DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee G

Christine Kim, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 19 – Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2015 House Policies
3. Council on Medical Service Report 4 – Requiring Payment for Physician Signatures
4. Council on Medical Service Report 7 – Impact of Patient Non-Adherence on Quality Scores
5. Resolution 708 – Advocating Against Prior Authorization for In-Person Visits with Physicians
6. Resolution 709 – Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients
7. Resolution 712 – Billing and Collections Transparency
8. Resolution 717 – Promoting Medication Continuity and Reducing Prior Authorization Burdens
9. Resolution 719 – Comprehensive AMA Policy Publication Regarding Employed Physicians

RECOMMENDED FOR ADOPTION AS AMENDED

10. Board of Trustees Report 6 – Transparency and Accountability of Hospitals and Hospital Systems
11. Council on Medical Service Report 3 – Regulation of Corporate Investment in the Health Care Sector
12. Resolution 702 – Strengthening Health Plan Accountability for Physician Satisfaction
13. Resolution 703 – Appropriate Use of Data from Surgical Practices
14. Resolution 706 – Increasing Transparency Surrounding Medicare Advantage Plans
15. Resolution 707 – Simplifying Correspondence from Health Insurers
16. Resolution 714 – Root Cause Analysis of the Causes of the Decline of Private Medical Practice

17. Resolution 715 – Grace Period for Timely Filing Due to Technology Failures Regardless of Cause
18. Resolution 716 – Minimum Payer Communication Quality Standards

RECOMMENDED FOR REFERRAL

19. Resolution 701 – Electronic Health Records Contract Termination
20. Resolution 704 – Mitigating the Impact of Excessive Prior Authorization Processes
21. Resolution 710 – Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible
22. Resolution 711 – Study of Practice Models for Physicians Working Across State Lines

RECOMMENDED FOR REFERRAL FOR DECISION

23. Resolution 718 – Safeguarding Medical Staff Bylaws and Accreditation Standards in VA Facilities

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

24. Resolution 705 – Elimination of Transaction Fees for Electronic Healthcare Payments
25. Resolution 713 – Aiding Members of Medical Staffs

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 19 – USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 19 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 19 adopted and the remainder of the report filed.

The Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded having been accomplished by this report and that the remainder of the report be filed.

Your Reference Committee heard unanimously supportive testimony on Board of Trustees Report 19, including from the sponsors of the resolution that prompted this report. Thus, your Reference Committee recommends that the recommendation in Board of Trustees Report 19 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

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

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 1. Therefore, your Reference Committee recommends that the recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - REQUIRING PAYMENT FOR PHYSICIAN SIGNATURES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-24 and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for fair payment of CPT codes that accurately describe the myriad of administrative tasks performed by physicians, which can include the prior authorization process, appeals, or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. (New HOD Policy)

2. That our AMA amend Policy D-320.978 by deletion as follows:

1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
~~4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:~~
~~a. the prior authorization process.~~
~~b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials~~. (Modify HOD Policy)

Your Reference Committee heard mostly supportive testimony on Council on Medical Service Report 4. Two delegations and an individual expressed support for the report's recommendations, citing the importance of the broader language offered in Recommendation 1. An individual and a delegation proffered opposing amendments regarding the phrase "established and future CPT codes" in Policy D-320.978. The individual recommended retaining it to ensure that support would not be inadvertently withdrawn for CPT codes dedicated to prior authorization, while the delegation recommended that sections 4a and 4b be reinstated with the specific exception of that phrase, to reflect the intent of the resolution more accurately. No additional testimony was offered in support of either amendment. One delegation testified against the report, citing that advocacy addressing administrative burden would be a better focus than pursuit of additional CPT codes, especially given budget neutrality limitations. Your Reference

Committee believes the recommendations of the report address the concerns of the delegation. With minimal support for the amendments and support for the report's original recommendations, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 7 - IMPACT OF PATIENT NON-ADHERENCE ON QUALITY SCORES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted and the remainder of the report filed.

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

1) That our American Medical Association (AMA) support the removal of physician outcome scores that are unfairly tied to patient non-adherence. (New HOD Policy)

2) That our AMA support the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. (New HOD Policy)

3) That our AMA support additional research to understand the intricacies of non-adherence and potential models/strategies to improve adherence. (New HOD Policy)

4) That our AMA amend Policy D-450.958, "Pain Medicine," by addition and deletion, including a change in title:

PAIN MEDICINE AND PATIENT ADHERENCE IN QUALITY CARE ASSESSMENT, D-450.958
Our AMA: (1) ~~continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2)~~ continues to advocate that the Centers for Medicare & Medicaid Services ~~CMS~~ not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems ~~CAHPS~~ Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys; and (2) ~~(3)~~ encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. (Revise HOD Policy)

5) That our AMA reaffirm Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance. (Reaffirm HOD Policy)

6) That our AMA reaffirm Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA and state medical societies to be involved in the assessment, as well as the development and implementation, of quality measures. (Reaffirm HOD Policy)

