AMA
AMERICAN MEDICAL ASSOCIATION

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INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2026 Meeting

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

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

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

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

Items highlighted in blue have been recommended for reaffirmation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
1	E&B	CEJA 01 – Guidelines on Chaperones for Sensitive Exams	RECOMMENDATION The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed: 1. Opinion 1.2.4 “Use of Chaperones” be amended by deletion and addition as follows: Chaperones should be authorized members of the health care team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients. ~~Efforts to provide a comfortable~~	Delegate instructed to listen; consider if provision (d) could be reconsidered.

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			~~and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clearly explaining various components of the physical examination, and the use of ~~having~~ a chaperone ~~available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure. Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, Physicians should: (a) Provide a chaperone for all sensitive exams, regardless of patient capacity, unless the delay in obtaining a chaperone would result in significant harm to the patient. (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam. i. If the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician. ii. In emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale. ~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~ ~~(d) In general, use a chaperone even when a patient's trusted companion is~~	

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			~~present.~~ ~~(e)~~(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is present. (d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries. (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision making between patient and physician. All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk. For non-sensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request. (Modify HOD/CEJA Policy) 2. Policy D-140.950 be rescinded as it has been accomplished by this report. (Rescind AMA Policy)	
2	E&B	CEJA 03 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	RECOMMENDATIONS The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed: 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows: Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~	Delegate instructed to oppose; Delegate to comment in the ORC and ask CEJA to reconsider that AMA avoid taking a position.

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			Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy. Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing. When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing. (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care.~~ Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws	

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			or laws pertaining to medical licensure or malpractice. Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care. (i) Physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care. (ii) Physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture. (iii) Physicians should avoid disruptive collective actions that could directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest. (c) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients. (d) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities. 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)	
3	E&B	Res. 007 – Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software (Indiana)	RESOLVED, that our American Medical Association pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy by mandating informed consent, opt-in for secondary use, data minimization, and federal vendor accountability. (Directive to Take Action)	Delegate instructed to seek referral.

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4	A	BOT 23 – Liberalized Remorse Period for Medicare Advantage Plans Insureds	RECOMMENDATIONS The Board of Trustees recommends that the following be adopted in lieu of Resolution 117-A-25 and the remainder of the report be filed: 1) That our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services to create a comprehensive strategy to educate people approaching the age of Medicare eligibility and for annual enrollment periods about key aspects of Medicare affecting choices between traditional Medicare and Medicare Advantage (MA) plans. (Directive to Take Action) 2) That our AMA support a Medicare policy that allows beneficiaries who enroll in MA for the first time to disenroll for any reason and return to traditional Medicare within the first 12 months of enrollment in the plan. (New HOD Policy) 3) That our AMA reaffirm Policy H-330.866, “Medigap Patient Protections.” (Reaffirm HOD Policy)	Delegate instructed to refer or amend – seek to remove second recommendation from final version.
5	A	CMS 08 – Rural Health Transformation Program Update & Workforce Challenges	RECOMMENDATIONS 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) monitor legislative and regulatory proposals related to the rural health transformation program or similar rural health initiatives to educate physicians and policymakers regarding the potential opportunities and challenges associated with such programs. (New HOD Policy) 2. That our AMA support the development of funding avenues designated to support costs associated with telehealth in rural hospitals and medical practices. (New HOD Policy) 3. That our AMA support the development and implementation of programs that ensure physicians practicing in rural settings have access to opportunities to meet continuing medical education and continuing professional development requirements. (New HOD Policy)	Delegate instructed to support.

