.26 POLICY PROPOSAL 6

Title: Resolution Supporting An Evidence-Based Immunization Schedule

Full Name*

Henry Griffin Cupstid, MD

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

Yes

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

South Carolina Academy of Family Physicians

Submission / Idea*

The South Carolina Medical Association will resolve to oppose the unilateral January 2026 changes to the CDC immunization schedule and endorse the schedule published by the American Academy of Pediatrics.

Evidence / Support for Proposal*

On January 5, 2026, U.S. Department of Health and Human Services officials directed changes to the CDC immunization schedule without holding a public Advisory Committee on Immunization Practices (ACIP) meeting or consulting with CDC career experts.

These changes reduced routine vaccination recommendations from 17 to 11 diseases and reclassified 6 additional vaccines for high-risk populations or shared clinical decision-making.

These modifications have generated confusion and distrust among healthcare providers and the public, raised concerns about future vaccine coverage and access, and increased the risk of disease outbreaks.

The American Academy of Pediatrics has published a 2026 Recommended Child and Adolescent Immunization Schedule that is based on decades of research, ongoing safety monitoring, and rigorous review by experts with specialized knowledge. This schedule has been endorse by 12 other medical organizations including the AMA, American Academy of

Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the Infectious Disease Society of America (IDSA).

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

The SCMA Board of Trustees will adopt the following Resolution:

NOW, THEREFORE, BE IT RESOLVED, that the South Carolina Medical Association affirms that all changes to immunization recommendations should be evidence-based through a transparent process centered on expert consensus; and

BE IT FURTHER RESOLVED, that the South Carolina Medical Association endorses the 2026 Recommended Child and Adolescent Immunization Schedule published by the American Academy of Pediatrics, and endorsed by the American Medical Association, as the standard for clinical practice; and

BE IT FURTHER RESOLVED, that the South Carolina Medical Association urges state legislators and public health officials to maintain existing school immunization requirements; and

BE IT FURTHER RESOLVED, that the Board of Trustees shall communicate this policy to relevant state and federal officials, member physicians, and the public.

Why is the Requested Action important?*

Vaccine policy decisions, including school immunization requirements, are established by individual states under their inherent public health authority. As the largest physician organization in the state of South Carolina, it is the SCMA's duty to ensure that changes to our state's immunization requirements are based on a transparent process centered on the protection of children, families, and communities from preventable disease.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

AAP 2026 Recommended Child and Adolescent Immunization Schedule
https://downloads.aap.org/AAP/PDF/AAP-Immunization-Schedule.pdf

AMA Statement on Changes to Childhood Vaccine Schedule
https://www.ama-assn.org/press-center/ama-press-releases/ama-statement-changes-childhood-vaccine-schedule

04.25.26 POLICY PROPOSAL 7
Title: Stock Inhaler Programs in SC Schools

Full Name*

Ben Meyer and Andrew Bennett

Designation*

Medical Students

Are you submitting on behalf of a county medical society, specialty society, or other member?*

Yes

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

Medical Student Section

Submission / Idea*

OBJECTIVE: To provide funding at the state level for the procurement and maintenance of stock inhaler programs for every school district in South Carolina.

BACKGROUND: Asthma is a significant health issue in the state of South Carolina; in 2023 it was estimated that 8.8% of South Carolinians had Asthma, including 5.4% of children. This prevalence is also modified by social determinants of health: an asthma diagnosis is more than twice as prevalent in households making <25k/year compared to households making >100k/year at 11.2% and 5.3% respectively, and 12% of people identified as non-hispanic black. Asthma exacerbations can be incredibly disruptive, and even deadly, leading to the death of 64 South Carolinians in 2022, and 18,323 emergency room visits in 2023, costing an estimated $117 millions dollars.

Focusing on school aged children (5-17), research has shown that students with asthma have lower performance and higher rates of absenteeism. During the 2022-2023 period in South Carolina, there were 4,017 emergency room visits associated with asthma exacerbations, at a cost of $13,421,573. 70% of those visits were funded by Medicaid, which paid $9,102,827. Additionally, the majority of these visits happen during the school year due to increased exposure to respiratory pathogens in the fall. States that provide emergency inhalers to students (stock-inhaler programs) have had promising results in combatting this trend, with decreases in 911 calls and EMS transports reported (although underpowered and lacking statistical significance).

