AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee B

Jennifer Hone, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 08 - Council on Legislation Sunset Review of 2016 House Policies
2. Board of Trustees Report 12 - The Uniform Health-Care Decisions Act
3. Board of Trustees Report 13 - Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes
4. Board of Trustees Report 21 - Abolishing Venue Shopping
5. *Board of Trustees Report 25 - Federal Legislation to Prohibit the Corporate Practice of Medicine
6. Board of Trustees Report 27 - Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
7. Resolution 209 - Protecting Mental Health Treatment Privacy in Legal Proceedings
8. Resolution 213 - Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
9. Resolution 218 - Opposing the Practice of Jury Anchoring in Medical Liability Cases
10. Resolution 228 - Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
11. Resolution 235 - Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
12. Resolution 237 - Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan

RECOMMENDED FOR ADOPTION AS AMENDED

13. Board of Trustees Report 14 - Binding Arbitration in Health Insurance Contracts
14. Board of Trustees Report 15 - Protecting the Prescriptive Authority of Plenary Licensed Physicians
15. *Board of Trustees Report 19 - Root Cause Analysis of the Causes of the Decline of Private Medical Practice
16. *Board of Trustees Report 24 - AMA Advocacy to Mitigate Medicaid Cuts
17. *Board of Trustees Report 28 - Accountability in the Use of Augmented Intelligence for Prior Authorization
18. *Resolution 203 - Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
19. Resolution 207 - Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program

20. Resolution 208 - Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
21. Resolution 212 - Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
22. Resolution 216 - Protecting Healthcare as a Sensitive Location
23. Resolution 219 - Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
24. Resolution 229 - Physicians are not Providers
25. Resolution 232 - Banning Flavored Cannabis E-Cigarettes
26. *Resolution 239 - Medicare Administrative Contractor Policy Modification
27. *Resolution 240 - Ending Private Equity Dividend Recapitalization in Healthcare
28. *Resolution 243 - Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
29. Resolution 244 - Eliminate Administrative Barriers to Appeal Wrongful Denials
30. Resolution 247 - Comprehensive ERISA Reform
31. *Resolution 248 - Medical Staff Oversight of Hospital Augmented Intelligence
32. *Resolution 250 - Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities
33. *Resolution 252 - Immediate Action to Prevent Further Immigrant Deaths
34. *Resolution 254 - OMB Proposed Rule: Regulation for Federal Financial Assistance

RECOMMENDED FOR ADOPTION IN LIEU OF

35. *Resolution 201 - Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
Resolution 233 - Banning Synthesized, Purified or Derivative Products from Kratom
36. *Resolution 222 - Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
37. Resolution 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
Resolution 230 - Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
38. *Resolution 238 - Prohibiting the Independent Practice of Medicine by Artificial Intelligence
Resolution 246 - Artificial Intelligence Scope of Practice
Resolution 249 - Bringing Physicians' Voices to the Implementation of AI Prescribers
39. *Resolution 251 - Minimum Standards for Public Health Leaders
40. *Resolution 253 - Protection of Medicaid Beneficiaries from Politically Motivated and Procedurally Deficient Federal Funding Deferrals

RECOMMENDED FOR REFERRAL

41. Resolution 202 - Using and Defining “Unsupervised Practice of Medicine”
42. *Resolution 206 - Overall Hospital Quality Star Ratings / CMS Star Ratings
43. Resolution 221 - Universal Newborn Congenital Cytomegalovirus Screening
44. *Resolution 223 - Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations

45. Resolution 225 - Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients
46. *Resolution 236 - Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
47. *Resolution 241 - Strengthening Our AMA Efforts Toward CPOM Prohibition
48. *Resolution 242 - Reducing Emergency Department Boarding through Payment Reform

RECOMMENDED FOR NOT ADOPTION

49. Resolution 245 - State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

50. Resolution 204 - D-400.982 Revision
51. Resolution 205 - Repeal of the Merit-Based Incentive Payment System (MIPS)
52. Resolution 210 - Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
53. Resolution 211 - Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
54. Resolution 214 - Medical Student Loans Should Not Be Capped
55. Resolution 215 - Oppose Medicare Efficiency Adjustments
56. Resolution 217 - Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
57. Resolution 220 - Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians
58. Resolution 224 - Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
59. Resolution 227 - Standby Capacity Payments and Health IT for Hospitals in Rural Areas
60. Resolution 231 - Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
61. Resolution 234 - Physician Unity in Advocacy Regarding Physician Reimbursement

RECOMMENDED FOR FILING

62. *Board of Trustees Report 37 – AMA Policies on Gender Affirming Care

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 08 - COUNCIL ON LEGISLATION SUNSET REVIEW OF 2016 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 08 be adopted, and the remainder of the Report be filed.

The Board of Trustees 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 testimony that was largely supportive of adopting the recommendations of Board of Trustees Report 08 regarding which AMA policies to retain and which to sunset. Although some commenters raise concerns with different actions recommended by the report, there is a clear consensus in favor of adopting the recommendations. It was noted that amendments should be made to D-35.979, but there was minimal testimony provided on this point. Therefore, your Reference Committee recommends that Board of Trustees Report 08 be adopted, and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 12 - THE UNIFORM HEALTH-CARE DECISIONS ACT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 12 be adopted, and the remainder of the Report be filed.

The Board recommends that the following be adopted in lieu of Resolution 250-A-24 and the remainder of the report be filed.

1. That Policy H-85.957, “Encouraging Standardized Advance Directives Forms Within States,” be reaffirmed. (Reaffirm HOD Policy)
2. That Policy H-140.845, “Encouraging the Use of Advance Directives and Health Care Powers of Attorney,” be reaffirmed. (Reaffirm HOD Policy)
3. That Policy H-85.956, “Educating Physicians About Advance Care Planning,” be reaffirmed. (Reaffirm HOD Policy)
4. That Policy H-140.970, “Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients,” be reaffirmed. (Reaffirm HOD Policy)
5. That Policy H-140.826, “Use of Psychiatric Advance Directives,” be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard limited but unanimous testimony in favor of adopting the recommendations of Board of Trustees Report 12. Commenters agreed with the Board of Trustees' assessment that it is not appropriate for our AMA to endorse the Uniform Health-Care Decisions Act (UHCDA) at this time given the conflict between the UHCDA and existing AMA policy and clinical practices. Instead, Board of Trustees Report 12 recommends reaffirmation of AMA policies relating to advance directives. Your Reference Committee agrees with the conclusions of the report and its recommendations. Therefore, your Reference Committee recommends that Board of Trustees Report 12 be adopted, and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 13 - REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED SUBSTANCES FOR LEGITIMATE MEDICAL PURPOSES

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the Report be filed.

The Board of Trustees recommends the following be adopted and the remainder of the report be filed.

1. That the referred clause from Resolution 209-A-25, "Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes," not be adopted.
2. That our American Medical Association advocate to the U.S. Department of Justice to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a legitimate medical purpose. (Directive to Take Action)
3. That our AMA advocate to the U.S. Department of Justice to work more closely with the AMA and its interested medical association partners to more clearly identify the factors it uses during an investigation to minimize disruptions to patient care. (Directive to Take Action)
4. That our AMA support the U.S. Centers for Disease Control and Prevention Opioid Rapid Response Program and similar state-based efforts that seek to ensure continuity of care when patients lose access to care due to a law enforcement or other action that results in the closure of a physician's practice. (New AMA Policy)

Your Reference Committee reviewed the testimony for Board of Trustees Report 13. The testimony was strongly in favor of adoption. Your Reference Committee agrees that physicians should control who and what defines a "legitimate medical purpose," and while medical boards may be subject to state legislative actions in some cases, medical boards also are comprised almost entirely of physicians, one of the many reasons our AMA supports licensure at the state level. Your Reference Committee also notes that our AMA may choose to use any AMA policy to support legal action on behalf of physicians. For these reasons, your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the report be filed.

(4) BOARD OF TRUSTEES REPORT 21 - ABOLISHING VENUE SHOPPING

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 21 be adopted, and the remainder of the Report be filed.

The Board of Trustees recommends that the following recommendations be adopted, and the remainder of the report be filed:

1) That our American Medical Association amend Policy D-438.968, "Abolishing Venue Shopping" by deletion of clause 2 as it has been accomplished by this report:

1) Our American Medical Association (AMA) opposes venue shopping in medical professional liability actions.

~~2. Our AMA will study avenues to most effectively combat venue shopping in state and federal medical professional liability actions with report back at A-26.~~ (Modify Current Policy)

2. That our AMA will work with interested medical society partners, to combat venue shopping in medical liability lawsuits. (New HOD Policy)

3. That our AMA opposes any efforts to move venue to jurisdictions that may apply a standard of care not reflecting specific resource constraints, available technology/equipment and community standards of the location where the patient's clinical care was actually delivered. (New HOD Policy)

Your Reference Committee heard strong support for the recommendations made in Board of Trustees Report 21, which would amend existing AMA policy to provide that our AMA will work with interested medical society partners to combat venue shopping in medical liability lawsuits. Commenters emphasize the harms of venue shopping, where attorneys seek out the most plaintiff-friendly jurisdiction in which to bring medical liability lawsuits, regardless of whether such jurisdiction is the most reasonable location in which to bring the suit, and urge our AMA to continue vigorous advocacy efforts to curb this practice. Your Reference Committee agrees, and therefore recommends Board of Trustees Report 21 be adopted and the remainder of the report be filed.

(5) BOARD OF TRUSTEES REPORT 25 - FEDERAL LEGISLATION TO PROHIBIT THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 25 be adopted and the remainder of the Report be filed.