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			4. That our AMA encourage the expansion of programs designed to define physician shortage areas and support physicians working in these areas to include specialties necessary to the functioning of a rural medical practice or hospital. (New HOD Policy) 5. That our AMA reaffirm Policy H-465.994, which details efforts to support, promote, and innovate solutions to improve rural health. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy D-200.980, which outlines support for various strategies to bolster the physician workforce in underserved areas, including rural communities. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy H-465.988, which specifies strategies and efforts to improve the physician workforce that focus on education and practice solutions. (Reaffirm HOD Policy)	
6	A	Res. 104 – Improving Choice, Competition, and Affordability in the ACA Marketplace (New England)	RESOLVED, that our American Medical Association support expanding choice and competition on ACA Marketplaces, including by allowing ACA premium tax credits to be applied to the entire premium for qualifying Marketplace health plans, including the portion of the premium attributable to benefits that are not considered Essential Health Benefits (New HOD Policy) RESOLVED, that our AMA support improving the benchmark plan on the ACA Marketplaces from the second-lowest cost silver plan to at least the second-lowest cost gold plan. (New HOD Policy)	Delegate instructed to listen.
7	A	Res. 105 – Oppose Medicare Advantage Auto Enrollment (New York)	RESOLVED, that our American Medical Association oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option. (New HOD Policy)	Delegate instructed to listen.
8	A	Res. 107 – Oversight of Medicare Advantage Plan	RESOLVED, that our American Medical Association support equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare (New HOD Policy)	Delegate instructed to amend or refer to

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		(Indiana)	RESOLVED, that our AMA support and seek legislation that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions (Directive to Take Action) RESOLVED, that our AMA support the revision of Medicare Advantage risk adjustment formulas to ensure that claims data is based on the actual cost of providing care (New HOD Policy); RESOLVED, that our AMA lobby in support of Medicare Payment Advisory Commission recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate fee-for-service-derived benchmarks (Directive to Take Action) RESOLVED, that our AMA support the allocation of federal funds to study how financial savings generated through enactment of Medicare Payment Advisory Commission recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare. (New HOD Policy)	remove the final two Resolve clauses.
9	A	Res. 108 – Ensuring Physician Input in the Development of CMMI Models (Integrated Physician Practice Section)	RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be participants in Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)	Delegate instructed to strongly support.
10	A	Res. 116 – Study of Cost Implications of Medicaid Managed Care Organizations	RESOLVED, That our American Medical Association study and report back to the HOD at I-26 on Medicaid managed care organizations and state-administered Medicaid programs, including: • The comparative fiscal implications of programs administered through Medicaid	Delegate instructed to listen.

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		Compared with State-Administered Medicaid Programs (American Academy of Pediatrics)	managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs. • Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models. • The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration. (Directive to Take Action)	
11	A	Res. 118 – Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs (American College of Rheumatology)	RESOLVED, that our American Medical Association remain committed to the position that international price indices or averages should not be used in isolation to set or determine prescription drug prices or payments (New HOD Policy) RESOLVED, that our AMA work with state medical societies and specialty societies to educate policymakers on the risks of misaligned reimbursement under international reference pricing models and to promote approaches that reduce drug costs without jeopardizing patient access or practice sustainability (Directive to Take Action); and be it further	Delegate instructed to listen.
12	B	BOT 24 – AMA Advocacy to Mitigate Medicaid Cuts	The Board of Trustees recommends that the fourth item of Policy D-290.970, “Call for Action by the AMA to Reverse or Mitigate Medicaid Cuts,” be rescinded as having been accomplished by this report and the remainder of the report be filed. 1. Publicly denounce cuts to Medicaid in Public Law 119-21 (known as the “One Big Beautiful Bill Act of 2025”); 2. Through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid; 3. Continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21; . ~~4. Report back to the AMA’s House of Delegates at A-26.~~ (Modify Current Policy)	Delegate instructed to listen.