In 2023, the state paved the way for such programs: it is now legal for schools to stock & administer certain life-saving medications (currently epinephrine, naloxone, and inhaled albuterol) to students who need them; with immunity from civil and criminal liability outside cases of negligence to those involved in administering the drug. However, despite the legality of such programs, there was no additional funding given to schools after the 2023 act to procure albuterol inhalers and inhalers; meaning that large school systems such as Greenville County Schools have been unable to implement a program.

Existing programs have reported a cost of approximately $114/year per school for supplies and administrative cost, which would total to approx. ~145,000/year for the ~1,281 public schools in South Carolina. That total is roughly 1.6% of the amount of money spent on asthma-related emergency room visits by school-aged children; phrased differently: preventing only 52 asthma-related emergency room visits across the entire state would pay for the implementation of this vital safety net.

Supporting the implementation of a stock inhaler program across South Carolina public schools would help support the health and learning environment for its most vulnerable students.

Evidence / Support for Proposal*

Research has shown that students with asthma have lower performance and higher rates of absenteeism. Asthma prevalence and control are also connected with social determinants of health, including socioeconomic status, health care access, and neighborhood environment. Implementing a stock inhaler program across South Carolina public schools would help support its most vulnerable students.

Programs initiated in other states have had promising results, with decreases in 911 calls and EMS transports reported (underpowered, not stat significant) at an estimated cost of $114 per school for supplies and management (approx. ~$145,000/year for ~1,281 public schools in South Carolina).

Evidence for the benefits of these programs are gradually coming out as more states and counties implement a school-based stock rescue inhaler program. In Pima County, AZ, stock inhalers were used for 1038 unique events across 152 schools over a single year period. 83.9% of students were able to return to class following administration of the medication, and only 6 events resulted in a 911 call. All schools reported a high level of satisfaction with the program, and all schools renewed participation for a second year.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

Enact legislation/set aside money in the state budget expressly to fund these stock inhaler programs at a state level.

Why is the Requested Action important?*

Asthma significantly affects the ability of students to perform in an academic environment and is more prevalent in vulnerable groups. During the 2022-2023 period, there were 4,107 total school-aged (ages 5-17) visits to the Emergency Department in South Carolina. Of that, the state paid for 2,793 visits through Medicaid. This cost Medicaid $9,102,827 with an average charge of $2,818 per visit. At an estimated program cost of $114 per school, this program would pay for itself after only 52 uses. To support the health and safety of students I believe that the SCMA should support this initiative to make sure all students have access to this life saving medication in school.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

Having communicated with the Greenville County School Board & administration it seems unlikely that this would be funded at a county level. Sustainable funding for these programs is essential for their implementation (ie: the school system is worried about what would happen if they implemented it for a year and then lost access to that resource). Similar programs are already being funded at a local-level in the state, including Charleston County and some schools in Rock Hill, according to head nurse for Greenville County School District Janet Lage. A statewide implementation would ensure consistency and broaden impact while improving the health and educational outcomes of children in our state.

04.25.26 POLICY PROPOSAL 8

Title: Increasing Implementation of Hospital Presumptive Eligibility

Full Name*

Morgan Walker

Designation*

Medical Student

Are you submitting on behalf of a county medical society, specialty society, or other member?*

Yes

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

Medical Student Section

Submission / Idea*

South Carolina Emergency Department Medicaid Screening & Presumptive Eligibility Act: a statement of support from SCMA to advocate that all state-licensed hospitals to perform Medicaid eligibility screening and offer Hospital Presumptive Eligibility (HPE) determinations for uninsured ED patients, with reporting, staff training, and quality monitoring to increase coverage, improve timely care, and reduce uncompensated care burdens.

Evidence / Support for Proposal*

1. Presumptive Eligibility (PE) is an established mechanism that allows hospitals to provide immediate, temporary Medicaid coverage while full applications are processed. The federal Medicaid program and model HPE materials document how hospitals can determine PE and why it helps bridge access.
2. State Medicaid rules already include PE procedures. South Carolina's Medicaid Policy & Procedures Manual contains a Presumptive Eligibility chapter, showing a regulatory pathway for hospital screening and HPE use. Requiring hospitals to implement existing rules is feasible.
3. Evidence HPE improves enrollment: large multi-state analyses show that HPE in EDs increases short-term Medicaid enrollment and is associated with higher 6-month enrollment rates for many recipients, supporting the policy's likely effectiveness.