7) That our AMA reaffirm Policy H-390.837, which encourages the Centers for Medicare & Medicaid Services (CMS) to revise the Merit-Based Incentive Payment System to a simplified quality and payment system, asks the AMA to advocate for appropriate scoring adjustments for physicians treating high risk beneficiaries in the Medicare Access and CHIP Reauthorization Act (MACRA) program, and urges CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients. (Reaffirm HOD Policy)

8) Rescind Policy D-450.950, as having been completed with this report. (Rescind HOD Policy)

Your Reference Committee heard unanimously supportive testimony on Council on Medical Service Report 7. Testimony indicated that the report appropriately addressed the concerns outlined in the original resolution and balanced the physician's role in adherence with actions that are not under physician control. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

(5) RESOLUTION 708 - ADVOCATING AGAINST PRIOR AUTHORIZATION FOR IN-PERSON VISITS WITH PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 708 be adopted.

HOD ACTION: Resolution 708 adopted.

RESOLVED, that our American Medical Association advocate against health insurance plan policies that require prior authorization for in-person visits with a physician. (Directive to Take Action)

Testimony on Resolution 708 was overwhelmingly supportive. Testimony supporting the resolution was received from one individual and four delegations, and one delegation submitted a clarification request. The delegation that submitted the clarification request asked for additional information regarding whether this resolution is specific to any procedures, evaluation types, follow-up, and/or office visits, or if this resolution is requesting that prior authorization be removed from any in-person office visit. In addition, this delegation also inquired if there are scenarios where an insurance company requires a patient to meet with a non-physician provider prior to being able to meet with a physician. Support for Resolution 708 was clear, and although your Reference Committee believes

answers to the posed clarifying questions would assist future AMA efforts in implementing this resolution, it is recommended that Resolution 708 be adopted.

(6) RESOLUTION 709 - ALLOWING TIMELY ACCESS TO PAIN MEDICATIONS IN DISCHARGED HOSPITAL AND AMBULATORY SURGERY PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 709 be adopted.

HOD ACTION: Resolution 709 adopted.

RESOLVED, that our American Medical Association shall advocate for legislation and/or regulation prohibiting ERISA and Medicare Advantage plans from requiring preauthorization for prescribed opioid pain medicine for post-surgery and post-hospital discharged patients for an initial 7-day supply. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony on Resolution 709 as written and against reaffirmation. Online testimony supported reaffirmation of this resolution, but in-person testimony highlighted how Resolution 709 differs from current AMA policy (e.g., H-125.974) and emphasized how this resolution will help ensure that patients can access their prescribed pain medications without having to obtain prior authorization approval or overcome other administrative barriers to care. Your Reference Committee recommends that Resolution 709 be adopted.

(7) RESOLUTION 712 - BILLINGS AND COLLECTIONS TRANSPARENCY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 712 be adopted.

HOD ACTION: Resolution 712 adopted.

RESOLVED, that our American Medical Association amend policy H-225.950, Principles for Physician Employment, to include a new section to read as follows:

6. Payment Agreements
a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA will educate physicians as to the importance of billing transparency and advocate for employed physicians to have full access to itemized statements of billing and remittances for medical services they provide (Directive to Take Action).

Your Reference Committee heard mostly supportive testimony on Resolution 712. There was testimony online and in-person that was supportive of the resolution as written. One delegation supported the spirit of the resolution but suggested that much of the added language is reaffirmation and called for ensuring that the correct entities are addressed to petition these changes. One delegation spoke in favor of reaffirmation. Testimony highlighted that the amendments to Policy H-225.950 in the original resolution were important and are needed to protect physicians from retaliation when they seek to review billing and collections information. An individual suggested a second order amendment to

strike the physician's right to override the initial decisions by revenue cycle management entities, but subsequent testimony addressed these concerns by stating that with proper training, this issue can be addressed. Other testimony in support of the original language stated that the language the second order amendment wanted to strike was a critical part of physician autonomy and should be retained. Your Reference Committee found this testimony compelling and therefore, your Reference Committee recommends that Resolution 712 be adopted.

(8) RESOLUTION 717 - PROMOTING MEDICATION CONTINUITY AND REDUCING PRIOR AUTHORIZATION BURDENS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 717 be adopted.

HOD ACTION: Resolution 717 adopted.

RESOLVED, that our American Medical Association advocates for federal and state legislation that minimizes the impact of prior authorization requirements and payer-specific formulary tiering policies for medications during transitions or lapses in insurance coverage (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with relevant stakeholders to develop and promote best practices for implementing medication continuity policies across different insurance plans and healthcare systems. (Directive to Take Action)

Testimony on Resolution 717 was overwhelmingly supportive. Several delegations supported the resolution as written both online and in-person. Testimony supported this resolution because patients frequently experience care delays and disruptions due to circumstances beyond their control, including losing a job, transitioning between insurance plans, or simply aging out of parental coverage, and these disruptions too often lead to unnecessary prior authorization delays, gaps in medication access, and preventable harms to patient health. Furthermore, testimony stated that reducing these barriers can help protect patients from harm and reduce administrative burdens placed on practices, allowing for more time to focus on care delivery rather than paperwork. Your Reference Committee recommends that Resolution 717 be adopted.