BOARD OF TRUSTEES REPORT 25 - FEDERAL LEGISLATION TO PROHIBIT THE CORPORATE PRACTICE OF MEDICINE

The Board recommends that the following be adopted in lieu of Resolution 225-I-25 and that the remainder of this report be filed:

1. That the American Medical Association, in order to protect physician autonomy and strengthen the physician-patient relationship, support federal legislation prohibiting lay entities, including but not limited to insurance companies, private equity firms, non-physician individual licensed health care professionals and other non-physician-owned entities or individuals, from interfering with, controlling, or otherwise directing 1) the independent professional judgment or clinical decisions of a physician, or 2) the operational authority of physicians within their practices, provided that any such legislation include a specific saving clause clarifying an intent to preserve the right of states to enact and enforce more stringent state laws. (New HOD Policy)
2. That the AMA support whistleblower programs that allow individuals to report knowledge of violations of a law prohibiting lay entities from interfering with, controlling, or otherwise directing the professional judgment, clinical decisions, or operational authority of a physician to the appropriate enforcement agency. (New HOD Policy)
3. That the AMA support the implementation and enforcement of strong state laws or regulations that prohibit the corporate practice of medicine (New HOD Policy)
4. That Policy H-215.981, "Corporate Practice of Medicine," be amended by addition and deletion as follows:

~~1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.~~

1.~~2.~~ Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine.

2.~~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.

3. 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.

4.~~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.

5.~~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 health care sector such that physician clinical autonomy and operational authority are preserved and protected.

6.~~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.

7.~~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.

8.~~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 Current HOD Policy)

Your Reference Committee heard testimony establishing that Board of Trustees Report 25 and Resolution 241 serve complementary but distinct purposes and accordingly considered them separately. Testimony regarding Board of Trustees Report 25 was overwhelmingly supportive. As such, your Reference Committee recommends that the recommendations contained in Board of Trustees Report 25 be adopted and the remainder of the report be filed.

(6) BOARD OF TRUSTEES REPORT 27 - UPDATE THE STATUS OF VIRTUAL CREDIT CARD POLICY, EFT FEES, AND LACK OF ENFORCEMENT OF ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS BY CMS

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 27 be adopted, and the remainder of the Report be filed.

The Board of Trustees recommends the following be adopted and the remainder of the report be filed.

1. That Policy D-190.965 be amended to read as follows: Our American Medical Association report at the Annual 2026~~6~~7 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Update HOD Policy)

2. That our AMA reaffirm Policies H-190.955, "Virtual Credit Card Payments;" D-190.968, "Amend Virtual Credit Card and Electronic Funds Transfer Fee;" and D-190.970, "CMS Administrative Requirements." (Reaffirm HOD Policy)

Your Reference Committee heard extensive testimony on Board of Trustees Report 27, with the majority consensus favoring adoption of the report's call for robust, ongoing action to address the financial burdens imposed on physician practices by virtual credit card (VCC) payment and fee-based electronic funds transfer (EFT) fees. Many commenters spoke to the harms these fees inflict on physician practices and the importance of continued advocacy by our AMA. Your Reference Committee agrees that the actions called for by the report—stronger CMS enforcement, clear regulatory action, and federal legislation (such as the No Fees for EFTs Act)—are needed. Therefore, your Reference Committee recommends that the Board of Trustees Report 27 be adopted, and the remainder of the report be filed.

(7) RESOLUTION 209 - PROTECTING MENTAL HEALTH TREATMENT PRIVACY IN LEGAL PROCEEDINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 209 be adopted.

RESOLVED, that our American Medical Association develop model state legislation ensuring that mental health treatment records are protected from discoverability in civil and criminal trials, thereby fostering a safe and supportive environment for healthcare professionals to seek necessary mental health care. (Directive to Take Action)

Your Reference Committee heard strong support for Resolution 209. Your Reference Committee appreciates the concern raised that the resolution could be interpreted as "overly broad." Your Reference Committee counsels that state and federal laws, as well as the courts, already balance privacy protections of medical information in numerous contexts, including medical records. Your Reference Committee does not agree that the resolution is overly broad because calling for "protections" is not viewed as an absolute bar given that the Health Insurance Portability and Accountability Act, 42 CFR Part 2, and the courts already provide for limited discovery, and balance in when such records may be disclosed. These balancing acts also are reflected throughout AMA policy, including H-315.983 and Ethics Policy 3.2.1. For these reasons, your Reference Committee recommends that Resolution 209 be adopted.

(8) RESOLUTION 213 - PROHIBITING PHARMACY BENEFIT MANAGERS FROM OWNING PHARMACIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 213 be adopted.

RESOLVED, that our American Medical Association develop model state legislation empowering state insurance regulating bodies to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies**.** (Directive to Take Action)

Your Reference Committee heard strong support for adoption of Resolution 213, which calls for our AMA to develop model state legislation to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies. Commenters noted that oversight of PBMs and vertical integration of PBMs and pharmacies is appropriate, needed, and in alignment with AMA policies. Your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 213 be adopted.

(9) RESOLUTION 218 - OPPOSING THE PRACTICE OF JURY ANCHORING IN MEDICAL LIABILITY CASES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 218 be adopted.

RESOLVED, that our American Medical Association opposes the practice of jury anchoring in medical liability litigation, specifically as it related to non-economic damages. (New HOD Policy)

Your Reference Committee received supportive testimony for Resolution 218. Commenters noted that while our AMA has done extensive work on medical liability reform, AMA policy does not include opposition to jury anchoring, a practice in which plaintiffs' attorneys attempt to bias juries by placing a specific, inflated dollar value on damages early in the trial process. Some commenters suggested replacing the term "jury anchoring" with "financial anchoring" or "damages anchoring" to make the resolution clearer. However, the term "jury anchoring" is a term of art that is understood to refer to a common practice in medical liability cases. Therefore, your Reference Committee recommends that Resolution 218 be adopted.

(10) RESOLUTION 228 - DEPARTMENT OF DEFENSE HEALTH CARE INVESTMENT AT MILITARY BASES IN MATERNITY CARE HEALTH PROFESSIONAL SHORTAGE AREAS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 228 be adopted.

RESOLVED, that our American Medical Association urge the Department of Defense to provide comprehensive reproductive health care coverage, funding and improved access to labor and delivery services for military personnel, military families, and non-military individuals working on military bases in maternity care health professional shortages areas (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to research and distribute successful state and specialty society models that have improved access to comprehensive reproductive care and maternal care in rural areas and reduced maternal mortality rates. (Directive to Take Action)

Your Reference Committee heard broad, unanimous support for Resolution 228. Commenters spoke to the importance of ensuring access to reproductive and maternal health care for military and non-military personnel working on military bases and note that the resolution aligns with our AMA's ongoing work in the maternal health care space. Your Reference Committee agrees. Though an amendment was provided that would have limited this policy to only those individuals that are eligible for TRICARE, your Reference

Committee notes that this was not the intention of the resolution, nor was it in alignment with the majority of the testimony. Therefore, your Reference Committee recommends that resolution 228 be adopted.

(11) RESOLUTION 235 - ESTABLISHING HEALTHCARE MONITORING AND ACCOUNTABILITY IN IMMIGRATION DETENTION FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 235 be adopted.

RESOLVED, that our American Medical Association support independent, transparent, unannounced inspections of all ICE detention facilities, with anti-retaliation protections for detainees and health staff who participate (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to reform ICE's waiver system by requiring that all waivers include clear expiration dates, transparent public reporting, and standardized criteria that limit their use to cases of demonstrated necessity. (New HOD Policy)

Your Reference Committee received supportive testimony for Resolution 235. Testimony highlighted the importance of accountability, independent inspections, revised waiver policies, and protecting patient safety and human rights in immigration detention. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

(12) RESOLUTION 237 - GUARANTEED 30-DAY TRANSITION FILL OF CURRENTLY PRESCRIBED INSULIN AT THE BEGINNING OF EACH YEAR PLAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 237 be adopted.

RESOLVED, that our American Medical Association adopt as policy and advocate that beneficiaries of ERISA-governed health plans be allowed a 30-day transition fill of insulin at the beginning of each plan year to allow time for the formulary preference to be determined by the patient and prescriber. (Directive to Take Action)

Your Reference Committee received minimal but supportive testimony for Resolution 237. Testimony noted that this policy would address dangerous insulin therapy interruptions, especially during insurance coverage or formulary changes, and support continuity of care. Given the unanimously supportive testimony, your Reference Committee recommends that Resolution 237 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(13) BOARD OF TRUSTEES REPORT 14 - BINDING ARBITRATION IN HEALTH INSURANCE CONTRACTS

RECOMMENDATION A:

Your Reference Committee recommends that the second recommendation of Board of Trustees Report 14 be amended by addition to read as follows:

That our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians can identify the advantages and disadvantages that may be present in those agreements. Resources shall include, but not be limited to: (1) developing model arbitration language that protects physicians when such clauses are used; (2) establishing fairness principles or standards for arbitration provisions in physician-insurer contracts that include but are not limited to clear timelines, enforcement mechanisms, reasonable limits on arbitration costs, neutral arbitrator selection, and safeguards against venue manipulation; (3) identifying specific contract red flags such as venue restrictions that physicians should be aware of when reviewing arbitration clauses; and (4) encouraging greater transparency or reporting around arbitration outcomes. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended, and the remainder of the Report be filed.