4. EMTALA requires medical screening and stabilization regardless of ability to pay; proactive Medicaid screening does not conflict with EMTALA and can reduce financial barriers and improve follow-up care for discharged ED patients. This policy focuses on access/stabilization measures which align it with federal obligations.
5. Expanding the use of Hospital Presumptive Eligibility may also reduce uncompensated care burdens on hospitals. Many emergency department patients who appear uninsured are actually eligible for Medicaid but not yet enrolled. By requiring hospitals to determine presumptive eligibility and bill Medicaid during the temporary coverage period, hospitals may receive reimbursement for services that would otherwise become uncompensated care, improving financial sustainability while expanding patient access to follow-up care
6. Medicaid enrollment is often hindered by administrative complexity and lack of assistance. Many individuals who qualify for Medicaid remain uninsured because the enrollment process can be difficult to navigate, particularly for patients seeking care during medical emergencies. Research shows that administrative barriers, including complex application procedures, documentation requirements, and lack of enrollment assistance, are a significant reason eligible individuals remain unenrolled. Hospital Presumptive Eligibility programs help address this barrier by allowing trained hospital staff to identify and temporarily enroll eligible patients at the point of care, connecting them to coverage they may otherwise fail to obtain.
7. Policy context in SC: with ongoing state debate over coverage and documented uninsured populations, a state-level intervention to increase coverage via ED screening is timely and could reduce uncompensated care and improve population health.
8. How other states have handled HPE: For example, Oregon requires hospitals to screen certain uninsured patients for presumptive eligibility, while states such as Minnesota and Washington have implemented systems that connect uninsured patients with application counselors who can help complete HPE determinations. These examples demonstrate potential implementation pathways that South Carolina could adapt.
9. Limitations in current PE eligibility categories: Current South Carolina policy restricts PE screening to specific populations (e.g., pregnant women, children under 19, certain parents/caretakers, former foster youth, and specific cancer programs). Expanding HPE screening may require state policy clarification regarding which groups hospitals should screen. However, expanding screening does not expand Medicaid eligibility beyond existing state policy; rather, it increases the identification of patients who already qualify under current eligibility categories but may otherwise leave the emergency department uninsured.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

Draft and pass state legislation (or an SCMA statement of support) that: (1) that encourages state-licensed hospitals to implement ED Medicaid eligibility screening and offer HPE determinations to all uninsured patients who present to the ED; (2) makes screening a pertinent implementation in patient care of uninsured patients; (3) staff training on HPE/eligibility workflows; and (4) establishes de-identified reporting to SC DHHS on HPE use, enrollment conversion rates, and short-term access metrics to enable evaluation. (Currently it is difficult to find SC data on HPE rates/utilization).

Key implementation steps: coordinate with SC DHHS to operationalize eligibility workflows, provide hospitals with model HPE forms and IT integration (leveraging the Medicaid.gov model application), fund initial training/pilot programs for large systems, and set simple reporting metrics and timelines.

Why is the Requested Action important?*

1. Expands coverage and access immediately: HPE gives eligible ED patients immediate temporary coverage so they can access needed care and follow-ups without delay. This reduces clinical risks from missed care after ED discharge.
2. Reduces uncompensated care and financial pressure on hospitals: Increased enrollment reduces bad debt and uncompensated-care costs. Helpful to hospital finances and to safety-net sustainability.
3. Aligns with EMTALA and improves continuity of care: Screening and HPE do not delay emergency stabilization; they facilitate follow-up care and outpatient linkage, improving outcomes and lowering return ED visits.
4. Feasible using existing mechanisms: Federal/state PE frameworks already exist (Medicaid State Plan options and model hospital PE applications); SC DHHS can operationalize and require implementation via licensing or rule making.
5. Improves care continuity and reduces repeat ED visits: Patients with insurance coverage are more likely to access outpatient follow-up care, improving outcomes and potentially lowering healthcare costs.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

This policy is within SCMA interests: it improves access for uninsured patients, reduces clinically harmful delays in follow-up care, protects hospital financial stability (preserving local access), and gives clinicians better tools to coordinate post-ED care. SCMA can credibly champion the policy to legislators and DHHS as a clinician-driven, evidence-based, non-ideological solution to decrease uninsured rates and improve outcomes.