(9) RESOLUTION 719 - COMPREHENSIVE AMA POLICY PUBLICATION REGARDING EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 719 be adopted.

HOD ACTION: Resolution 719 adopted.

RESOLVED, that our American Medical Association comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:

- The changing context and expectations of different practice models
- Factors which have led to physicians increasingly choosing an employment practice model over independent practice
- The employed physician relationship with healthcare organizations, including those controlled by private equity
- The evolution of collective bargaining by, and unionization of, physicians;

(Directive to Take Action); and be it further

RESOLVED, that our AMA create a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:

- Employment contracting
- Different compensation models
- Professional accountability to, and as a member of, the medical staff
- Primacy of the doctor-patient relationship within the context of employment;

(Directive to Take Action); and be it further

RESOLVED, that our AMA will have a comprehensive policy publication regarding employed physicians available to all physicians, in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians (Directive to Take Action).

Your Reference Committee heard mostly supportive testimony on Resolution 719. Testimony highlighted that even though much of this information is available, it is fragmented, so the resolution aims to bring the information together in a cohesive way. There was concern that the language of the resolution is too narrow; however, the Reference Committee finds the phrasing “including but not limited to” broad enough to address these concerns and thus recommends that Resolution 719 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) BOARD OF TRUSTEES REPORT 6 - TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 6 be amended by addition to read as follows:

1. That the first directive of Policy D-200.971 be amended by addition and deletion as follows: Our American Medical Association supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports and the Centers for Medicare & Medicaid Services quality websites and will report back to the HOD every two (2) years through 2029 any AMA and/or industry efforts to advance this effort. ~~to include periodic report back to the HOD with the first update to be given at A-25.~~ (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends:

1. That the first directive of Policy D 200.971 be amended by addition and deletion as follows: Our American Medical Association supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports and will report back to the HOD every two (2) years through 2029 any AMA and/or industry efforts to advance this effort. ~~to include periodic report back to the HOD with the first update to be given at A-25.~~ (Modify HOD Policy)
2. That the remainder of this report be filed.

Your Reference Committee heard supportive testimony on Board of Trustees Report 6. One delegation provided testimony in favor of the report recommendations as written. An amendment was suggested by an individual, which the Reference Committee felt

strengthened the original recommendation. The Board of Trustees reviewed and accepted the amendment as in line with the original recommendation. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 6 be adopted as amended and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 3 - REGULATION OF CORPORATE INVESTMENT IN THE HEALTH CARE SECTOR

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) amend Policy H-160.891, "Corporate Investors," by addition and deletion, including a change in title:

CORPORATE INVESTORS AND OTHER CORPORATE ENTITIES, H-160.891

1. Our American Medical Association encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:

a) Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.

b) Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.

c) External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.

d) Retaining negotiators to advocate for best interests of the practice and its employees should be considered.

e) Physicians should consider whether and how corporate ~~investor~~ ~~partnerships~~ relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.

f) Physicians should consider the potential impact of corporate ~~investor~~ ~~partnerships~~ relationships on physician and practice employee satisfaction and future physician recruitment.

g) Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate ~~investor~~ relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate ~~partnership~~ relationship.

h) Physicians should consider corporate procedures ~~investor processes~~ for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.

i) Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate ~~investor~~ ~~partnerships~~ relationships.

j. Prior to entering into a ~~partnership~~ relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:

i. Determining which diagnostic tests are appropriate;

ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;

iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;

iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;

v. Determining the content of patient medical records;

vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;

vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;

viii. Making decisions regarding coding and billing procedures for patient care services; and

ix. Approving the selection of medical equipment and medical supplies.

k. ~~j.~~ Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.

l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.

m. ~~k.~~ Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor ~~partnerships~~ relationships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship ~~partners~~. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

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

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

1. That our American Medical Association (AMA) amend Policy H-160.891, "Corporate Investors," by addition and deletion, including a change in title:

CORPORATE INVESTORS AND OTHER CORPORATE ENTITIES, H-160.891
1. Our American Medical Association encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
a) Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
b) Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
c) External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
d) Retaining negotiators to advocate for best interests of the practice and its employees should be considered.

e) Physicians should consider whether and how corporate ~~investor~~ partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f) Physicians should consider the potential impact of corporate ~~investor~~ partnerships on physician and practice employee satisfaction and future physician recruitment.
g) Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate ~~investor~~ relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate partnership.
h) Physicians should consider corporate procedures ~~investor processes~~ for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
i) Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate ~~investor~~ partnerships.
j. Prior to entering into a partnership with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
i. Determining which diagnostic tests are appropriate;
ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
v. Determining the content of patient medical records;
vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
viii. Making decisions regarding coding and billing procedures for patient care services; and
ix. Approving the selection of medical equipment and medical supplies.
k. ~~j.~~ Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m. ~~k.~~ Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.

