AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
(312) 464-5000

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2024 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations Key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
1	.CON	CCB 03 – AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)	The Council on Constitution and Bylaws recommends that the following recommendations be adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed. 1) That our AMA Bylaws be amended by insertion to add the following provisions. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting: 3. Officers 3.6 Vacancies. 3.6.4 Absences. If an officer misses 6 consecutive regular meetings of the Board, this matter shall be reported to the House of Delegates by the Board of Trustees and the office shall be considered vacant. The vacancy shall be filled as provided in Bylaw 3.6.1 or Bylaw 3.6.3.	Delegate instructed to refer.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			3.6.5 Removal for Cause. Any officer may be removed for cause in accordance with procedures established by the House of Delegates. 6. Councils 6.0.1.4 Removal. A Council member may be removed for cause in accordance with procedures approved by the House of Delegates. 7. Sections 7.0.3.4 Removal. A Governing Council member may be removed for cause in accordance with procedures approved by the House of Delegates. (Modify Bylaws) 2) That the Councils on Constitution and Bylaws, Long Range Planning and Development and the Ethical and Judicial Affairs and the House develop the procedures to remove a trustee, council member or governing council member for cause. (Directive to Take Action) 3) That the Election Committee address the need for policy to remove candidates who are found to violate AMA policy G-610.090, AMA Election Rules and Guiding Principles. (Directive to Take Action)	
2	.CON	CEJA 03 – Establishing Ethical Principles for Physicians Involved in Private Equity	In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, “Contracts to Deliver Health Care Services,” be amended by addition and deletion as follows and the remainder of this report be filed: Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires them to that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and	Delegate instructed to support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			conditions of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards of informed consent and fidelity to patients and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients. As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while many some arrangements have the potential to promote desired improvements in care, some other arrangements also have the potential to impede put patients' interests at risk and to interfere with physician autonomy. When contracting partnering with entities, or having a representative do so on their behalf, to provide health care services, physicians should: (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, or have a representative do so on their behalf to assure themselves that the arrangement: (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;	

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk; (iii) allows ensures the physician can to appropriately exercise professional judgment; (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients; (v) is transparent and permits disclosure to patients. (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing. (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards. When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians must: (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism. (d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment. (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues. (Modify HOD/CEJA Policy)	

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
3	.CON	Res. 001 – Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout (Integrated Physician Practice Section)	RESOLVED, that our American Medical Association monitor and report on the research regarding technology, measures, and effective use of personal and biological data which supports professional workforce wellbeing and mitigates burnout (Directive to Take Action); RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of personal and biological data for the professional workforce (Directive to Take Action)	Delegate instructed to support.
4	.CON	Res. 008 – Consolidated Health Care Market (Barbara L. McAneny, MD)	RESOLVED, that our American Medical Association investigate the possibility of filing a class action lawsuit against Optum, United Health Group and Change Health to recoup the damages from the disruption caused by the breach, and to distribute the unfair enrichment profits made by Optum et al to the practices whose retained payments allowed them to generate interest and investment profits (Directive to Take Action) RESOLVED, that our AMA investigate the acquisition of practices by Optum in the aftermath of the breach and determine if the independence of those practices can be resurrected, and if not, if damages are due to the physician owners of the acquired practices. (Directive to Take Action)	Delegate instructed to refer.
5	.CON	Res. 012 – Ethical Procedures that Protect Insured Patients (Mississippi)	RESOLVED, that our American Medical Association advocate for policies that limit the cost of a medication to an insured patient with medication coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer's free discount card (such as GoodRx) (Directive to Take Action) RESOLVED, that our AMA write a letter to lawmakers and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients. (Directive to Take Action)	Delegate instructed to listen.

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
6	A	CMS 02 – Improving Affordability of Employment-Based Health Coverage	The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition and deletion to read: Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the ~~level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage~~ maximum percentage of income they would be required to pay towards premiums after accounting for subsidies ~~in~~ for an Affordable Care Act (ACA) marketplaces benchmark plan. (Modify HOD Policy) 2. That our AMA amend Policy H-165.843 by addition and deletion to read: Our AMA encourages employers to: a) promote greater individual choice and ownership of plans; b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria; c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance; ~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs; ~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices; ~~d~~f) support increased fairness and uniformity in the health insurance market; and ~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)	Delegate instructed to Refer.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			3. That our AMA support efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards, like those required of nongroup marketplace plans. (New HOD Policy) 4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it, and other principles related to health insurance. (Reaffirm HOD Policy)	
7	A	CMS 08 – Sustainable Payment for Community Practices	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed: 1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid. (New HOD Policy) 2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows: Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990 Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, the value of the care provided, and includes an inflation-based update; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee s~~Schedule. (Modify Current HOD Policy) 3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows: Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976 1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~ Children's Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds. 2. Our AMA affirms its commitment to advocating for ~~reasonable S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, ~~reimbursement for its medical providers, defined as at minimum~~ and is no less than 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy) 4. That our AMA amend Policy H-385.921 by addition and deletion as follows: Health Care Access for Medicaid Patients H-385.921 It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice, the value of the care provided, and include inflation-based updates, and is no less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable. (Modify Current HOD Policy) 5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)	