An additional patient protection detail is to guarantee no collection of immigration status beyond what federal Medicaid rules require for eligibility, require language access, and forbid eligibility screening from being used to deny or delay emergency care.

04.25.26 POLICY PROPOSAL 9

Title: Closing the Health Literacy Gap: A Physician-Led Approach to Patient Communication in South Carolina. Submitted by the South Carolina Oncology Society (SCOS), in collaboration with Oncology101.org, a physician-led health literacy initiative.

Full Name*

Joanna Metzner-Sadurski

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

Yes

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

SCOS

Submission / Idea*

On behalf of the South Carolina Oncology Society (SCOS), we propose that the South Carolina Medical Association (SCMA) adopt policy supporting initiatives that strengthen health literacy and patient communication across healthcare systems. Physician-led platforms such as Oncology101.org provide real-world evidence that this approach is feasible in community oncology and can be adapted and scaled across diverse clinical settings.

Health literacy is essential to safe, effective, and equitable care. According to the South Carolina Institute of Medicine & Public Health (2024), South Carolina has one of the highest rates of functional illiteracy in the nation, disproportionately affecting rural communities. Nationally, nearly half of adults struggle to understand basic health information. As a result, patients are at risk of misunderstanding diagnoses, medications, and treatment plans, leading to medication errors, poor adherence, increased emergency department utilization, and higher hospital readmission rates.

These challenges are particularly evident in oncology and other complex medical fields, where patients must make critical decisions while processing large amounts of unfamiliar

and often overwhelming information. Short clinical encounters and highly technical medical language further limit patient understanding.

Social determinants of health including: geographic barriers, limited access to specialists, transportation challenges, and digital access, compound these issues, particularly in rural communities. These barriers contribute to disparities in care and poorer outcomes.

Physicians are uniquely positioned to address these challenges by delivering clear, accessible, and patient-centered communication tailored to individual patient needs. Evidence-based communication strategies—including plain-language materials, visual aids, and short educational videos—have been shown to significantly improve patient understanding, confidence, and adherence.

Emerging digital tools now allow patients and families to review structured educational content outside of clinical visits, reinforcing understanding and supporting shared decision-making. Early physician-led initiatives, including those developed within South Carolina, demonstrate the feasibility and impact of scalable patient education models.

Strengthening patient communication and health literacy should be recognized as a core component of healthcare quality, patient safety, and system efficiency.

Evidence / Support for Proposal*

1. Prevalence of Limited Health Literacy
   The U.S. Department of Health and Human Services reports that nearly half of American adults have difficulty understanding and using basic health information needed to make appropriate healthcare decisions. In South Carolina, functional illiteracy rates are among the highest in the nation, disproportionately affecting rural populations (South Carolina Institute of Medicine & Public Health, 2024).

2. Impact on Healthcare Outcomes Limited health literacy is strongly associated with poorer clinical outcomes, including:
   - Increased emergency department utilization
   - Higher hospital readmission rates
   - Medication errors
   - Poor adherence to treatment plans
   - Increased overall healthcare costs

   Patients with low health literacy are more likely to misunderstand discharge instructions and medication regimens, contributing to preventable complications.

3. Communication as a System-Level Issue
   Evidence demonstrates that communication gaps are often due to how healthcare information is delivered rather than patient limitations. Studies show that when information is presented using plain language and structured formats, patient comprehension significantly improves.

4. Effectiveness of Evidence-Based Education Tools Research supports the use of:
   - Plain-language written materials
   - Visual aids and diagrams
   - Short, structured video-based education
   - Digital platforms accessible outside clinical visits

   These tools improve patient understanding, confidence, engagement, and adherence to treatment.

5. Rural Healthcare Disparities
   Rural populations face additional barriers, including limited access to specialists, transportation challenges, and fewer educational resources. Health literacy interventions that are scalable and accessible outside the clinic are particularly effective in addressing these disparities.