3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization partners. (Modify HOD Policy)

2. That our AMA amend Policy H-215.981, "Corporate Practice of Medicine," by addition:

CORPORATE PRACTICE OF MEDICINE, H-215.981

1) Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2) Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3) Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4) Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6) Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7) Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8) Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9) Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify HOD Policy)

3. That our AMA reaffirm Policy H-285.910, The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community, which provides a recommended clause to include in physician employment agreements and which states that in caring for patients physicians shall have the unfettered right to exercise

independent and professional judgment and be guided by personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Furthermore, nothing in the employment agreement shall prevent physicians from exercising their own medical judgment and employers may not retaliate against the physician in any way based on the physician's right to exercise their medical judgment. (Reaffirm HOD Policy)

4. That our AMA rescind Policy D-160.904, as it is accomplished by this report. (Rescind HOD Policy)

5. That our AMA rescind Policy D-215.982, as it is accomplished by this report. (Rescind HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 3. Supportive testimony included the individual who authored the resolution that prompted this report in support of the recommendations as written. An amendment was suggested to replace the term “partnerships” with “relationships” throughout the first recommendation, as the former has a legal connotation which may not apply to all situations, and the latter broadens the language of the policy further. The Council on Medical Service provided testimony in support of the amendment. Thus, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(12) RESOLUTION 702 - STRENGTHENING HEALTH PLAN ACCOUNTABILITY FOR PHYSICIAN SATISFACTION

RECOMMENDATION A:

Your Reference Committee recommends Resolution 702 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive, validated, and updated physician satisfaction metrics (Directive to Take Action).

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

RESOLVED, that our American Medical Association advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive physician satisfaction metrics. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 702. Testimony noted that incorporating physician satisfaction metrics would more accurately ensure a meaningful view of health plans. One individual proffered an amendment to include the language, "validated and updated," suggesting that incorporating physician satisfaction metrics can be helpful only if they are relevant. Another individual proffered an amendment suggesting specific metrics should be utilized to capture the physician experience more accurately with health plans. However, your Reference Committee does not believe specific metrics are germane to the original intent of resolution and should not be included. Therefore, your Reference Committee recommends that Resolution 702 be adopted as amended.

(13) RESOLUTION 703 - APPROPRIATE USE OF DATA FROM SURGICAL PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 703 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for policies that ensure data collected from surgical practices, including but not limited to surgical video recordings, time on surgical console, operative times, and perioperative outcomes data, are used primarily to support

surgical education, quality improvement, ~~and~~ patient safety, and research and development with appropriate protections to prevent misuse (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 703 be amended by addition of a new second Resolve clause to read as follows:

RESOLVED, that our AMA oppose the use of surgical data collected for education, research and quality improvement as the sole or primary basis for legal proceedings, institutional hiring and firing practices, and reimbursement as they lack surgical context and complexity. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 703 be adopted as amended.

HOD ACTION: Resolution 703 adopted as amended.

RESOLVED, that our American Medical Association advocate for policies that ensure data collected from surgical practices are used primarily to support surgical education, quality improvement, and patient safety, with appropriate protections to prevent misuse (New HOD Policy); and be it further

RESOLVED, that our AMA support physician leadership and involvement in the collection, interpretation, and application of surgical data to ensure that its use respects clinical complexity, preserves professional judgment, and accounts for patient-specific factors, surgical variability, and the nuances of individual operative decision-making (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of surgical data by hospital administrators or other stakeholders to create rigid productivity benchmarks, comparative performance metrics, or incentive/penalty systems that fail to account for the educational value of training environments, differences in case complexity, or surgeon-specific clinical contexts. (New HOD Policy)

Your Reference Committee heard supportive online testimony on Resolution 703. The resolution was recommended for reaffirmation but the author, two delegations, and one individual testified in support of Resolution 703, and against reaffirmation, suggesting that while the policies outlined for reaffirmation appropriately emphasize physician involvement in data use, transparency, and quality improvement, they do not address the exponential growth of surgical data collection made possible by modern technologies. One delegation testified in support of reaffirmation suggesting that AMA policy already addresses the key components of Resolution 703. Additionally, one delegation testified in support of Resolution 703 with a proffered amendment to the first clause to clarify both the type of

data referenced and the second clause to reflect the clinical expertise required to interpret it. While no online testimony was offered in support of this amendment, one delegation, with the support of five other delegations, offered another amendment during in-person testimony to expand protections of and restrict the use of data. Your Reference Committee felt that amended language fulfilled the intent of the resolution and, therefore, recommended Resolution 703 be adopted as amended.