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			6. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians. (Reaffirm HOD Policy) 8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy)	
8	A	Res. 103 – Medicare Advantage Plans (Oklahoma)	RESOLVED, that our American Medical Association urge the United States Congress and Centers for Medicare and Medicaid Services to take steps ~~to end the upcoding for Medicare Advantage plans that results in high subsidies which are unfair to traditional Medicare and burdensome to the public treasury and many beneficiaries~~ to reform the Medicare Advantage payment system to end the inappropriate upcoding by some Medicare Advantage plans (New HOD Policy). RESOLVED, that our AMA encourages Congress and the Centers for Medicare and Medicaid Services to improve the attractiveness of traditional Medicare so that the option remains robust ~~and available giving beneficiaries greater traditional choices for this option and to seek better care for themselves~~ including physician payment rates to protect patient access to care, and ensure that both traditional Medicare and Medicare Advantage are appropriately funded and viable to ensure choice of providers and access to care for all Medicare beneficiaries (New HOD Policy).	Delegate instructed to suppose amendments proposed by California.
9	A	Res. 111 – Protections for	RESOLVED, that our American Medical Association pursue all necessary legislative and administrative measures to ensure that Medicare beneficiaries have the freedom	Delegate instructed to refer.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
		"Guarantee Issue" of Medigap Insurance and Traditional Medicare (Ohio)	to switch back to Traditional Medicare and obtain Medigap insurance under federal "guaranteed issue" protections. (Directive to Take Action)	
10	B	BOT 13 – Prohibiting Covenants Not-To-Compete	The Board of Trustees recommends that the following policy be adopted, and the remainder of the report be filed: 1. That the American Medical Association (AMA) continue to assist interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA's state restrictive covenant legislative template. (New HOD Policy)	Delegate instructed to support.
11	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 1 of 4	The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23 and that the remainder of the report be filed: AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE General Governance • Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent. • Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration. • Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient. • Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in	See IPPS Report B.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			Health Care H-480.939 at (1)] • Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. • Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow. • Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]	
12	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 2 of 4	When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies • When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request. • When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record. • AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review. • When health care content is generated by generative AI, including by large language models, it should be clearly disclosed within the content that was generated by an AI-enabled technology. • When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set	See IPPS Report B.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			coverage limitations, use of those systems or programs must be disclosed to impacted parties. • The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology.	
13	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 3 of 4	• When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization: -Regulatory approval status -Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology -Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use -Intended population and intended practice setting -Clear description of any limitations or risks for use, including possible disparate impact -Description of how impacted populations were engaged during the AI lifecycle -Detailed information regarding data used to train the model: •Data provenance •Data size and completeness •Data timeframes •Data diversity •Data labeling accuracy -Validation Data/Information and evidence of: •Clinical expert validation in intended population and practice setting and intended clinical outcomes •Constraint to evidence-based outcomes and mitigation of “hallucination” or other output error •Algorithmic validation •External validation processes for ongoing evaluation of the model	See IPPS Report B.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			performance, e.g., accounting for AI model drift and degradation •Comprehensiveness of data and steps taken to mitigate biased outcomes •Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings •Post-market surveillance activities aimed at ensuring continued safety, performance, and equity -Data Use Policy •Privacy •Security •Special considerations for protected populations or groups put at increased risk -Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training -Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review	
14	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 4 of 4	• Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]	See IPPS Report B.
15	B	Res. 202 – Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims	RESOLVED, that our American Medical Association adopt as policy that Commercial third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health plans ensure they are making medical necessity determinations based on the circumstances of the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that does not account for an individual's circumstances (New HOD Policy) RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity determination must be reviewed by a physician in the same specialty or by	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
		(American Association of Clinical Urologists)	another appropriate health care professional for non-physician health care providers. (New HOD Policy)	
16	B	Res. 207 – Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse (Medical Student Section)	~~RESOLVED, that our American Medical Association support economic incentives to increase physician use of less expensive biosimilars instead of their reference biologics (New HOD Policy); and be it further~~ RESOLVED, that our ~~AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DoJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake~~ American Medical Association educate physicians about prescribing biosimilars as there is no clinically meaningful difference compared to its reference biologic and can promote affordability for individual patients and the health care system (New HOD Policy).	Delegate instructed to support proposed amendments from California.
17	B	Res. 210 – Support for Physicians Pursuing Collective Bargaining and Unionization (Oregon, American College of Physicians)	RESOLVED, that our American Medical Association convenes an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)	Delegate instructed to listen.
18	B	Res. 213 – Access to Covered Benefits with an Out of Network Ordering Physician (Private Practice Physician Section)	RESOLVED, that our American Medical Association develop model legislation to protect patients in direct primary care plans and non-network plans thus furthering the ability of direct primary care physicians and other out-of-network physicians to provide covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, even if it is an HMO or point of service plan (Directive to Take Action) RESOLVED, that our AMA develop resources, tool kits, education, and internal	Delegate instructed to refer.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			experts to support direct primary care and other out-of-network models. (Directive to Take Action)	
19	B	Res. 221 – Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability (California)	RESOLVED, that our American Medical Association support the creation of a new reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug, and 2) Ensures adequate compensation for the cost of acquisition, inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price (New HOD Policy) RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. (New HOD Policy)	Delegate instructed to listen.
20	B	Res. 227 – Medicare Reimbursement for Telemedicine (Missouri)	RESOLVED, that our American Medical Association ~~support~~ advocate removal of the December 31, 2024 “sunset” date currently set for Medicare to cease reimbursement for services provided via telemedicine, such that reimbursement of medical services provided by telemedicine be continued indefinitely into the future, consistent with what would be determined by the Relative Value Update Committee (“RUC”). (New HOD Policy)	Delegate instructed to amend as indicated.
21	B	Res. 232 – Medicare Advantage Part B Drug Coverage (Association for Clinical Oncology, American College of Rheumatology)	RESOLVED, that our American Medical Association will advocate with Congress, through the appropriate oversight committees, and with the Centers for Medicare & Medicaid Services (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay (Directive to Take Action)	Delegate instructed to listen.