The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association Policy D-435.967, “Binding Arbitration in Health Insurance Contracts,” be rescinded having been accomplished by this report. (Rescind HOD Policy)
2. That our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians can identify the advantages and disadvantages that may be present in those agreements. Resources shall include, but not be limited to: (1) developing model arbitration language that protects physicians when such clauses are used; (2) establishing fairness principles or standards for arbitration provisions in physician-insurer contracts; (3) identifying specific contract red flags such as venue restrictions that physicians should be aware of when reviewing arbitration clauses; and (4) encouraging greater transparency or reporting around arbitration outcomes. (New HOD Policy)

3. That our AMA (1) opposes requiring mandatory binding arbitration as a condition of participation in an insurance company's provider network; (2) supports a physician's right to choose between arbitration and the public court system after a dispute arises, rather than being forced to waive their right to a jury trial; (3) believes that no physician should be required to participate in an arbitration or mediation process that is not the result of meaningful mutual agreement between the physician and health insurer; (4) advocates that all arbitration awards involving physician-payer disputes be reported to a centralized de-identified database to ensure transparency and to identify patterns of frequent bad-faith claims settlement practices by insurers. (New HOD Policy)

Your Reference Committee notes that the testimony for Board of Trustees Report 14 was generally in favor of adoption, with some commenters suggesting amendments. Wide support was heard for the development of resources to help physicians navigate the pitfalls of arbitration agreements and negotiate those agreements where possible. A friendly amendment was offered that would ensure that the materials to be developed include timelines and enforcement considerations. This amendment received support from other commenters.

Your Reference Committee agrees that our AMA should provide guidance to physicians facing arbitration proceedings in health insurance contracts and further agrees that including timelines and enforcement considerations in this guidance would be beneficial. Therefore, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended, and that the remainder of the report be filed.

(14) BOARD OF TRUSTEES REPORT 15 - PROTECTING THE PRESCRIPTIVE AUTHORITY OF PLENARY LICENSED PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that recommendation 1 of Board of Trustees Report 15 be amended by addition to read as follows:

That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas, with report back at A-27. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that recommendation 2 of Board of Trustees Report 15 be amended by addition and deletion to read as follows:

That our AMA work with ~~urge~~ pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action).

RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 15 be adopted as amended, and the remainder of the Report be filed.

The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed.

1. That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas. (Directive to Take Action)
2. That our AMA urge pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action).
3. That our AMA Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be reaffirmed. (Reaffirm HOD Policy)
4. That Policy D-120.920 "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be amended by deletion of the first item to read as follows:

1. ~~Our American Medical Association will study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.~~
Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.

~~3.~~2. Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.

~~4.~~3. Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.

~~5.~~4. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care. (Modify Current HOD Policy)

Your Reference Committee received mostly supportive testimony for Board of Trustees Report 15. Some minor amendments were offered that received additional supportive testimony including a proposed amendment seeking a report back to the House of Delegates and a proposal to work with pharmacies to develop a reporting framework on refusals to fill. Therefore, your Reference Committee recommends that of Board of Trustees Report 15 be adopted as amended and that the remainder of the report be filed.

(15) BOARD OF TRUSTEES REPORT 19 - ROOT CAUSE ANALYSIS OF THE CAUSES OF THE DECLINE OF PRIVATE MEDICAL PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 19 be amended by addition and deletion to read as follows:

That consistent with Policy D-405.965, "Root Cause Analysis of the Causes of the Decline of Private Medical Practice" ~~be~~ our AMA further study and report back on the role of physician non-compete agreements and other physician employment restrictions as potential contributors to the decline of private medical practice, including their impact on physician mobility, the ability of physicians to establish or re-establish independent practices, patient access and continuity of care, and the maintenance of market power by dominant health systems ~~rescinded as being accomplished by this report~~. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Board of Trustees Report 19 be adopted as amended, and the remainder of the Report be filed.

The Board of Trustees recommends the following be adopted and the remainder of this report be filed:

1. That our AMA reaffirm the following policies:

a. H-330.932, "Cuts in Medicare and Medicaid Reimbursement";
b. H-400.957, "Medicare Reimbursement of Office-Based Procedures";
c. H-390.879, "Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service";
d. D-330.902, "The Site-of-Service Differential";
e. H-240.958, "Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service";
f. D-240.994, "Payment Variations Across Outpatient Sites of Service"; D-330.997, "Appropriate Payment Level Differences by Place and Type of Service";
g. D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule";
h. H-385.921, "Health Care Access for Medicaid Patients";
i. D-160.907, "Health System Consolidation";
j. D-215.984, "Health System Consolidation";
k. H-180.947, "Maintaining Freedom of Choice with Insurance Products";

l. D-160.906, “Strengthening Efforts Against Horizontal & Vertical Consolidation”;
m. D-160.908, “Vertical Consolidation in Health Care – Markets or Monopolies”;
n. D-385.940, “Stark Law Self-Referral Ban”;
o. H-215.960, “Hospital Consolidation”;
p. H-215.969, “Hospital Merger Study”;
q. D-225.995, “Hospital Merger Study”;
r. H-383.988, “Physicians' Ability to Negotiate and Undergo Practice Consolidation”;
s. H-160.885, “Impact of Integration and Consolidation on Patients and Physicians”;
t. H-160.960, “Corporate Ownership of Established Private Medical Practices”;
u. D-405.988, “The Preservation of the Private Practice of Medicine”;
v. D-160.909, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations”;
w. D-330.909, “Study the Costs of Administrative and Regulatory Burdens”;
x. H-110.985, "340B Drug Discount Program"; and
y. H-155.976, “Administrative Costs and Access to Health Care” (Reaffirm HOD Policy)

2. Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions. (New HOD Policy)

3. That Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice” be rescinded as being accomplished by this report. (Rescind HOD Policy)

Your Reference Committee received limited and mixed testimony for Board of Trustees Report 19. However, weighty testimony was provided in support of Board of Trustees Report 19. Multiple commenters supported adopting the report’s recommendation to reaffirm existing AMA policies that remain relevant and aligned with the concerns raised in the original resolution that prompted the report, particularly regarding the preservation of physician autonomy, reduction of unnecessary administrative burden, and support for independent practice sustainability. Reaffirming existing policy recognizes the continued importance of these positions while maintaining consistency with our AMA’s longstanding advocacy efforts in this area. In addition to this, testimony was heard, and amendments were provided, that supported retaining D-405.965 for one additional year so that our AMA can continue to study the role of physician non-compete agreements. Testimony favored providing this additional information and noted that, though it was positive to reaffirm policy, it should also be supported by continued action. Therefore, your Reference Committee recommends that the Board of Trustees Report 19 be adopted as amended, and the remainder of the report be filed.

(16) BOARD OF TRUSTEES REPORT 24 - AMA ADVOCACY TO MITIGATE MEDICAID CUTS

RECOMMENDATION A:

Your Reference Committee recommends that the first sentence of the recommendation made by Board of Trustees Report 24 be amended by addition and deletion to read as follows:

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 amended by striking "A-26" and inserting "A-27"~~a rescinded as having been accomplished by this report~~ and that the remainder of the report be filed.

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 24 be amended by addition of the following new recommendation to read as follows:

The Board of Trustees recommends that existing AMA policies "Preservation of Medicaid" (H-290.951), "Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts" (D-290.970), "Opposition to Medicaid Work Requirements" (H-290.961), and "Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding" (H-285.898) be reaffirmed.

RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended, and the remainder of the Report be filed.

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)

Your Reference Committee heard broad support for Board of Trustees Report 24 and AMA's advocacy to mitigate Medicaid cuts enacted by Public Law 119-21. Commenters endorsed strong, ongoing advocacy and requested continued updates from the Board of Trustees to the House of Delegates. An amendment was offered to require the Board of Trustees to report back at the 2027 Annual Meeting of the House of Delegates to allow the House to assess our AMA's progress on Medicaid advocacy as more significant cuts made by Public Law 119-21 begin to take effect. This amendment received support, including from the Board of Trustees.

An amendment was offered to further elevate mitigation of Medicaid cuts made by Public Law 119-21 (also known as the "One Big Beautiful Bill Act"), including delaying work requirements and establishing an appropriate definition of medical frailty, as a top advocacy priority. Your Reference Committee appreciates that the cuts made by P.L. 119-21 are a pressing issue, and that advocacy to reverse or mitigate these cuts is urgently needed. However, the cuts in P.L. 119-21 are already addressed through existing AMA policies in conjunction with Resolution 243, which relates to the medical frailty exemption and which your Reference Committee is recommending be adopted as amended. Existing policy already establishes preserving Medicaid as a "top legislative advocacy priority" of our AMA, opposes work requirements as a condition of Medicaid eligibility, supports the use of state provider and managed care organization taxes to finance Medicaid, and specifically directs our AMA to advocate to reverse or mitigate P.L. 119-21's cuts. Furthermore, our AMA is actively and aggressively carrying out these policies through sustained and committed advocacy on these issues. Our AMA is leading an advocacy campaign on P.L. 119-21 changes, and many of the resources, advocacy work, and press statements that are part of this campaign are available on a dedicated website. Beyond this public-facing advocacy, our AMA is directly engaged with policymakers at the state and federal levels, urging policies that will implement P.L. 119-21's cuts in the least harmful manner possible.

Our AMA's advocacy work on P.L. 119-21 is comprehensive and includes the specific issue of medical frailty raised by the proposed amendment. When the Centers for Medicare & Medicaid Services issued an interim final rule that adopted stringent requirements for medical frailty exemptions, our AMA, responding to unconfirmed reports that the rule would include unduly harsh requirements, had already sent a public letter to CMS urging the agency not to adopt these requirements. Now that the rule is public, our AMA will continue to advocate vigorously for revisions that will avoid inflicting unnecessary harm to eligible patients and burden on physicians.

Finally, your Reference Committee believes it is inadvisable to adopt policy that effectively prioritizes one set of Medicaid issues above other Medicaid issues. Our policies are long-lasting, and today's priorities may not be the same as tomorrow's priorities. Competing policies that elevate different aspects of Medicaid could create confusion and undermine our advocacy as new challenges arise.