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13	B	BOT 28 – Accountability in the Use of Augmented Intelligence for Prior Authorization	The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed. 1. Our American Medical Association (AMA) will: 1) Advance federal advocacy to ensure that insurer use of AI in prior authorization and claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines derived from national medical specialty societies and peer-reviewed literature. 2) Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to review by qualified, specialty-appropriate clinicians who are not incentivized to deny coverage for care, and to ensure that automated systems do not supplant individualized clinical judgment. 3) Support and seek advancement of federal legislation to promote transparency in Medicare Advantage prior authorization programs, including public reporting of AI and automated decision-making use. 4) Advocate for enhanced transparency and accountability in insurer use of AI, including clear disclosure when AI is used in coverage determinations and meaningful access for patients and physicians to the criteria, clinical guidelines, and data underlying those determinations. 5) Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI-generated recommendations without direct review of the patient record by a qualified clinician. 6) Support development and adoption of state-level guardrails that limit reliance on automated systems as the sole basis for medical necessity denials and promote clinician oversight, audit authority, and protections against algorithmic discrimination. 7) Engage in national AI technical standards discussions to strengthen transparency regarding whether human review occurred in coverage determinations and to facilitate identification of reviewer specialty. (Directive to Take Action) 2. That item two of Policy D-480.956, “Use of Augmented Intelligence for Prior Authorization,” be rescinded as having been accomplished by this report. (Modify Current HOD Policy)	Delegate instructed to support.

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14	B	Res. 206 – Overall Hospital Quality Star Ratings/CMS Star Ratings (American Association of Clinical Urologists)	RESOLVED, that our American Medical Association advocate to CMS that the Overall Hospital Quality Star Ratings (CMS Star Ratings) include a 6th measured group defined as Physician Experience which would include those physicians who have membership on the hospital medical staff. (Directive to Take Action)	Delegate instructed to listen.
15	B	Res. 207 – Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program (American College of Obstetricians and Gynecologists)	RESOLVED, that our American Medical Association update existing policy D 255.985 ”Conrad 30- J1 Visa Waivers” to address current challenges and modernize the program by addition as follows: • advocate for the redistribution (or recapture) of unused waiver capacity to high-need states; and • advocate for the streamlining of administrative requirements to shorten timelines for employers and physicians, such as establishing a medical national interest exception and implementing mandatory expedited processing for physician and medical trainee applicants. (Modify Current HOD Policy)	Delegate instructed to support.
16	B	Res. 211 – Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians (Mississippi)	RESOLVED, that our American Medical Association advocate for the patients of any physician practicing in the same county (or equivalent region) that contains a covered 340B entity to receive reduced cost medications under the 340b program through the covered entity’s contracted pharmacy. (Directive to Take Action)	Delegate instructed to support, suggest a change in title to “equal access to 340B programs” to avoid the appearance of an adversarial relationship between employed and independent physicians over 340B programs.
17	B	Res. 222 – Advocating for a	RESOLVED, that our American Medical Association advocate for the development and maintenance overseen by the Centers for Medicare & Medicaid Services of a	Delegate instructed to listen.

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		Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage (Georgia)	centralized, official Medicare enrollment platform that provides clear, neutral, accurate, and easily understandable comparisons of coverage options under Traditional Medicare, Medicare Advantage, and supplemental coverage, including information on provider networks, prior authorization requirements, benefits, and out-of-pocket costs (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for ongoing oversight and evaluation of such platform to ensure the accuracy of plan and directory information, neutrality, usability, accessibility, and protection of beneficiaries from deceptive or coercive practices (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for federal policies that prohibit telemarketing firms and third-party marketing organizations from directly enrolling Medicare beneficiaries, and instead require that beneficiaries be directed to the official Medicare enrollment platform for plan enrollment (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for robust privacy and data security safeguards, including disclosure of data breaches, within any official Medicare enrollment platform, including protections against unauthorized access, misuse, or commercial exploitation of beneficiary information and prohibitions on the sale, transfer, or sharing of beneficiary enrollment data with third parties for commercial purposes (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for comprehensive outreach, education, and accessibility initiatives to ensure that beneficiaries and physicians, including those in rural, elderly, disabled, underserved, and technologically disadvantaged populations, can effectively use the official Medicare enrollment platform (Directive to Take Action); and be it further RESOLVED, that our AMA oppose legislative, regulatory, or administrative actions that would reduce access to, limit funding for, or otherwise disadvantage either Traditional Medicare or Medicare Advantage. (New HOD Policy)	