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
22	B	Res. 235 – Establish a Cyber-Security Relief Fund (New Jersey)	RESOLVED, that our American Medical Association, through appropriate channels, advocate for a 'Cyber Security Relief Fund" to be established by Congress (Directive to Take Action) RESOLVED, that the "Cyber Security Relief Fund" be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer (Directive to Take Action) RESOLVED, that the "Cyber Security Relief Fund" only be utilized for 'uninterrupted' payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. (Directive to Take Action)	Delegate instructed to refer.
23	B	Res. 246 – Augmented Intelligence in Health Care (Texas)	RESOLVED, that our American Medical Association amend its augmented intelligence policy to align with the following: Augmented Intelligence in Health Care The American Medical Association supports the use of augmented intelligence (AI) when used appropriately to support physician decision-making, enhance patient care, improve administrative functions, and improve public health without reducing the importance of physician decision-making. Augmented intelligence also should be used in ways that reduce physician burden and increase professional satisfaction. Sufficient safeguards should be in place to assign appropriate liability inherent in augmented intelligence to the software developers and not to those with no control over the software content and integrity, such as physicians and other users. Ultimately, it is the physician's responsibility to uphold the standard of care. The American Medical Association adopts the following principles for augmented intelligence in health care: 1. Augmented intelligence should be the preferred health care term over artificial intelligence as it should be used to augment care by providing information for consideration. Augmented intelligence, whether assistive or fully autonomous, is	TBD