Therefore, in lieu of adopting the proposed amendment, your Reference Committee recommends reaffirmation of the AMA policies that collectively provide robust guidance and direction for the AMA's advocacy. Specifically, Policy H-290.951, "Preservation of Medicaid," elevates Medicaid to an urgent and top legislative advocacy priority and supports protecting and preserving Medicaid as an essential component of the healthcare safety net. Policy D-290.970, "Call for Action by the

American Medical Association to Reverse or Mitigate Medicaid Cuts," denounces cuts to Medicaid and directs AMA to continue advocacy efforts to reverse or mitigate Medicaid funding reductions in P.L. 119-21 to ensure continued access to care. Policy H-290.961, "Opposition to Medicaid Work Requirements", states that AMA opposes work requirements for Medicaid eligibility, recognizing they may hinder access for vulnerable populations. Policy H-258.898, "Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding," supports the use of certain financing tools, sharply curtailed by P.L. 119-21, that states have long used to support their Medicaid programs.

These reaffirmed policies, alongside AMA's robust advocacy and the provisions of Resolution 243, sufficiently address the concerns raised. Therefore, your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended, existing policy be reaffirmed, and that the remainder of the report be filed.

Preservation of Medicaid H-290.951

1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility.
2. Our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts D-290.970

1. Our American Medical Association publicly denounces cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025").

2. Our AMA 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. Our AMA will 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. Our AMA will report back to the AMA's House of Delegates at A-26.

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding H-285.898

1. Our American Medical Association supports the use of broad-based, uniform Provider (hospital and nursing home) and Managed Care Organization (MCO) taxes to generate state funds to match with federal Medicaid funding that sustain or improve Medicaid patients' access to care while not financially burdening physician practices.
2. Our AMA opposes federal proposals that would restrict or eliminate states' ability to assess Provider (hospital and nursing home) and Managed Care Organization Taxes to finance their Medicaid programs and protect patient access to care, as long as physician practices are not financially harmed.

(17) BOARD OF TRUSTEES REPORT 28 - ACCOUNTABILITY IN THE USE OF AUGMENTED INTELLIGENCE FOR PRIOR AUTHORIZATION

RECOMMENDATION A:

Your Reference Committee recommends that recommendation 1.2 of Board of Trustees Report 28 be amended by addition and deletion to read as follows:

2) Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to appeal and to review by a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided, (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request ~~qualified, specialty appropriate clinicians~~, and (c) who are not incentivized to deny coverage for care~~, and~~ to ensure that automated systems do not supplant individualized clinical judgment.

RECOMMENDATION B:

Your Reference Committee recommends that recommendation 1.3 of Board of Trustees Report 28 be amended by addition and deletion to read as follows:

3) Support and seek advancement of federal legislation to promote transparency in all ~~Medicare Advantage~~ prior authorization programs, including public reporting of AI and automated decision-making use.

RECOMMENDATION C:

Your Reference Committee recommends that recommendation 1.5 of Board of Trustees Report 28 be amended by addition and deletion to read as follows:

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 physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided and (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request ~~qualified clinician~~.

RECOMMENDATION D:

Your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended, and the remainder of the Report be filed.

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)

Your Reference Committee heard testimony reflecting a strong consensus in support of Board of Trustees Report 28. However, an amendment was offered to ensure that under recommendation 1.2 and 1.5 there is consistency in the definition of “qualified specialty-appropriate physician” with H-480.931, where it is defined as a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health

care service involved in the request prior to issuance of any final determination. Another amendment asked for an expansion of the scope of recommendation 1.4 beyond Medicare Advantage to also include all payers. Both amendments were supported by your Board of Trustees.

Your Reference Committee agrees with the adoption of these amendments. Therefore, your Reference Committee recommends Board of Trustee Report 28 be adopted as amended and the remainder of the report be filed.

(18) RESOLUTION 203 - SUPPORT FOR INDEPENDENT EVALUATION OF OUTCOMES ASSOCIATED WITH UNSUPERVISED NURSE PRACTITIONER PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for and support funding of independent, academically rigorous studies performing comparative effectiveness analyses of patient outcomes between autonomous non-physician practitioners and physician-led (MD/DO) team based care models, including measures of patient safety, quality, utilization, access, cost, and health outcomes, with a goal of publication in peer-reviewed scientific journals ~~and support funding of independent, academically rigorous studies comparing patient outcomes between unsupervised nurse practitioner care and physician-led team-based care, including measures of patient safety, quality, utilization, access, and health outcomes, with a goal of publication in peer-reviewed literature~~. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 203 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 203 be changed to read as follows:

SUPPORT FOR EVALUATION OF OUTCOMES ASSOCIATED WITH NON-PHYSICIAN PRACTITIONER PRACTICE

RESOLVED, that our American Medical Association advocate for and support funding of independent, academically rigorous studies comparing patient outcomes between unsupervised nurse practitioner care and physician-led team-based care, including measures of patient safety, quality, utilization, access, and health outcomes, with a goal of publication in peer-reviewed literature. (Directive to Take Action)

Your Reference Committee heard extensive testimony in support of Resolution 203. Commentors broadly called for reinstatement of language calling on the AMA to support funding of studies on outcomes associated with unsupervised practice by non-physicians, and further recommended that cost be added to the enumerated measures to be examined. Your Reference Committee agrees with both recommendations and otherwise

finds that the language offered in the preliminary report is sufficient to encompass studies addressing a broad range of practice models and patient outcomes. Your Reference Committee therefore recommends that Resolution 203 be adopted as amended.

(19) RESOLUTION 207 - ADDRESSING RURAL MATERNITY CARE DESERTS THROUGH THE CONRAD 30 WAIVER PROGRAM

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 207 be amended by addition and deletion to read as follows:

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 waivers ~~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~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 207 be amended by addition of a new resolve as follows:

RESOLVED, That policies D-255.980, D-255.966, and H-255.961 be reaffirmed.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 207 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 207 be changed to read as follows:

ADDRESSING RURAL CARE DESERTS THROUGH THE CONRAD 30 WAIVER PROGRAM

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.

Testimony for Resolution 207 reflected the importance of the Conrad 30 Waiver Program to communities facing health care access challenges. Testimony appreciated the resolution's creative and timely approach to addressing workforce shortages. However, commenters noted that some aspects of the resolution are covered by existing AMA policy, and that our AMA is already engaged in extensive work in this space, supporting legislation to expand the Conrad 30 program, allow for the redistribution of unused Conrad 30 slots, and more. An amendment was proposed to remove potentially divisive wording relating to the distribution of waiver slots among states. Finally, one commenter suggested, in addition to taking action on Resolution 207, that existing AMA policies supporting immigration policies that address health care workforce issues be reaffirmed.

Your Reference Committee agrees that Resolution 207 adds to our AMA's existing body of policy to the extent that it explicitly calls for the redistribution or recapture of unused Conrad 30 waivers. However, your Reference Committee found the proposed amendments and the rationale surrounding ensuring that the Conrad 30 Program remains bipartisan highly persuasive. Your Reference Committee also favors changing the title of the resolution to remove the reference to "maternity care deserts" because the resolution itself does not explicitly reference maternity care deserts and the Conrad 30 Program is not solely or primarily related to addressing maternity care deserts. However, your Reference Committee does note that there are additional J-waiver programs such as the HHS Exchange Visitor J-1 Visa Waiver Program where additional maternity care is provided in high need areas by our international medical graduates.

Your Reference Committee appreciates the growing lack of maternity care and supports creative approaches to help and mitigate these shortages. Your Reference Committee also supports the Conrad 30 Program being used to supplement shortage areas where appropriate. However, your Committee believes that the Conrad 30 Program and our current AMA advocacy are already broad enough to support Conrad 30 slots being filled by physicians that provide maternal care. Furthermore, your Reference Committee heard that the states that are currently most in need are having the hardest time recruiting Conrad 30 participants. Testimony noted that the resolution as written would not help to mitigate this problem and instead would incentivize these individuals to go to the states that are already considered more desirable and are currently able to fill all of their slots.

In addition, your Reference Committee agrees with the suggestion to reaffirm existing AMA policies that support removing immigration-driven barriers to strengthening our health care workforce. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended, and that existing AMA policies D-255.980, D-255.966, and H-255.961 be reaffirmed.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs.

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

(20) RESOLUTION 208 - INCORPORATING CRITICAL MEDICAL TREATMENT PLANNING INTO EMERGENCY/DISASTER PREPAREDNESS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the development of ~~develop model state~~ legislation and/or ~~and~~ guidelines that ~~for~~ incorporate~~in g~~ critical medical treatment planning into emergency/disaster preparedness plans (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 208 be adopted as amended.

RESOLVED, that our American Medical Association develop model state legislation and guidelines for incorporating critical medical treatment planning into emergency/disaster preparedness plans (Directive to Take Action); and be it further

RESOLVED, that our AMA support interdisciplinary cooperative planning agreements to ensure continuity of critical medical treatments during emergencies. (New HOD Policy)

Your Reference Committee heard testimony from numerous commenters supporting Resolution 208, including testimony that emphasized the importance of ensuring continuity of critical medical treatments such as dialysis, chemotherapy, and advanced therapies during disasters and emergencies. Several comments highlighted the value of interdisciplinary and cooperative planning agreements to maintain access to care for medically vulnerable populations.

Online testimony raised substantive concerns regarding the directive for our AMA to develop model state legislation. Multiple commenters stressed that disaster and emergency management is a specialized field with highly localized needs, regulatory frameworks, and technical standards that vary widely across jurisdictions. While the intent to support continuity of care is broadly supported, testimony found the model legislation directive overly prescriptive and outside our AMA's core expertise.