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18	B	Res. 223 – Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations (Georgia)	RESOLVED, that our American Medical Association oppose the use of artificial intelligence, algorithms, or automated decision-making systems as the sole basis for any adverse health insurance determination, including denials, delays, or limitations of coverage and adverse eligibility, underwriting, or enrollment determinations affecting health insurance applicants or insured patients (New HOD Policy); and be it further RESOLVED, that our AMA advocate that when artificial intelligence or automated decision-making systems are used in adverse health insurance determinations, any required human review must be conducted through the independent judgment of a licensed physician in accordance with existing AMA peer review policy, and must not be overridden, dictated, or unduly influenced by the output of such systems (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for policies requiring that patients and physicians be provided a clear and accessible explanation when artificial intelligence or automated decision-making systems materially contributed to an adverse health insurance determination, including an explanation of the role of the system in the decision, in both coverage determinations and eligibility, underwriting, or enrollment decisions (Directive to Take Action); and be it further RESOLVED, that our AMA support and advocate for payer-specific regulatory standards governing the use of artificial intelligence and automated decision-making systems in adverse health insurance determinations, including requirements for auditable records of AI-assisted decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and oversight by appropriate regulatory bodies (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for the uniform application of safeguards governing artificial intelligence and automated decision-making systems across all payer types and markets, including commercial insurance, individual and small-group markets, employer-sponsored coverage, and government insurance, with particular	Delegate instructed to listen.

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			attention to applicant-facing eligibility, underwriting, and enrollment decisions. (Directive to Take Action)	
19	B	Res. 226 – Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System (Academic Physicians Section)	RESOLVED, that our American Medical Association, in conjunction with other key organizations, study the potential impact of a proposed $100,000 employment-based visa fee on: • International Medical Graduates participation in the National Resident Matching Program (NRMP) Match; and • Graduate medical education programs; and • Critical access hospitals; and • Waiver and non-waiver recruitment into all specialties; and • Physician workforce development and access to care in communities across all 50 states and U.S. territories.	Delegate instructed to support.
20	B	Res. 238 – Prohibiting the Independent Practice of Medicine by Artificial Intelligence (Texas)	RESOLVED, that our American Medical Association advocate for legislation and regulation prohibiting the use of artificial intelligence (AI) as an independent diagnostic or prescriptive tool or as a care management substitute for a physician. (Directive to Take Action)	Delegate instructed to support.
21	B	Res. 241 – Strengthening Our AMA Efforts Toward CPOM Prohibition (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in section 1 as follows: "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:~~ supports policies that preserve physician ownership, governance, and independent medical judgment in physician practices and opposes corporate ownership or contractual arrangements that permit non-licensed entities to exercise control over the practice of medicine." (Modify Current HOD Policy); and be it further	Governing Council seeks IPPS Assembly input.

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			RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in the introductory clause preceding subsections (a)–(c) as follows: "~~Physicians who are contemplating corporate investor partnerships or corporate entity relationships~~ Physicians and policymakers evaluating corporate investment in physician practices should consider the following principles to ensure that any such relationships remain subordinate to physician ownership, governance, and professional medical judgment" (Modify Current HOD Policy); and be it further RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (d) as follows: "(d) ~~Physicians should ensure that contractual arrangements preserve physician autonomy in clinical decision making.~~Physician practices delivering medical care should be majority owned by licensed physicians who are actively practicing in the entity, and those licensed physicians must retain final authority over clinical decision making and over operational and administrative decisions that affect patient care, including clinical staffing, scope of services, clinical policies and standards, compensation structures tied to clinical services, coding and billing policies, payer contracting, and practice governance." (Modify Current HOD Policy); and be it further RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (e) as follows: "(e) ~~Physicians should carefully review contractual provisions governing governance structures, compensation arrangements, and management responsibilities when entering relationships with corporate investors.~~ Our AMA opposes stock transfer restriction agreements, "friendly PC" arrangements, succession rights, compelled sale provisions, management agreements, or other contractual mechanisms that permit non-licensed entities to exercise direct or de facto control over physician practices or over physicians' professional medical judgment. Physicians should review contractual provisions governing governance structures, compensation arrangements, and management responsibilities to ensure that such arrangements do not transfer control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities." (Modify Current HOD	