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			intended to co-exist with human decision-making and should not be used to replace physician reasoning and knowledge. 2. Physicians should not be mandated to use augmented intelligence without having input or feedback into how the tool is used either individually or as a medical staff. 3. Augmented intelligence must not replace or diminish the patient-physician relationship. 4. Algorithms developed to augment user intelligence must be designed for the benefit, safety, and privacy of the patient. The AMA should research opportunities to place practicing physicians on public and private panels, work groups, and committees that will evaluate products as they are developed. 5. Sellers and distributors of augmented intelligence should disclose that it has met all state and federal legal and regulatory compliance with regulations such as, but not limited to, those of HIPAA, the U.S. Department of Health and Human Services, and the U.S. Food and Drug Administration. 6. Use of augmented intelligence, machine learning, and clinical decision support has inherent known risks. These risks should be recognized, and legal and ethical responsibility for the use and output of these products must be assumed by, including but not limited to, developers, distributors, and users with each entity owning responsibility for its respective role in the development, dissemination, implementation, and use of products used in clinical care. 7. Users should have clear guidelines for how and where to report any identified anomalies. Additionally, as with all technology, there should be a national database for reporting errors that holds developers accountable for correcting identified issues. 8. Before using augmented intelligence, physicians and all users should receive adequate training and have educational materials available for reference, especially in instances where the technology is not intuitive and there are periods of nonuse. 9. Physicians should inquire about whether the AI used is a “continuously learning system” versus a “locked system.” A locked system is more appropriate for clinical care, although a hybrid system may be appropriate as long as the clinical output is based on locked training sets. A locked system gives a predictable output, whereas a continuous learning system will change over time. 10. Algorithms and other information used to derive the information presented as augmented intelligence to physicians and other clinicians should:	

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			a. Be developed transparently in a way that is accessible, explainable, and understandable to clinicians and patients and details the benefits and limitations of the clinical decision support, and/or augmented intelligence; b. Have reproducible and explainable outputs; c. Function in a way that promotes health equities while eliminating potential biases that exacerbate health disparities; d. Use best practices for user-centered design that allows for efficient and satisfactory use of the technology; e. Safeguard patient information by employing privacy and security standards that comply with HIPAA and state privacy regulations; f. Have a feedback loop that allows users who identify potential safety hazards to easily report problems and malfunctions as well as opportunities to report methods for improvements; and g. Contain a level of compatibility to allow use of information between hardware and software made by different manufacturers. 11. Medical students and residents need to learn about the opportunities and limitations of augmented intelligence as they are prepared for future medical practice. 12. The AMA will advocate, through legislation or regulation, for payment to physicians for utilization of artificial intelligence tools that have additional cost or require additional time. 13. Recognizing the rapid pace of change in augmented intelligence, it is important to 37 continually assess and update the AMA's principles at regular intervals. (Modify Current HOD Policy)	
24	D	Res. 401 – Addressing Social Determinants of Health Through Closed Loop Referral Systems (Integrated Physician Practice Section)	RESOLVED, that our American Medical Association study the effectiveness and best practices of closed loop referral systems in addressing social determinants of health. (Directive to Take Action)	Delegate instructed to support.

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
25	D	Res. 414 – Addressing the Health Sector's Contributions to the Climate Crisis (California)	RESOLVED, that our American Medical Association recognizes that clinical quality and safety should not be sacrificed as strategies for reducing greenhouse gasses and waste (New HOD Policy); RESOLVED, that our AMA recognizes that animal-based agriculture is a significant contributor to greenhouse gas emissions and supports efforts to increase and promote plant-based menu options in hospital food services, for both health and environmental reasons (New HOD Policy); RESOLVED, that our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions (New HOD Policy); RESOLVED, that our AMA opposes corporate "greenwashing," or the act of making misleading statements about the environmental benefits of products and/or services (New HOD Policy); RESOLVED, that our AMA supports the development of locally managed and reliable electrical microgrids that operate independently from the larger electrical grid for hospitals and other health care facilities to use as a way to reduce reliance on diesel generation for back-up services while maintaining critical care functions during emergencies and supports grants being provided to independent practices to facilitate this development (New HOD Policy); RESOLVED, that our AMA supports the use of virtual health care, where appropriate, with reasonable reimbursement, as a strategy to reduce the carbon footprint of health care (New HOD Policy); RESOLVED, that our AMA support financial assistance for health care entities, including community health centers, clinics, rural health centers, small- and medium-sized physician practices, transitioning to environmentally sustainable operations (New HOD Policy);	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			RESOLVED, that our AMA support the development of concise clinical guidelines and patient education materials to assist physician practices and patients to reduce adverse organizational and personal impacts on climate change. (New HOD Policy)	
26	D	Res. 415 – Building Environmental Resiliency in Health Systems and Physician Practices (California)	RESOLVED, that our American Medical Association support a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change (New HOD Policy) RESOLVED, that our AMA encourage health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities (New HOD Policy) RESOLVED, that our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity. (New HOD Policy)	Delegate instructed to listen.
27	E	CSAPH 05 – Biosimilar/ Interchangeable Terminology	The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed: 1. That Policy H-125.976, “Biosimilar Interchangeability Pathway” be rescinded. (Rescind HOD Policy) 2. That our AMA encourage the FDA to continually collect data and critically evaluate biosimilar utilization including the appropriateness of the term “interchangeable” in regulatory activities. (Directive to Take Action) 3. That Policy D-125.989 “Substitution of Biosimilar Medicines and Related Medical Products” be amended by addition and deletion to read as follows: Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of ~~an interchangeable~~ a biologic or biosimilar product; (3) ~~limit the authority of pharmacists to automatically substitute only~~	Delegate instructed to strongly support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
			~~those biosimilar products that are deemed interchangeable by the FDA.~~ in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product. (Modify Current HOD Policy) 4. That Policy D-125.987, "Biosimilar Product Naming and Labeling" be reaffirmed. (Reaffirm HOD Policy)	
28	E	Res. 504 – FDA Regulation of Biosimilars (California)	RESOLVED, that our American Medical Association recognize that, by definition, Biosimilar medications are clinically equivalent to their reference Biologic and therefore do not need a designation of "interchangeability;" (New HOD Policy) RESOLVED, that our AMA support a rigorous approval process for Biosimilar medications and oppose the application of the redundant designation of "interchangeability" with the reference biologic drug (New HOD Policy) RESOLVED, that AMA support the development of a model and a process for biologic and biosimilar medication prescribing that protects physician decision-making when a pharmacy-level substitution is not clinically appropriate (New HOD Policy) RESOLVED, that our AMA support physician education on the clinical equivalence of Biosimilars, the FDA approval process and the post-market surveillance that is required. (New HOD Policy)	Delegate instructed to support.
29	F	CLRPD 01 – Establishment of a LGBTQ+ Section	The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That our American Medical Association transition the Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) Issues to the LGBTQ+ Section as a delineated section. (Directive to Take Action) 2. That our AMA develop bylaw language to recognize the LGBTQ+ Section. (Directive to Take Action)	Delegate instructed to support.