(14) RESOLUTION 706 - INCREASING TRANSPARENCY SURROUNDING MEDICARE ADVANTAGE PLANS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 706 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association support policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, ~~provider contracts,~~ and provider networks. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 706 be adopted as amended.

HOD ACTION: Resolution 706 adopted as amended.

RESOLVED, that our American Medical Association support policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, provider contracts, and provider networks. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 706, stating that while transparency does not guarantee reform, it often helps and, therefore, Resolution 706 would bolster financial transparency of Medicare Advantage. One delegation proffered an amendment, suggesting that while networks should be public, contracts should not, and suggested removal of “provider contracts.” While there was no testimony against this amendment, one delegation expressed concern about the potential significant negative market effects that may be caused by total transparency and recommended referral. However, several delegations provided testimony in support of the amended resolution in subsequent testimony. Therefore, your Reference Committee recommends that Resolution 706 be adopted as amended.

(15) RESOLUTION 707 - SIMPLIFYING CORRESPONDENCE FROM HEALTH INSURERS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 707 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association advocate for the ~~regulation and~~ standardization of correspondence from health insurers for the goal of simplifying the message, making it more readable, more quickly processed, and more efficiently reviewed. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 707 be adopted as amended.

HOD ACTION: Resolution 707 adopted as amended.

RESOLVED, that our American Medical Association advocate for the regulation and standardization of correspondence from health insurers for the goal of simplifying the message, making it more readable, more quickly processed, and more efficiently reviewed. (Directive to Take Action)

Your Reference Committee heard limited, but supportive testimony on Resolution 707. One delegation suggested an amendment to strike “regulation and” as it is unclear how correspondence would be regulated and stated that standardization is a reasonable first step toward the goal of this resolution. At the in-person hearing the author of the resolution provided testimony in support of the Reference Committee’s recommendation, which we interpret as acceptance of the proposed amended resolution. Your Reference Committee recommends that Resolution 707 be adopted as amended.

(16) RESOLUTION 714 - ROOT CAUSE ANALYSIS OF THE CAUSES OF THE DECLINE OF PRIVATE MEDICAL PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 714 be amended by addition to read as follows:

RESOLVED, that our American Medical Association study and report back on the root cause of the decline in private practice to include consideration of at least the following factors:

1. The declining inflation-adjusted Medicare rates
2. Stark laws, which allow hospitals, but not private physicians, to self-refer
3. The development of insurance plans that had no out-of-network benefits
4. The permitted consolidation of insurers and hospitals
5. Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees
6. Increased government influence by insurers and hospitals and decreased influence by doctors
7. Inadequate formal education on the business of medicine
8. Educational debt of early career physicians
9. Evolving lifestyle preference of early career physicians.
10. Overhead expenditures such as Electronic Health Records, personnel, and administrative costs.
11. Provider based facility fees charged by hospital employers but not by private practitioners.

(Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 714 be adopted as amended.

HOD ACTION: Resolution 714 adopted as amended.

RESOLVED, that our American Medical Association study and report back on the root cause of the decline in private practice to include consideration of at least the following factors:

1. The declining inflation-adjusted Medicare rates
2. Stark laws, which allow hospitals, but not private physicians, to self-refer
3. The development of insurance plans that had no out-of-network benefits
4. The permitted consolidation of insurers and hospitals
5. Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees

6. Increased government influence by insurers and hospitals and decreased influence by doctors.
(Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 714. Several delegations provided testimony in favor of adoption and believe this study will help the AMA uncover the causes in the shift away from private practice and inform advocacy on how to better support private practice physicians. There was an amendment that suggested to add three more topics of study. This amendment was well-received by the authors and subsequent testimony. One delegation and one individual provided testimony in favor of not adoption stating that while sympathetic to these concerns, many of the stated research proposals are known and it would be difficult to determine how each variable individually contributes to the decline of private practice. Your Reference Committee agrees with testimony stating that the findings of this study will be valuable and recommends that Resolution 714 be adopted as amended.

(17) RESOLUTION 715 - GRACE PERIOD FOR TIMELY FILING DUE TO TECHNOLOGY FAILURES REGARDLESS OF CAUSE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 715 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for a two-year grace period from the date of a claims processing failure due to technology failure, allowing payers to resolve claims before denying them based on a "timely filing limit." (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 715 be adopted as amended.

HOD ACTION: Resolution 715 adopted as amended.

RESOLVED, that our American Medical Association advocate for a two-year grace period from the date of a claims processing failure, allowing payers to resolve claims before denying them based on a "timely filing limit." (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 715. One delegation proffered an amendment online, suggesting a shorter time frame would be more consistent with standard timely filing limits. However, the author recommended not adopting this amendment, citing the original intent of the resolution was to help physicians affected by the February 2024 Change Healthcare data breach. An additional amendment was proffered in-person by a delegation to specify claims processing failures due to technology failure. Your Reference Committee agreed that the amended language fulfilled

the intent of the resolution and therefore, your Reference Committee recommends that Resolution 715 be adopted as amended.