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			Policy); and be it further RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (f) to read as follows, and renumbering the subsequent subsections accordingly: "(f) Our AMA opposes management services organizations, private equity firms, and other non-licensed entities, and their owners, officers, directors, employees, or agents, from exercising governance authority or management control within a professional medical entity in a manner that directs, controls, or unduly influences clinical decision making, physician employment conditions affecting patient care, or other decisions reserved to licensed physicians." (Modify Current HOD Policy); and be it further RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (g) to read as follows, and renumbering the subsequent subsections accordingly: "(g) Our AMA opposes noncompetition, nondisclosure, non-disparagement, and non-interference clauses that restrict a physician's ability to exercise independent professional judgment, advocate for patients, report unsafe or unethical conditions, or continue caring for patients consistent with ethical and legal obligations." (Modify Current HOD Policy); and be it further RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (h) as follows: "(h) Physicians should seek transparency regarding the financial and ownership structures associated with corporate investors and related entities. Our AMA supports clear disclosure of physician practice ownership, governance, management agreements, and contractual control rights so that physicians, patients, regulators, and policymakers can identify who holds financial and operational control over the practice entity." (Modify Current HOD Policy); and be it further RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in item 2 as follows:	

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			"2. Physicians should understand and evaluate the financial and governance implications of corporate investment in medical practices before entering such arrangements and ensure that any such arrangements do not transfer ownership, governance authority, or operational control over clinical decision making to non-licensed entities." (Modify Current HOD Policy)	
22	B	Res. 243 – Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions (Association for Clinical Oncology)	RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services and state Medicaid agencies establish a standard with which to define "medical frailty" and "complex medical conditions" to be adopted by state Medicaid agencies; this definition shall explicitly include, at a minimum, any individual currently undergoing diagnostic testing for, receiving treatment for, or under active surveillance or monitoring for a life-threatening or complex chronic medical condition, as well as conditions in which the disease or its treatment results in functional limitation or an ongoing need for medical care, while preserving the authority of states to expand these protections to additional populations (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for federal and state Medicaid guidance to provide automatic exemptions from community engagement and work requirements for patients and primary caregivers of patients with complex medical conditions, utilizing evidence-based clinical data and claims-based algorithms to ensure treatment adherence and continuity of care (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians. (Directive to Take Action)	Delegate instructed to support.
23	B	Res. 245 – State Regulation of Non-Preempted "Non-Central Matters" of ERISA Plans—Rutledge v. PCMA	RESOLVED, that our American Medical Association will examine the strategic and operational opportunities physicians should consider under the U.S. Supreme Court holding in Rutledge v. PCMA as they pertain to the Employment Retirement Income Security Act (ERISA) with a report back at the Annual 2027 meeting with recommendations for operational best practices (Directive to Take Action); and be it further	Delegate instructed to listen.