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
30	F	Speakers' 01 – Report of the Resolution Modernization Task Force Update	The Resolution Modification Task Force recommends that the following be adopted to be implemented for Interim 2024 and the remainder of the report be filed: 1. The bylaws be amended so that the resolution submission deadline be 45 days prior to the opening session of the House of Delegates. (Directive to take Action) 2. The bylaws be amended so that the definition of a late resolution shall be all resolutions submitted after the resolution submission deadline and prior to the beginning of the Opening Session of the House of Delegates. (Directive to take Action) 3. The bylaws be amended so that the definition of an emergency resolution shall be all resolutions submitted after the beginning of the Opening Session of the House of Delegates. (Directive to take Action) 4. The bylaws be amended so that the term of committees of the House of Delegates shall commence upon their formation and shall conclude at the end of the meeting for which they were appointed, unless otherwise directed by the House of Delegates. (Directive to take Action) 5. That our AMA will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days. This shall be accomplished in lieu of Policy G-600.045. (New HOD Policy) 6. Prior to House of Delegates meetings, reference committees will convene after the close of the Online Reference Committee Hearings to develop a Preliminary Reference Committee Report. These reports shall include preliminary recommendations and will serve as the agenda for the in-person reference committee hearing. This shall be accomplished in lieu of Policy G-600.060(8). (New HOD Policy) 7. That Policy D-600.956 be rescinded. (Rescind HOD Policy)	Delegate instructed to listen.
31	G	Res. 703 – Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning	RESOLVED, that our American Medical Association advocates for transparency, accountability, and fair pricing practices in pharmaceutical pricing, opposing differential pricing of medications manufactured by the same company with the same active ingredient, without clear clinical necessity (Directive to Take Action) RESOLVED, that our AMA condemns interference with a physician's ability to	Delegate instructed to listen, oppose Resolve 2.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
		Pharmaceutical Price Manipulation (Resident and Fellow Section)	prescribe one medication over another with the same active ingredient, without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices. (New HOD Policy)	
32	G	Res. 710 – The Regulation of Private Equity in the Healthcare Sector (American College of Emergency Physicians)	RESOLVED, that our American Medical Association propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy in clinical care is preserved and protected (Directive to Take Action) RESOLVED, that our AMA modify policy H-215.981, Corporate Practice of Medicine, by addition: 4. Our AMA will work with the federal government and other interested parties to develop and advocate for regulations pertaining to the use of private equity in the healthcare sector such that physician autonomy in clinical care is preserved and protected. (Modify Current HOD Policy)	Delegate instructed to listen.
33	G	Res. 711 – Insurer Accountability When Prior Authorization Harms Patients (Ohio)	RESOLVED, that our American Medical Association advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts. (Directive to Take Action)	Delegate instructed to listen.

END