(18) RESOLUTION 716 - MINIMUM PAYER COMMUNICATION QUALITY STANDARDS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 716 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our AMA advocate for the adoption of physician/provider satisfaction quality metrics for Medicare Advantage plan star ratings to measure the efficiency of health plan customer service, addressing provider questions and concerns, payment efficiency, and resolution of appeals. (Directive To Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 716 be adopted as amended.

HOD ACTION: Resolution 716 adopted as amended.

RESOLVED, that our American Medical Association advocate for payer minimum quality standards to include immediate access to a live representative during business hours. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony on Resolution 716. Testimony indicated that augmented intelligence may be used to create efficiencies in the insurance industry and this resolution's intent is to mitigate the potential for these efficiencies to be at the expense of the physician practice. An individual proffered an amendment, suggesting that while the Centers for Medicare & Medicaid Services requires that Medicare Advantage track patient experience, they recommend that each plan be required to report similar metrics. Additional testimony supported the amendment. Your Reference Committee recommends that Resolution 716 be adopted as amended.

RECOMMENDED FOR REFERRAL

(19) RESOLUTION 701 - ELECTRONIC HEALTH RECORDS CONTRACT TERMINATION

RECOMMENDATION:

Your Reference Committee recommends Resolution 701 be referred.

HOD ACTION: Resolution 701 referred for decision.

RESOLVED, that our American Medical Association adopt as policy that Electronic Health Record (EHR) vendors provide physician practices with a minimum 180-day notification of contract termination without cause (New HOD Policy); and be it further

RESOLVED, that our AMA petition the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) to mandate that EHR vendors provide a minimum 180-day notification of contract termination without cause to physician practices. (Directive To Take Action)

Your Reference Committee heard supportive testimony on Resolution 701. Testimony indicated that sudden termination of electronic health records (EHR) contracts can cause disrupted patient care, leading to potential increased risks for morbidity and mortality. The Council on Medical Service proffered amendments to reflect federal certification policy more accurately, adequately capture the legislative authority responsible for EHR vendors, and recommend that the AMA provide standard contract language which can be inserted into EHR contracts. The author was amenable to the Council's amendments but suggested that a 180-day minimum notification should be captured within the amended language as it is necessary to achieve seamless transfer to a new EHR. Further testimony agreed with the author, suggesting that a 180-day notification period would allow for unencumbered transfer of patient records to a different system. A delegation proffered another amendment to align the language with current AMA policy and promote a collaborative environment among the Office of the National Coordinator for Health Information Technology, Office for Science Technology Policy, and the AMA. In-person testimony was mixed, however. Two delegations expressed concern with the nuance of the amended language as it provides an arbitrary notification timeline, which raises concerns about the ability of less-resourced hospitals to meet this timeline. Therefore, testimony recommended referral to study the issue. Your Reference Committee agrees there is sufficient uncertainty regarding the appropriate notification period to warrant further study. Thus, your Reference Committee recommends Resolution 701 be referred.

(20) RESOLUTION 704 - MITIGATING THE IMPACT OF EXCESSIVE PRIOR AUTHORIZATION PROCESSES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 704 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 704 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 704 be adopted.

HOD ACTION: The first and third Resolve clauses of Resolution 704 adopted and the second Resolve clause of Resolution 704 referred.

RESOLVED, that our American Medical Association actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers (Directive to Take Action); and be it further

RESOLVED, that our AMA working with legal experts, determine whether and to what extent it may be appropriate to initiate and/or support a class action lawsuit against insurance companies based on the identified prior authorization data, and, if so appropriate, collaborate with patient advocacy groups to support potential lawsuits (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources. (Directive to Take Action)

Your Reference Committee heard mixed but generally supportive testimony on Resolution 704; however, there was more support for the first and third resolve clauses than there was for the second resolve clause. Testimony regarding the first and third resolve clauses was primarily supportive, with specific testimony highlighting the value that a prior authorization database, as called for in the first resolve, could provide in support of future prior authorization advocacy efforts. Although one delegation noted that it may be challenging to collect and consolidate prior authorization impact data in a format that will be useful for the AMA's prior authorization advocacy, the general consensus amongst those testifying was that it is necessary to move forward with collecting and storing prior authorization impact data in a database so that the AMA can quantify the impact of prior authorization in an effort to further support the AMA's advocacy efforts.

Some testimony voiced concern about the large fiscal note attached to this resolution; however, additional testimony generally downplayed these fiscal concerns by highlighting that the potential benefits from developing and maintaining a prior authorization impact database would most likely outweigh the costs.

With regard to the second resolve clause, your Reference Committee heard mixed testimony. Some testimony supported class action lawsuits generally. However, other testimony questioned whether the proposed prior authorization database would provide the supporting evidence to ultimately pursue a class action lawsuit. This varying testimony allowed the Reference Committee to appreciate the complexities of the second resolve clause and therefore recommend referral.