Your Reference Committee agrees that continuity of critical medical treatments during disasters and emergencies is an important priority for our AMA. However, your Reference Committee believes our AMA can make the greatest contribution by supporting guidance, best practices, and cooperative planning efforts that can be adapted to differing state and local circumstances, rather than by developing prescriptive model legislation. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(21) RESOLUTION 212 - PROTECTING PATIENT ACCESS TO CLINICAL TRIALS AND MITIGATING ADMINISTRATIVE DISRUPTIONS TO NIH FUNDING

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend Policy D-460.960 by addition and deletion to read as follows:

Our AMA advocates against reorganization, or consolidation or re-prioritization of the NIH when such action:

a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; ~~and~~
b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care; ~~and~~ or
c. is driven by frameworks that bypass validated, merit-based scientific peer-review processes or violate ethical obligations to human subjects. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate against (1) any delay or inappropriate interference by the Office of Management and Budget (OMB), or any other entity within the Executive Branch, in the approval, apportionment, or distribution of funds appropriated to the NIH, and (2) any other administrative actions that ~~for the immediate approval of the NIH spend plan and the full apportionment of congressionally appropriated funds by the Office of Management and Budget (OMB), and advocate against any future use of administrative apportionment delays to artificially~~ restrict or impound biomedical research funding (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 212 be adopted as amended.

RESOLVED, that our American Medical Association amend Policy D-460.960 by addition and deletion to read as follows:
2. Our AMA advocates against reorganization, ~~or~~ consolidation or re-prioritization of the NIH when such action:

a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; and
b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care; and
c. is driven by frameworks that bypass validated, merit-based scientific peer-review processes or violate ethical obligations to human subjects. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for the immediate approval of the NIH spend plan and the full apportionment of congressionally appropriated funds by the Office of Management and Budget (OMB), and advocate against any future use of administrative apportionment delays to artificially restrict or impound biomedical research funding (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate against the mandatory "forward-funding" or "front-loading" of multi-year NIH grants, which is the practice of distributing the entire multi-year total value of a grant upfront out of a single fiscal year's limited appropriation rather than the historical practice of disbursing annual grant allowances from the appropriations of those individual years, to prevent drastic reductions to the total number of potential new grants and clinical trials that can be awarded (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy D-460.961, which opposes arbitrary and unilateral caps on indirect costs in federal grants. (Directive to Take Action)

Your Reference Committee heard extensive testimony in favor of Resolution 212's core goal of safeguarding funding for the National Institutes of Health (NIH). Our AMA has actively supported funding for NIH research, including through letters to Congressional appropriators seeking adequate NIH funding levels, letters opposing caps on indirect cost recovery for NIH grants, and public statements on the importance of NIH funding for medical research. Your Reference Committee heard testimony that Resolution 212 would expand on our AMA's existing body of policy in this area, allowing for continued effective advocacy.

A friendly amendment, which received support, was offered and would clarify that our AMA will advocate against a reorganization, consolidation, or reprioritization of NIH funding that meets any of the listed criteria (as opposed to all three), and would change the second resolved clause to accurately reflect recent developments to the status of 2026 NIH funding and generalize the policy to allow our AMA to oppose future administrative actions that interfere with NIH or biomedical research funding. Your Reference Committee agrees

that this amendment captures the spirit of the original resolution while making useful modifications to update and expand the language. Therefore, your Reference Committee recommends that Resolution 212 be adopted as amended.

(22) RESOLUTION 216 - PROTECTING HEALTHCARE AS A SENSITIVE LOCATION

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 216 be amended by deletion to read as follows:

RESOLVED that our AMA collaborate with state societies where immigration enforcement in health care facility guidance has been developed, and with the AMA Advocacy Resource Center, to develop model legislation and regulation for states to adopt to better protect patients and health care workers from ~~inappropriate~~ intrusion of federal immigration agents in health care facilities (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 216 be adopted as amended.

RESOLVED, that our American Medical Association reaffirm its policies Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare (D-160.921), Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients (H-440.876), Mass Deportation as a Public Health Issue (H-440.793), and Patient and Physician Rights Regarding Immigration Status (H-315.966) (Reaffirm HOD Policy); and be it further

RESOLVED that our AMA collaborate with state societies where immigration enforcement in health care facility guidance has been developed, and with the AMA Advocacy Resource Center, to develop model legislation and regulation for states to adopt to better protect patients and health care workers from inappropriate intrusion of federal immigration agents in health care facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, to develop health care facility standards related to immigration enforcement. (Directive to Take Action)

Your Reference Committee heard extensive testimony in strong support of Resolution 216. Testimony highlighted the negative impact of federal immigration enforcement activities in healthcare facilities on patient and clinician safety, trust, and public health outcomes.

Multiple commenters supported amending the second resolved clause by removing the word "inappropriate," arguing that its inclusion introduces ambiguity and legal uncertainty. Your Reference Committee agrees that the deletion of "inappropriate" clarifies the resolution, preventing subjective interpretation and avoiding the need for referral for further definition. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

(23) RESOLUTION 219 - INCORPORATING EVIDENCE-BASED LIFESTYLE MEDICINE INTO RURAL HEALTH TRANSFORMATION PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourage State ~~Constituent~~ Medical Associations to work collaboratively with their ~~respective~~ State Departments of Health to incorporate ~~implementation of~~ the principles and practices of lifestyle medicine into ~~within the design of~~ their ~~respective~~ State's Rural Health Transformation Program initiatives, ~~thereby satisfying some of the scored requirements/categories of the Rural Health Transformation Program application~~; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage State ~~Constituent~~ Medical Associations to work collaboratively with their ~~respective~~ State Departments of Health to offer ~~include~~ nutrition continuing medical education as part of ~~an effective strategy to satisfy one of the scored requirements/categories of~~ the Rural Health Transformation Program ~~application~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 219 be adopted as amended.

RESOLVED, that our American Medical Association encourage State Constituent Medical Associations to work collaboratively with their respective State Departments of Health to incorporate implementation of the principles and practices of lifestyle medicine within the

design of their respective State's Rural Health Transformation Program, thereby satisfying some of the scored requirements/categories of the Rural Health Transformation Program application (New HOD Policy); and be it further

RESOLVED, that our AMA encourage State Constituent Medical Associations to work collaboratively with their respective State Departments of Health to include nutrition continuing medical education as an effective strategy to satisfy one of the scored requirements/categories of the Rural Health Transformation Program application. (New HOD Policy)

Your Reference Committee heard testimony from many commenters supporting Resolution 219. Your Reference Committee heard that addressing chronic disease and health disparities in rural communities through evidence-based lifestyle medicine and enhanced nutrition education is urgently needed, and that lifestyle medicine aligns closely with preventive health strategies and the core goals of Rural Health Transformation Program (RHTP) initiatives, with testimony citing direct benefits for patient outcomes, clinician preparedness, and rural system sustainability.

A friendly amendment was offered to clarify the resolution by encouraging collaboration with state departments of health and the inclusion of lifestyle medicine in RHTP implementation, rather than prescribing mandatory continuing education requirements or targeting already submitted state applications. Testimony argued that the proposed amendment ensures the resolution is consistent with current program realities, provides flexibility for state associations, while maintaining the resolution's focus on supporting evidence-based and scalable approaches without creating new mandates.

Your Reference Committee favors adopting Resolution 219 with this amendment, as it preserves the resolution's intent to strengthen rural health and promote evidence-based preventive care while clarifying the resolution's language and supporting our AMA's ongoing state-level collaboration in RHTP implementation. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(24) RESOLUTION 229 - PHYSICIANS ARE NOT PROVIDERS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 229 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term "physician" when discussing those with an MD or DO~~, and either "clinician" or "health care professional" as appropriate to describe those with other varying credentials~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA believes that the use of the term "provider" when used to include physicians negatively impacts ~~evaluate the issue of overbroad terminology using Provider for Physician and others be evaluated for effect on~~ patient education~~/~~ and awareness, transparency and the ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the fourth resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA refer the issue of "Physicians are not Providers" ~~to the board for study and report back including~~ for possible consideration by the American Medical Association's Council on Ethical and Judicial Affairs (CEJA).

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 229 be adopted as amended.

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term "physician" when

discussing those with an MD or DO, and either “clinician” or “health care professional” as appropriate to describe those with other varying credentials (Directive to Take Action); and be it further

RESOLVED, that our AMA Oppose the use of the term “provider” when used to include physicians (New HOD Policy); and be it further

RESOLVED, that our AMA evaluate the issue of overbroad terminology using Provider for Physician and others be evaluated for effect on patient education/awareness, transparency and ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further

RESOLVED, that our AMA refer the issue of “Physicians are not Providers” to the board for study and report back including possible consideration by the American Medical Association’s Council on Ethical and Judicial Affairs (CEJA). (Directive to Take Action)

Your Reference Committee heard extensive testimony in support of Resolution 229. Commenters noted that using the term “provider” to refer to physicians minimizes the education, training, expertise, and licensure of physicians and can be misleading to patients.

Multiple friendly amendments were offered, including one that would strengthen the resolution by positively stating, in the third resolved clause, that our AMA believes that referring to physicians as “providers” has negative impacts, rather than calling on our AMA to study the issue, and by directing our AMA, in the fourth resolved clause, to immediately refer the issue for possible consideration by the AMA Council on Ethical and Judicial Affairs (CEJA). Testimony noted that these amendments fell in line with our existing scope of practice work and gave the resolution immediate and direct effect as adopted policy rather than framing it as an evaluation, as these concerns are already well established. However, testimony highlighted that this issue has not been fully assessed from an ethical perspective and may warrant further consideration by the Council on Ethical and Judicial Affairs.

Your Reference Committee agrees with the goals of Resolution 229 and believes that these proposed amendments do strengthen the resolution. Your Reference Committee would further amend the resolution, in the first resolved clause, by removing the language calling for the use of the term “clinician” or “health care professional” to refer to non-physicians with other credentials, as your Reference Committee believes that it is not necessary for our AMA to take a position on this question.

Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

(25) RESOLUTION 232 - BANNING FLAVORED CANNABIS E-CIGARETTES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling intoxicating hemp products ~~and public health entities~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA pursue legislative changes supporting ~~concerning~~ a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 232 be adopted as amended.

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling hemp products and public health entities (Directive to Take Action); and be it further

RESOLVED, that our AMA pursue legislative changes concerning a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States. (Directive to Take Action)

Your Reference Committee heard unanimous testimony in support of Resolution 232. One commenter offered a friendly amendment with minor technical corrections to improve the clarity of the resolution. Your Reference Committee agrees with the offered amendment and, therefore, recommends that Resolution 232 be adopted as amended.

(26) RESOLUTION 239 - MEDICARE ADMINISTRATIVE CONTRACTOR POLICY MODIFICATION

RECOMMENDATION A:

Your Reference Committee recommends that the new sixth bullet of Policy D-330.897 in the first resolve clause be amended by addition to read as follows:

Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA, LCD Reference Article, or Billing and Coding Article, and to require MACs to allow a 90-day public comment period after this explanation has been provided (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the first resolve clause of Policy D-330.987 be amended by addition of the following new seventh bullet:

7. Our AMA will support federal legislation to improve the LCD process, including to make the LCD process more transparent and responsive to stakeholders such as providers with subject matter expertise so that patients can receive medically necessary and appropriate care.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 239 be adopted as amended.

RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder Engagement in Medicare Administrative Contractor Policy, by addition to read:

1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.
2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing

comment, or without an associated LCD and the required LCD stakeholder review and input process.

3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.
4. Our AMA will advocate and work with CMS to require a minimum 90-day public comment period for new or revised LCDs.
5. Our AMA will advocate and work with CMS to require expedited reconsideration timelines for new or revised LCDs that involve patient access to an intervention that may preserve life and/or function.
6. Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National Coverage Decisions (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage Determination Process. (Reaffirm HOD Policy)

Your Reference Committee heard uniformly supportive testimony for Resolution 239 including support for a minimum 90-day public comment period for new or revised LCDs, expedited reconsideration timelines, and explanations for the removal of diagnostic codes from LCAs. An amendment was offered requiring a medical explanation for diagnostic code removal and a 90-day comment period before such a removal takes effect.

Your Reference Committee believes Resolution 239 would bolster our AMA's policies on Medicare Administrative Contractors. The amendment's "medical explanation" requirement may be overly restrictive, as there are often legitimate non-medical reasons for removing diagnostic codes, but the additional amendment offered strengthens the resolution by adding a 90-day comment period before removal takes effect. An additional amendment, which your Reference Committee accepted, supports federal legislation that would improve the LCD process. Additional testimony supported this amendment which your Committee adopted. Therefore, your Reference Committee recommends that Resolution 239 be adopted as amended.

(27) RESOLUTION 240 - ENDING PRIVATE EQUITY DIVIDEND RECAPITALIZATION IN HEALTHCARE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 240 be amended by addition to read as follows:

RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors that permit any non-physician licensed entities to exercise control over the practice of medicine (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 240 be amended by deletion to read as follows:

RESOLVED, that our AMA will develop model ~~federal and~~ state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 240 be adopted as amended.

RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors (Directive to Take Action); and be it further

RESOLVED, that our AMA will develop model federal and state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations. (Directive to Take Action)

Testimony on Resolution 240 was limited but generally favorable. An amendment was offered to broaden the scope of the policy's opposition to dividend recapitalization to encompass all non-physician investors, not private equity firms alone. Your Reference Committee appreciates this amendment and notes that the model bill that our AMA will develop based on this policy, pursuant to the second Resolved clause, will be friendly to physician practices. Your Reference Committee therefore recommends that Resolution 240 be adopted as amended.

(28) RESOLUTION 243 - STANDARDIZING MEDICAL FRAILTY TO STREAMLINE MEDICAID COMMUNITY ENGAGEMENT & WORK EXEMPTIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 243 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association continue to work with ~~advocate that~~ the Centers for Medicare & Medicaid Services ~~and~~ , state Medicaid agencies, and state and specialty medical associations to establish medical frailty exemptions from Medicaid work and community engagement requirements, that are clinically grounded and protective of all individuals who are medically frail, while preserving state flexibility to build upon federal definitions and to design clinically appropriate, accessible, and locally tailored exemption processes ~~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

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve clause of Resolution 243 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA continue to 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~~ existing data to ensure treatment adherence and continuity of care (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve clause of Resolution 243 be amended by addition to read as follows:

RESOLVED, that our AMA continue to advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians.; and be it further

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 243 be amended by addition of a new fourth resolve to read as follows:

RESOLVED, that our AMA continue to urge policymakers, in defining and operationalizing medical frailty exemptions, to adopt policies that encompass the full range of serious and complex conditions, including conditions associated with functional impairment, that are life-threatening, chronic, episodic, relapsing, co-occurring, not yet diagnosed but evidenced by significant healthcare utilization, or that require significant, ongoing interaction with the health care system.

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 243 be adopted as amended.

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)

Your Reference Committee heard support for the intent of Resolution 243 and agrees that individuals who are medically frail should be protected from losing Medicaid coverage due to work and community engagement requirements. Testimony emphasized the importance of ensuring that medical frailty exemptions are sufficiently broad and clinically grounded while minimizing administrative and other burdens on patients and physicians.

Since issuance of the preliminary report, additional testimony and amendment language were offered that sought to further clarify the types of conditions and circumstances that should qualify an individual for protection. Your Reference Committee appreciates these efforts and agrees that individuals undergoing diagnostic evaluation, treatment, active surveillance, or ongoing monitoring for serious health conditions may have substantial health care needs that warrant protection. The Committee also recognizes that serious medical conditions do not always fit neatly into diagnostic categories and that individuals may experience significant health care needs, functional limitations, or intensive interaction with the health care system even before a definitive diagnosis has been established.

Your Reference Committee combined aspects of different amendments it received into our recommendation for Resolution 243, and believes this language incorporates the strongest elements of the various proposals presented during the hearing. The amendment establishes a broad framework that encompasses the full range of serious and complex conditions. This approach positions our AMA to advocate for comprehensive protections for medically vulnerable individuals as federal and state policies continue to evolve.

Accordingly, your Reference Committee recommends that Resolution 243 be adopted as amended.

(29) RESOLUTION 244 - ELIMINATE ADMINISTRATIVE BARRIERS TO APPEAL WRONGFUL DENIALS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 244 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal denials ~~plans~~ without requiring plan-specific forms (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 244 be adopted as amended.

RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal plans without requiring plan-specific forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded ERISA plans once the patient has assigned benefits to the physician. (Directive to Take Action)

Your Reference Committee heard substantial testimony in favor of Resolution 244. Commenters widely view the resolution as consistent with existing AMA policy and a necessary step to reduce administrative barriers, protect patient choice, and empower physicians. A friendly amendment was offered to correct a typo in the language and was endorsed by the author of the resolution. Therefore, your Reference Committee recommends that Resolution 244 be adopted as amended.

(30) RESOLUTION 247 - COMPREHENSIVE ERISA REFORM

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 247 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support federal regulation and/or legislation under ERISA to establish rules for prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and related matters, and that such be modeled after states' ~~the Texas~~ Prompt Pay laws and rules, requiring a report back at the following annual meeting.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 247 be adopted as amended.

RESOLVED, that our American Medical Association support federal regulation and/or legislation under ERISA to establish rules for prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and related matters, and that such be modeled after the Texas Prompt Pay laws and rules, requiring a report back at the following annual meeting. (New HOD Policy)

Your Reference Committee received mixed testimony for Resolution 247. Though a strong argument was made for reaffirmation of existing AMA policy, the majority of testifiers supported adoption of the resolution. However, testimony also highlighted that with our House of Delegates having debated and adopted extensive policy addressing prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and other related issues, it is important that our advocacy relies on such AMA policy and not Texas law. While Texas law may currently align with AMA policy, laws regularly change. Testimony noted concerns that the resolution could potentially circumvent AMA policy on these issues by tethering our advocacy to Texas law. Accordingly, amendments were offered to mitigate this issue, and to remove the reference to Texas law. Your Reference Committee agrees with this amendment. Therefore, your Reference Committee recommends that Resolution 247 be adopted as amended.

(31) RESOLUTION 248 - MEDICAL STAFF OVERSIGHT OF HOSPITAL AUGMENTED INTELLIGENCE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 248 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recommends medical staffs of hospitals and other healthcare facilities include physician oversight ~~reviews~~ of ~~all~~ augmented intelligence tools and applications, including but not limited to recommendations that impact patient care (Directive to Take Action).

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 248 be adopted as amended.

RESOLVED, that our American Medical Association recommends medical staffs of hospitals and other healthcare facilities include physician reviews of all augmented intelligence tools and applications, including but not limited to recommendations that impact patient care (Directive to Take Action).

Your Reference Committee heard testimony largely in support of Resolution 248. Isolated testimony expressed concern that language in the resolution requiring medical staff at hospitals and health systems to review all AI tools and applications may be impractical if interpreted literally. Testimony therefore recommended amending this language to make it less absolute, while still preserving the important intent of physician oversight of an AI tool's application and implementation. Your Reference Committee agrees with these amendments. Therefore, your Reference Committee recommends that Resolution 248 be adopted as amended.

(32) RESOLUTION 250 - PROTECTING RESIDENT PHYSICIANS WITH PENDING IMMIGRATION STATUS AND ENSURING SAFE PARTICIPATION IN PROFESSIONAL ACTIVITIES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve clause of Resolution 250 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) urgently advocate on behalf of ~~for the Department of Homeland Security (DHS) and other relevant federal agencies to temporarily cease immigration enforcement for~~ non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve clause of Resolution 250 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support the development and dissemination of ~~develop and disseminate~~ a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 250 be adopted as amended.