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		(Private Practice Physicians Section)	RESOLVED, that our AMA will explore and, as appropriate, provide related educational programming at Interim and/or Annual Meetings and through other appropriate venues, including potential educational modules, regarding ERISA and its practical implications for private practice physicians (Directive to Take Action); and be it further RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways that can eliminate problems that some independent physicians experience, including: 1. Interest payments on overdue “clean” health insurance claims not otherwise addressed by ERISA’s statutory mandate; 2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources; 3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan; 4. Payment for the administrative burden of prior authorization and successful denial appeals; 5. Parity for telehealth-delivered services; 6. Timely payment of “clean claims” when the insurer’s obligation to pay the claim is reasonably distinct from timely determination of claims; 7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies; 8. Requiring that when health plan payment recovery or recoupment is due to coordination of benefit failure, the health plan shall seek recovery from the patient and/or the correct payor. (Directive to Take Action)	

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24	B	Res. 246 – Artificial Intelligence Scope of Practice (Private Practice Physicians Section)	RESOLVED, that our American Medical Association will develop model legislation declaring that artificial intelligence will not be used as a prescriptive or care management substitute for a physician (Directive to Take Action); and be it further RESOLVED, that our AMA will develop model legislation prohibiting the Federation of State Medical Boards from enabling independent licensure be granted to artificial intelligence "providers." (Directive to Take Action)	Delegate instructed to support.
25	D	CSAPH 04 – Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	Your Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 404-A-25 and the remainder of the report be filed. That Policy H-185.936 "Lung Cancer Screening to be Considered Standard Care," be amended by addition to read as follows: 1. Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit. 2. Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States. 3. Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. 4. Our AMA, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR), will create and share educational resources and training to help physicians efficiently discuss and document low-dose computed tomography (LDCT) lung cancer screening during shared decision-making visits for high-risk populations. 5. Our AMA will promote physician education and awareness regarding the value of low-dose CT in detecting lung cancer, and will encourage education, technological	Delegate instructed to support.

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			innovation, and continued research around the detection of coronary artery calcification on low-dose CT performed as a part of a lung cancer screening program. 6. Our AMA will support efforts by key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to research interventions to improve access to and utilization of lung cancer screening with low-dose CT scans in high-risk patients. (Modify Current HOD Policy)	
26	D	Res. 423 – Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP) (LGBTQ+ Section)	RESOLVED, that our American Medical Association supports advocacy, research funding, and targeted programmatic support to address disparities in PrEP access among populations disproportionately affected by HIV, ensuring that strategies are tailored to the unique needs of these communities (New HOD Policy); and be it further RESOLVED, that our AMA supports efforts to expand PrEP access to all individuals in alignment with evidence-based guidelines and shared decision making, including but not limited to innovative delivery models across various care settings and strategies to address social determinants of health that impede PrEP uptake such as housing instability, transportation barriers, and stigma. (New HOD Policy)	Delegate instructed to support.
27	D	Res. 424 – Supporting Education and Access to Postexposure Doxycycline (DoxyPrEP) (LGBTQ+ Section)	RESOLVED, that our AMA supports physician and trainee education on Postexposure Doxycycline (DoxyPEP) and other anti-microbial postexposure treatments (New HOD Policy); and be it further RESOLVED, that our AMA supports prescribing and insurance coverage of Postexposure Doxycycline (DoxyPEP) for sexually transmitted infection (STI) prevention. (New HOD Policy)	Delegate instructed to support.
28	D	Res. 425 – Prioritizing, Measuring, and Preventing Workplace Violence in Health Care	RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies (New HOD Policy); and be it further RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents	Delegate instructed to support.

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			across all health care settings, with appropriate protections for patient and worker privacy (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition (Directive to Take Action); and be it further RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings (New HOD Policy); and be it further RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce (Directive to Take Action); and be it further RESOLVED, that our AMA rescind existing policies H-515.957 (Preventing Violent Acts Against Health Care Providers), D-515.983 (Preventing Violent Acts Against Health Care Providers), and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy)	
29	E	CSAPH 07 – Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed: 1. That our AMA will: a. Recognize and promote the importance of ~~transparency and explainability of~~ physicians having sufficient information to make sound clinical decisions when using an AI ~~tools used in~~ clinical decision support tool, which, depending on the tool, may include information such as ~~to ensure the quality of medical evidence and~~ the grading	Delegate instructed to support the California amendment, shown here.