There were also questions raised about what rises to the threshold of AMA legal action. The Reference Committee wants to share that the AMA Litigation Center is holding an information session on Sunday, June 8th from 1:30-3:30 PM for those who may be interested. Your Reference Committee recommends that the first and third resolve clauses of Resolution 704 be adopted and the second resolve clause of Resolution 704 be referred.

(21) RESOLUTION 710 - REQUIRING INSURANCES TO APPLY DISCOUNTED COST MEDICATION TO THE PATIENT'S DEDUCTIBLE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 710 be referred.

HOD ACTION: Resolution 710 referred.

RESOLVED, that our American Medical Association advocate for legislation or other appropriate means to ensure that all payment made by patients for prescription medications outside of their insurance coverage (such as pharmaceutical discount programs) count towards that patient's annual deductible and out of pocket maximum. (Directive to Take Action)

Your Reference Committee heard supportive online testimony on Resolution 710. In-person testimony was mixed. Several delegations provided testimony in favor of the resolution, one delegation offered an amendment, and one delegation suggested referral. While there was support for the resolution as written, your Reference Committee found testimony calling for referral compelling. There were important questions raised about which medications and programs should be considered under this umbrella and the nuances discussed in testimony could lead to unintended consequences. Your Reference Committee did not believe that these concerns were addressed by the proposed amendment and a study addressing these questions would ensure that all scenarios are considered in the resulting policy recommendations. Thus, your Reference Committee recommends that Resolution 710 be referred.

(22) RESOLUTION 711 - STUDY OF PRACTICE MODELS FOR PHYSICIANS WORKING ACROSS STATE LINES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 711 be referred.

HOD ACTION: Resolution 711 referred.

RESOLVED, that our American Medical Association undertake a thorough review of the practice models for physicians relying on transfer agreements between corporate healthcare entities, rather than physician-to-physician backup agreements for back up coverage, their rates of expected and unexpected complications, the impact of this model on local patients and on local physician medical liability costs (Directive to Take Action); and be it further

RESOLVED, that our AMA should collect and analyze data regarding patient outcomes, complications, and continuity of care issues associated with licensed physicians who primarily practice out of state without appropriate backup agreements (Directive to Take Action); and be it further

RESOLVED, that our AMA's study should include an extensive review of the impact this practice model has on physicians thrust into cross coverage without adequate handoff or fore-knowledge of the patient, impact on physician malpractice costs, patient safety, and physician well-being in our country. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 711. Two delegations supported referral of this resolution. Testimony admitted that referral seems redundant since a significant portion of the resolve clauses call for a study; however, there are portions of the language in the resolve clauses that need revision. Specifically, testimony questioned the feasibility of the first and second resolve clauses and noted that the third resolve clause seems to overlap with the first. Testimony further suggested that each state has professional and facility regulations and accreditation standards that address the matter proposed by the resolution and that the AMA should emphasize standards and enforcement at a local level by relevant facility and professional licensure authorities. Finally, testimony addressed the impact of these practice models on emergency departments and recommended that this also be addressed by a report. At the in-person hearing the author of this resolution supported referral, as it achieves the goal of a study, which was the original intent. Your Reference Committee recommends that Resolution 711 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(23) RESOLUTION 718 - SAFEGUARDING MEDICAL STAFF BYLAWS AND ACCREDITATION STANDARDS IN VA FACILITIES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 718 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 718 be adopted.

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 718 be referred for decision.

RECOMMENDATION D:

Your Reference Committee recommends that the fourth Resolve clause of Resolution 718 be referred for decision.

HOD ACTION: The first and second Resolve clauses of Resolution 718 be adopted and the third and fourth Resolve clauses of Resolution 718 referred for decision.

RESOLVED, that our American Medical Association reaffirms its commitment to medical staff self-governance, as outlined in its AMA Physician's Guide to Medical Staff Organization Bylaws, Seventh edition, and supported by the Organized Medical Staff Section and urges all healthcare institutions, including the U.S. Department of Veterans Affairs, to ensure that any amendments to medical staff bylaws are subject to approval by the medical staff in accordance with Joint Commission standards (Reaffirmation of Policy); and be it further

RESOLVED, that our AMA opposes any administrative action that bypass the organized medical staff's voting authority in revising medical staff bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the U.S. Department of Veterans Affairs to restore compliance with Joint Commission Standard MS.01.01.01 by requiring medical staff member approval for any modifications to their bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for urgent federal-level oversight and corrective action to protect accreditation standards, medical staff governance, and patient care quality at Veterans Affairs facilities nationwide (Directive to Take Action).