RESOLVED, that our American Medical Association (AMA) urgently advocate for the Department of Homeland Security (DHS) and other relevant federal agencies to temporarily cease immigration enforcement for non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched; and be it further

RESOLVED, that our AMA develop and disseminate a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

Your Reference Committee heard mixed testimony on Resolution 250. Your Reference Committee heard about the rapidly shifting immigration landscape which has caused some international medical graduates (IMGs) to lose valid visa status and to be detained by the Department of Homeland Security (DHS). Your Reference Committee appreciates how

difficult visa processing has been under this current Administration. However, your Reference Committee also heard that advocating for the complete cessation of immigration enforcement or physicians was too broad of an ask that would undermine our AMA's credibility with the Administration and decrease our chances of success in advocating on immigration issues in general. The complete cessation of enforcement would be seen as a security risk for our country.

Moreover, testimony highlighted that our AMA should support the development of resources for IMGs since there are other leading entities in this space (such as Intealth) that can and do create these resources. These entities, as the primary sponsors of physicians with J-1 visas, have additional information and subject matter expertise that should be respected, and our AMA should allow these entities to take the lead and continue to work with them. Therefore, your Reference Committee recommends that Resolution 250 be adopted as amended.

(33) RESOLUTION 252 - IMMEDIATE ACTION TO PREVENT FURTHER IMMIGRANT DEATHS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by supporting ~~actively and vocally advocating for and endorsing~~ policies that:

- make immigration status and place of birth protected health information
- prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge
- ~~require~~ encourage health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities
- oppose mandated inquiries about patient immigration status in health care facilities; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve be amended by deletion to read as follows:

RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966~~, and will advocate in an urgent, timely manner all HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 252 be adopted as amended.

RESOLVED, that our American Medical Association (AMA) support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by actively and vocally advocating for and endorsing policies that:

- make immigration status and place of birth protected health information

- prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge
- require health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities
- oppose mandated inquiries about patient immigration status in health care facilities; and be it further

RESOLVED, that our AMA supports physician and other health care worker efforts to organize in support of immigrants' right to safe and high-quality health care in medical settings; and be it further

RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966, and will advocate in an urgent, timely manner all HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers.

Your Reference Committee heard testimony on the importance of ensuring that immigrants can safely seek and receive health care. Testimony highlighted the importance of immigrant patients feeling safe while seeking health care and noted that ensuring that medical facilities are identified as sensitive locations will help in this effort. Amendments were offered. Testimony noted that the language should be broadened to allow our AMA to support the protection of sensitive locations while still being able to aid other organizations, like the National Immigration Law Center, in areas where they should rightfully take the lead as they are the subject matter experts. Testimony further noted that our AMA cannot require health care facilities to adopt these guidelines but that our AMA can and should encourage adoption of these standards. Testimony additionally noted that our AMA will always work in an expeditious manner to ensure the implementation of our policy. Your Reference Committee notes that the offered amendments address these concerns and believes that with the amended language this Resolution will nicely support Resolution 216. Therefore, your Reference Committee recommends that Resolution 252 be adopted as amended.

(34) RESOLUTION 254 - OMB PROPOSED RULE: REGULATION FOR FEDERAL FINANCIAL ASSISTANCE

RECOMMENDATION A:

Your Reference Committee recommends that the second clause of Resolution 254 be amended by addition to read as follows:

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule titled "Regulation for Federal Financial Assistance" (91 Federal Register 32198) issued on May 29, 2026; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 254 be adopted as amended.

RESOLVED, that our American Medical Association expresses its strong support for the scientific peer review process, academic journal independence and the immense value of merit-based scientific investments unimpeded by political interference; and be it further

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule; and be it further

RESOLVED, that our AMA consider taking legal action to challenge implementation of the proposed OMB rule.

Your Reference Committee heard strong supportive testimony for Resolution 254. Testimony noted the hardships that would ensue if this proposed rule were to be passed. Your Reference Committee agrees that scientific peer review, academic independence, and merit-based research funding are foundational to medical progress and the development of biomedical innovations and public health interventions. The resolution raises valid concerns that the proposed Office of Management and Budget rule could introduce inappropriate political considerations into federal research funding decisions, grant administration, scientific dissemination, and other critical health research activities.

Your Reference Committee believes that preserving the integrity and independence of the scientific enterprise is essential to advancing patient care and protecting the nation's biomedical research infrastructure. Your Reference Committee is proposing a minor technical amendment to add the title and Federal Register citation for the proposed rule referenced in the first and second Resolved clauses. Therefore, your Reference Committee recommends that Resolution 254 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(35) RESOLUTION 201 - PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

RESOLUTION 233 - BANNING SYNTHESIZED, PURIFIED OR DERIVATIVE PRODUCTS FROM KRATOM

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of Resolutions 201 and 233.

PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

RESOLVED, that our American Medical Association our AMA amend policy H-95.903 Regulate Kratom and Ban Over-The-Counter Sales, by addition to read:

1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom, and its derivatives, for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom, and its derivatives, only for personal use should not face criminal consequences.
4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition; (Modify Current HOD Policy); and be it further

RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action)

RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom products as adulterated or misbranded when sold in child-appealing forms, prohibit their availability in physical retail stores and online platforms accessible to minors (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for public education campaigns by physicians warning parents and youth of 7-OH kratom risks, including adverse cutaneous effects, and support research into pediatric exposures and optimal regulatory frameworks. (Directive to Take Action)

RESOLUTION 201 - PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

RESOLVED, that our American Medical Association our AMA amend policy H-95.903 by addition, Regulate Kratom and Ban Over-The-Counter Sales, to read:

1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition; (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA adopt a policy to ban the sale, distribution, or marketing of 7-hydroxymitragynine (7-OH) concentrated kratom products (New HOD Policy); and be it further

RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom products as adulterated or misbranded when sold in child-appealing forms, prohibit their availability in physical retail stores and online platforms accessible to minors (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for public education campaigns by physicians warning parents and youth of 7-OH kratom risks, and support research into pediatric exposures and optimal regulatory frameworks. (Directive to Take Action)

RESOLUTION 233 - BANNING SYNTHESIZED, PURIFIED OR DERIVATIVE PRODUCTS FROM KRATOM

RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action)

Your Reference Committee agrees with the overwhelming online testimony in support of Resolution 201 and Resolution 233, which both relate to the dangers of unregulated kratom products, including 7-hydroxymitragynine (7-OH) kratom products and other synthesized, purified, or derivative kratom products. However, your Reference Committee does not agree with the proposed amendment to limit the resolution only to “commercial” entities. Your Reference Committee notes that current policies (See H-95.901 and H-95.903) emphasize that individuals using kratom or other substances for personal use should not face criminal charges. Additional testimony noted that since the Resolutions covered very similar issues, they should be combined. Your Reference Committee agrees.

Your Reference Committee further supports an amendment proffered during the Reference Committee hearing to include adverse cutaneous effects. Therefore, your Reference Committee recommends that Alternate Resolution 201, a combination of Resolutions 201 and 233, be adopted in lieu of Resolutions 201 and 233.

(36) RESOLUTION 222 - ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 222 be adopted in lieu of Resolution 222.

ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE

RESOLVED, that our American Medical Association advocate for the development and maintenance of a centralized, official Medicare enrollment platform overseen by the Centers for Medicare & Medicaid Services 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 existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

RESOLVED, that our American Medical Association advocate for the development and maintenance overseen by the Centers for Medicare & Medicaid Services of a 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)

Your Reference Committee heard testimony reflecting genuine concern about Medicare Advantage marketing and enrollment, including that older beneficiaries are frequently misled by aggressive advertising and inducements and often do not understand the coverage they select. Other testimony supported reaffirmation, noting that our AMA maintains an extensive body of policy addressing Medicare Advantage transparency, marketing, directory accuracy, and beneficiary privacy. An informational statement on behalf of CMS confirmed that existing federal rules already prohibit misleading marketing and inducements, require accurate provider directories, and provide enrollment protections, with recent rulemaking and legislation further strengthening directory accuracy. Testimony also distinguished the first resolved clause, which calls for a unified, official online Medicare enrollment platform that incorporates education and clear presentation of provider networks, prior authorization requirements, and out-of-pocket costs, as new policy not fully captured by existing AMA policy.

Your Reference Committee agrees that the concerns raised by the resolution are highly concerning. With respect to the first resolved clause, your Reference Committee finds that the call for a unified, official Medicare enrollment platform represents new policy worthy of adoption. As to the remaining resolved clauses, your Reference Committee finds that our AMA already maintains strong and broad policy addressing each concern, and that reaffirmation preserves our AMA's flexibility to continue advocating aggressively for Medicare Advantage accountability across prior authorization reform, denial transparency, marketing oversight, and payment integrity. Therefore, your Reference Committee recommends that the first resolved of Resolution 222 be adopted and that existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Increasing Transparency Surrounding Medicare Advantage Plans H-330.862

Our AMA supports policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, and provider networks.

Medicare Advantage Policies H-330.878

1. Our American Medical Association supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate:
    a. for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients.
    b. that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided.
    c. that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Ban on Medicare Advantage "No Cause" Network Terminations H-285.902

1. Our American Medical Association urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by:
    a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network;
    b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies;
    c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder;
    d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following:
        i. civil monetary penalties;
        ii. enrollment sanctions; or
        iii. incorporating the accuracy score into the Stars rating for each plan; e. Requiring MA plans

immediately remove from provider directories providers who no longer participate in their network.