6. Alignment with National Priorities
   Improving health literacy aligns with national quality and safety priorities, including reducing readmissions, improving patient engagement, and advancing health equity. Organizations such as the CDC, NIH, and AHRQ recognize health literacy as a key driver of improved healthcare outcomes.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

The South Carolina Medical Association should adopt a policy supporting the following actions:

- Encourage healthcare institutions to adopt plain-language standards for patient-facing medical information
- Support implementation of structured patient education tools, including visual aids, short educational videos, and digital patient education platforms that allow patients and families to review information outside the clinical visit
- Encourage the development of training programs for healthcare professionals focused on patient-centered communication and health literacy principles

- Support pilot programs in rural healthcare systems to implement scalable patient education platforms
- Encourage evaluation of outcomes, including patient understanding, treatment adherence, patient satisfaction, emergency department utilization, and hospital readmissions associated with communication gaps
- Advocate for initiatives that support physician-led innovation in patient education and communication

Why is the Requested Action important?*
Enhancing patient understanding is one of the most effective strategies to improve healthcare outcomes, reduce preventable complications, and lower healthcare costs. Patients who clearly understand their diagnosis and treatment plan are more likely to adhere to therapy, recognize early warning signs of complications, and actively participate in their care. In contrast, poor communication contributes to medication errors, avoidable emergency department visits, and preventable hospitalizations. Strengthening health literacy is particularly important in South Carolina, where rural communities face significant challenges accessing healthcare. Improving communication systems across healthcare settings would help:

- Improve patient safety
- Reduce hospital readmissions
- Reduce avoidable emergency department utilization
- Improve chronic disease management
- Strengthen rural healthcare delivery

Health literacy, therefore, is not simply a patient education initiative. It is a complex, multifactorial issue that must be addressed to improve healthcare quality, patient safety, and health equity.

SCMA is uniquely positioned to lead this effort; by supporting physician-driven health literacy initiatives, the Association can advance patient safety, reduce healthcare disparities, and affirm the essential role of physicians as educators and advocates in South Carolina's healthcare system.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

This proposal reflects a physician-led initiative grounded in real-world clinical experience. Physicians are on the front lines of patient communication and uniquely understand the challenges patients face when navigating complex medical information. As such, physician

leadership is essential to designing, implementing, and evaluating effective health literacy solutions that are practical, scalable, and directly aligned with patient needs.

04.25.26 POLICY PROPOSAL 10

Title: Bridging the Dermatology Care Gap: Reimbursement Reform for Medicaid Patients

Full Name*

Alison Renner

Designation*

Physician

Are you submitting on behalf of a county medical society, specialty society, or other member?*

No

If YES, please indicate the name of the county medical society, specialty society, or other member(s) for which you represent.

N/A

Submission / Idea*

To increase availability of dermatology services for medicaid patients by advocating for improved reimbursement rates for dermatology services and dermatological procedures.

Evidence / Support for Proposal*

In 2019, acceptance of new Medicaid patients by dermatologists nationwide was 29.6%, compared with Medicare (93.2%) and private insurance (97.2%) (Coates, 2021). The access for dermatologic care is significantly lower for medicaid patients compared to patients with medicare and private insurance. Some reports indicate that only 17% of Medicaid patients successfully obtain appointments for dermatology care, resulting in delayed treatment and poorer health outcomes (Nicholas et al., 2025). This lack of access to dermatologic specialists contributes to significant disparities in the early detection and management of skin diseases, underscoring the need for greater participation of dermatologists in Medicaid to reduce the burden of dermatologic disease among underserved populations.

As of now, there are not any dermatologists in Spartanburg county who see Medicaid patients thus patients have to see a specialist 40 minutes to an hour away, and these are only two specialists who are serving Medicaid patients for the entire upstate, including Anderson, Greenville, and Spartanburg counties.

Requested Action: What action is required to achieve this idea?
*(i.e. Enact legislation, have a state agency review an issue, enact an SCMA policy statement on a topic, or other action?)**

SCMA policy statement, as well as working with state Medicaid agencies to ensure pay parity for reimbursement. We're also working to establish systems to increase services for primary care physicians to telederm or other services that might help to bridge the gap between Medicaid patients and dermatology.

Why is the Requested Action important?*

Helps to maintain independent practice of groups as well since Medicaid with larger systems do you have to pay rates comparable to private insurance? This allows for increased availability of these services will also still allowing physicians to maintain independence and practice with pay parity. This could certainly be widened in its breath to apply to any specialty, but we particularly notice the decreased access to dermatologist services when it comes to this concept.

If there are additional details not addressed above that you would like to share, please provide them here.
(If you feel that the above information is sufficient, you may skip.)

N/A