Your Reference Committee heard testimony that supported the spirit of the resolution, but there were several questions raised that warrant further study. The first and second resolve clauses received supportive testimony. The questions were mostly directed towards the third and fourth resolve clauses and whether the Joint Commission requirements supersede federal regulations, or vice versa. Further testimony did not offer clarifications on these points and therefore the Reference Committee believes that further scrutiny would allow for better understanding of the process as it stands, as well as what changes will be most impactful for physicians affected by these changes. Because of the timeliness of this issue, your Reference Committee believes that referral for decision is most appropriate for urgent action. Your Reference Committee recommends that the first and second resolve clauses of Resolution 718 be adopted and the third and fourth resolve clauses of Resolution 718 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(24) RESOLUTION 705 - ELIMINATION OF TRANSACTION FEES FOR ELECTRONIC HEALTHCARE PAYMENTS

RECOMMENDATION:

Your Reference Committee recommends that Policies D-190.968 and H-190.955 be reaffirmed in lieu of Resolution 705.

HOD ACTION: Resolution 705 referred for decision.

RESOLVED, that our American Medical Association continue to advocate to the United States Congress to eliminate transaction fees for electronic payments for healthcare. (Directive to Take Action)

Your Reference Committee heard testimony in favor of reaffirmation of AMA policies in lieu of Resolution 705. Online testimony acknowledged the positive intent behind Resolution 705 but supported reaffirmation because the ask is already addressed by AMA policy. At the in-person hearing the author spoke in favor of the original resolution; however, no clarifications were offered to differentiate between the ask of this resolution and existing AMA policy. Additional testimony noted the negative impact that electronic transaction fees have on practice payment rates. An amendment was suggested that called for the AMA to report on implementation of pertinent AMA policies, including D-190.968 and H-190.955, at the 2025 Annual meeting. Because it is impossible to produce a report regarding the implementation progress of these policies in time for the 2025 AMA Annual meeting and the testimony agreed that AMA policy covers the ask of this resolution, your Reference Committee recommends that Policies D-190.968 and H-190.955 be reaffirmed in lieu of Resolution 705.

AMEND VIRTUAL CREDIT CARD AND ELECTRONIC FUNDS TRANSFER FEE POLICY, D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:

a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.

b. CMS enforcement activities related to this issue.
c. Physician access to a timely no fee EFT option as an alternative to VCCs.
(Res. 819, I-23)

VIRTUAL CREDIT CARD PAYMENTS, H-190.955
1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.
(Sub. Res. 704, A-15)

(25) RESOLUTION 713 - AIDING MEMBERS OF MEDICAL STAFFS

RECOMMENDATION:

Your Reference Committee recommends that Policies H-225.942, H-225.957, and H-235.980 be reaffirmed in lieu of Resolution 713.

HOD ACTION: Resolution 713 adopted.

RESOLVED, that our American Medical Association establish and promote a well-defined procedure with access to resources to guide physicians on how to challenge adverse institutional actions or policies to practice medicine (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 713. One delegation provided testimony in support of reaffirmation and the individual author of the resolution spoke against reaffirmation and in support of the resolution as written both online and in-person. Your Reference Committee has reviewed the listed policies and agrees that AMA policy sufficiently covers the ask of this resolution. Additionally, the Physician's Guide to Medical Staff Organization Bylaws, published by the AMA Office of General Counsel and Organized Medical Staff Section, is an additional resource available to physicians who

have questions about adverse institutional actions or policies to practice medicine. Therefore, your Reference Committee recommends that Policies H-225.942, H-225.957, and H-235.980 be reaffirmed in lieu of Resolution 713.

PHYSICIAN AND MEDICAL STAFF MEMBER BILL OF RIGHTS, H-225.942

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

Preamble

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

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

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

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

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

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

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

c. The responsibility to participate in the health care organization's operational and strategic planning to

safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

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

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

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

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

a. The right to be self-governed, which includes but is not limited to

i. initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations,

ii. selecting and removing medical staff leaders,

iii. controlling the use of medical staff funds,

iv. being advised by independent legal counsel, and

v. establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

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

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

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

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

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

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

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
g. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

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

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting

membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

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

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

(BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21; Reaffirmation: A-22; Modified: Speakers Rep. 02, I-24)

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP, H-225.957

The following twelve principles are our American Medical Association policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital

managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the

organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws:

1. The qualifications for holding office.

2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.

3. The qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any

medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

(Res. 828, I-07; Reaffirmed in lieu of Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmation: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 024, A-24)

HOSPITAL MEDICAL STAFF SELF-GOVERNANCE, H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.

2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.

3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:

(a) Application, reapplication, credentialing and privileging standards;

(b) Fair hearing and appeal process;

(c) Selection, election and removal of medical staff officers;

(d) Clinical criteria and standards which manage quality assurance, utilization review;

(e) Structure of the medical staff organization;

(f) Rules and regulations that affect the entire medical staff.

4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

(Sub Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub Res. 817, I-01; Reaffirmation: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15)

This concludes the report of Reference Committee G. I would like to thank Anna Brown, MD, MPhil, Chris Bush, MD, Tra'Chella Foy, MD, Maximilian Pany, MD, PhD, Peter Rheinstein, MD, JD, MS, David Whalen, MD, and all those who testified before the Committee.

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