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			of medical evidence including the data sources ~~are clearly conveyed to physicians so clinical recommendations and outputs can be accurately verified and validated as tools to assist physicians in making clinical decisions~~. b. Collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems. c. Encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making. d. Monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care. (Directive to Take Action) 2. Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," be rescinded as having been accomplished by this report. (Rescind AMA Policy)	
30	E	Res. 505 – Avoiding Misuse of Artificial Intelligence (AI) in Clinical Practice (New York)	RESOLVED, that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document (New HOD Policy); and be it further RESOLVED, that any physician or healthcare professional, who chooses to use Artificial Intelligence (AI) in the creation of the medical record, understands that the accuracy of that record is completely the responsibility of that author. (New HOD Policy)	Delegate instructed to listen.
31	E	Res. 509 – Preserving Gender-Affirming Surgical Care Access (LGBTQ+ Section)	RESOLVED, that our American Medical Association reaffirm and recognize that decisions regarding gender-affirming surgical care rest with physicians, patients, and families, and support evidence-based, patient-centered, shared decision-making for such care (New HOD Policy); and be it further RESOLVED, that our AMA advocate and support funding and opportunities for gender-affirming care research across modalities and age ranges, ensuring that such	Delegate instructed to support.

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			research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity (Directive to Take Action); and be it further RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making gender-affirming surgical and medical care. (Directive to Take Action)	
32	E	Res. 515 – Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure (Association for Clinical Oncology)	RESOLVED, that our American Medical Association advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians with the specific clinical logic, evidence-based sources, and version history of any augmented intelligence (AI) or algorithmic tools used in the issuance of an adverse determination (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited to ensure it reflects the most recent peer-reviewed clinical guidelines and recognized standards of care. (Directive to Take Action)	Delegate instructed to listen, ask for clarification of what “audit” and similar terms could mean here.
33	G	CMS 06 – Study of Practice Models for Physicians Performing Procedures Across State Lines	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 711-A-25 and the remainder of the report be filed. 1. That our American Medical Association (AMA) supports the following principles for physicians employed by ambulatory surgical centers (ASC) or office-based laboratories (OBL) who may travel from their primary practice location to provide patient care: a. A transfer agreement with a physician or physician group licensed in the patient’s state should be arranged to address in-person care needs that may arise from a patient receiving care from a physician who primarily practices out of state or out of the immediate area or from a physician with no admitting privileges to the local hospital. b. A referral system with a local physician, physician practice, or other facility for	Delegate instructed to listen.

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			appropriate treatment should be established if a patient's conditions or symptoms are beyond the scope of services provided by the ASC or OBL. c. Transfer agreements and backup plans should be coordinated between physicians. i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician that would be among those receiving the patient must give explicit consent to the agreement to provide follow-up care. ii. When patient transfer is required, a direct hand off of the patient and patient records should be completed. iii. Transfer and referral agreements should be evidence-based and risk-based to balance access to care and patient safety. d. Protocols for ensuring continuity of care with physicians in the local community should be established. e. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process. f. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements. (New HOD Policy) 2. That our AMA reaffirm Policy H-475.984, which lists Core Principles for Office-Based Surgery Regulations, with a focus on Core Principle #4 which states that physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospitals or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or to maintain an emergency transfer agreement with a nearby hospital. (Reaffirm HOD Policy)	
34	G	CMS 09 – Nonprofit Status	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed. 1. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows: NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954	Delegate instructed to listen.

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			1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. 2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. 3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. 4. Our AMA advocates for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities and eligibility for nonprofit status. 5. Our AMA advocates for the development of a transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios. 6. Our AMA advocates for transparency and consistency regarding ~~the expansion of~~ governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status. 7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)	

END