2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:
    a. requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year;
    b. publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy;
    c. conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; and
    d. evaluating alternative/additional measures of adequacy.
3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by:
    a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form;
    b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include:
        i. the number of contracted physicians in each specialty and county;
        ii. the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and
        iii. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.

7. Our AMA urges CMS to ban “no cause” terminations of MA network physicians during the initial term or any subsequent renewal term of a physician’s participation contract with a MA plan.

Medicare Advantage Opt Out Rules H-330.913

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Patient Privacy and Confidentiality H-315.983

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
    c. that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
    d. that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
    e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms:
    a. that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients;
    b. that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;
    c. that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
    a. Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
    b. Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
    c. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
    d. A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate

law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:
    a. the establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records;
    b. the establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes;
    c. the establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or

care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

(37) RESOLUTION 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

RESOLUTION 230 - EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 226 be adopted in lieu of Resolutions 226 and 230.

EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RESOLVED, that our AMA monitor and report on the impact of Presidential Proclamations restricting entry into the United States and how such policies affect International Medical Graduate participation, physician workforce supply, and patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)

RESOLVED, that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.

RESOLUTION 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

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. (Directive to Take Action)

RESOLUTION 230 - EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

RESOLVED, that our American Medical Association advocate for policies that ensure appropriate consideration and avoidance of undue delays in visa processing, issuance, and entry into the United States for fully vetted international medical graduates entering to participate in accredited graduate medical education or provide patient care, while maintaining necessary security and vetting procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA monitor and report on the impact of such policies on International Medical Graduate participation, physician workforce supply, patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)

Mixed testimony was received for Resolutions 226 and 230. Your Reference Committee noted that these two resolutions covered the same topic areas and had very similar asks, that of a study that explores the impact of the recent immigration changes in the United States on International Medical Graduates (IMGs) in addition to asking for advocacy surrounding visa delays. Given the overlapping asks your Reference Committee combined Resolutions 226 and 230.

Testimony highlighted the existing policy that our AMA has in this space and the extensive work that has already been done to help mitigate the $100,000 fee, address visa issues, and generally advocate for our IMG colleagues. This extensive work can be seen in the extensive work our AMA has done in this space including:

- The AMA continues to push for an exception to this proclamation for physicians and has worked intimately with Congress to get H.R. 7961, the "H-1Bs for the Physician and Healthcare Workforce Act" introduced. This bill would exempt physicians and health care workers from the $100,000 fee implemented by the Proclamation and would tie future fees to the Immigration and Nationality Act levels to ensure that this does not happen again. The legislation was introduced by Representatives Mike Lawler (R-NY), Sanford D. Bishop, Jr. (D-GA), Maria Elvira Salazar (R-FL), and Yvette Clarke (D-NY) and is already garnering bipartisan cosponsors. AMA grassroots have been activated, and the House bill generated solid press coverage, including an article in the New York Times featuring a quote from Dr. Mukkamala. AMA is working on introducing a companion bill in the Senate.
    - On April 13, 2026, the AMA sent a letter strongly supporting H.R. 7961, the "H-1Bs for Physicians and Healthcare Workforce Act." This legislation would exempt physicians and health care workers involved in direct patient care from the $100,000 fee implemented by the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers." The legislation would also prevent future fees from exceeding limits previously established by Congress following enactment of the Immigration and Nationality Act, thus ensuring greater predictability for employers looking to hire physicians and other health care workers via H-1B visas.
    - On April 15, 2026, the AMA signed onto a letter in support of the "H-1Bs for the Physicians and Healthcare Workforce Act" (H.R. 7961).

- The AMA led a sign on letter to the Department of Homeland Security (DHS) concerning the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers." The letter urged DHS to issue clarifying guidance stating that H-1B physicians' entry into the U.S. is in the national interest of the country thereby exempting them from the Proclamation and the $100,000 fee.
- Responses were received to both the AMA led sign on letter as well as to a private Congressional letter that the AMA helped to orchestrate concerning the H-1B filing fees. Additionally, the AMA initiated conversations which resulted in the New Dems letter concerning the H-1B filing fee. In addition, Reps. Yvette Clarke (D-NY) and Mike Lawler (R-NY), as well as Reps. Jill Tokuda (D-HI) and Don Bacon (R-NE), have released two other letters for members of Congress to sign requesting a blanket exemption for all health care workers from the new, higher $100K filing fee.
- The AMA has created a grassroots campaign on this issue. You can find that information here: Be Heard | Physicians Grassroots Network.
- On March 24th the AMA sent two letters advocating on behalf of international medical graduates. The first letter was to the U.S. Citizenship and Immigration Services (USCIS) in which the AMA urged USCIS to reconsider its suspension of premium processing and instead expand the premium processing option to H-1B visas so that H-1B physicians can continue to provide invaluable health care to U.S. patients. The second letter was sent to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting that they open visa processing at embassies and consulates worldwide for physicians seeking to enter the U.S. to join residency programs on July 1, 2020.
- On April 3, 2020, the AMA wrote a letter to Vice President Pence and USCIS urging the Administration to permit IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic. We also urged the Administration to expedite work permits and renewal applications for all IMG physicians who are beginning their residency or a fellowship or are currently in training.
- On April 14, 2020, the AMA sent a letter urging USCIS to recognize COVID-19 as an extraordinary circumstance beyond the control of the non-U.S. citizen IMG applicant or their employer and thus, expedite approvals of extensions and changes of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In addition, the AMA urged the Administration to extend the current 60-day maximum grace period to a 180-day grace period to allow any non-U.S. citizen IMG who has been furloughed or laid-off as a result of the pandemic to remain in the U.S. and find new employment.
- On May 4, 2020, the AMA sent a letter to Vice President Pence urging the Administration to allow J-1, H-1B, and O-1 International Medical Graduates (IMGs) to be exempt from any future immigration bans or limitations, so that these physicians can maintain their lawful non-immigrant status while responding to the urgent COVID-19 pandemic.
- On June 26, 2020, the AMA sent a letter to the Department of State and the Department of Homeland Security urging the Administration to consider J-1 and H-1B International Medical Graduates (IMGs) and their families' entry into the U.S. to be in the national interest of the country.

- On July 8, 2020, the AMA authored and coordinated a sign-on letter urging DOS and DHS to issue clarifying guidance pertaining to the Proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest of the country.
- On October 23, 2020, the AMA commented on the U.S. Department of Homeland Security's proposed rule concerning "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media." The proposed rule would have eliminated "duration of status" as an authorized period of stay.
- On February 15, 2022, the AMA submitted a statement for the record to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled, "Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System."
- On July 1, 2022, the AMA submitted comments on the Temporary Increase of the Automatic Extension Period of Employment Authorization and Documentation for Certain Renewal Applicants temporary final rule.
- On September 14, 2022, the AMA submitted a Statement for the Record to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."
- On June 18, 2025, the AMA sent a letter urging the Department of State to immediately resume the scheduling of new visa appointments, especially J-1 appointments, for foreign national physicians which were paused by the U.S. Department of State in May 2025.
- On September 24, 2025, the AMA offered comments to the Department of Homeland Security (DHS) concerning DHS Docket No. ICEB-2025-0001: Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media. This proposed rule would eliminate "duration of status" for F, J, and I visa recipients, and their dependents, and instead would require adherence to an admission for a fixed time period disrupting the medical specialty and subspecialty training of thousands of foreign national physicians and in turn negatively impacting patient care in the United States.
- On February 27, 2026, the AMA sent a letter to the U.S. Department of Homeland Security and the U.S. Department of State urging for the exemption of physicians from the partial and complete suspension of entry into the U.S., as indicated in Proclamation 10998 entitled "Restricting and Limiting the Entry of Foreign Nationals to Protect the Security of the United States." In alignment with this request, the AMA asked that the adjudicative hold for physicians' pending benefit applications be lifted, and that reliable timelines for application review and approval be implemented, so that these individuals can continue providing much needed medical care in the U.S.
- On March 10, 2026, the AMA sent a letter to HHS concerning the U.S. Exchange Visitor Program. The letter highlighted communications that the AMA received from physicians expressing their deep concern about the current HHS administrative hold and their projected inability to meet their contractually obligated start date. Therefore, due to the current administrative delay within the Waiver

Program, the AMA urged HHS to utilize emergency batch processing for physicians with July 1 start dates.

However, despite the extensive work and policy in this space, your Reference Committee acknowledges that a study was requested in both resolutions. Therefore, your Reference Committee recommends that Alternate Resolution 226 be adopted in lieu of Resolutions 226 and 230 and that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.

Physician Visa Protection and Pathway to U.S. Permanent Residency D-255.967

1. Our American Medical Association advocates for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.
2. Our AMA advocates for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.
3. Our AMA advocates for the creation of a dedicated visa pathway specifically for physicians.

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
    c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs.

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of

medical schools other than those in the United States and Canada.

2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and

c. evidence of good standing within the local medical community.

13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

(38) RESOLUTION 238 - PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

RESOLUTION 246 - ARTIFICIAL INTELLIGENCE SCOPE OF PRACTICE

RESOLUTION 249 - BRINGING PHYSICIANS' VOICES TO THE IMPLEMENTATION OF AI PRESCRIBERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 238 be adopted in lieu of Resolution 238, 246, and 249.

PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

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.

RESOLVED, that our AMA will study emerging concepts around the regulation and licensure of autonomous artificial intelligence performing clinical functions. (Directive to Take Action).

RESOLUTION 238 - PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

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)

RESOLUTION 246 - ARTIFICIAL INTELLIGENCE SCOPE OF PRACTICE

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)

RESOLUTION 249 - BRINGING PHYSICIANS' VOICES TO THE IMPLEMENTATION OF AI PRESCRIBERS

RESOLVED, that our American Medical Association (AMA) advocate that autonomous clinical artificial/augmented intelligence (AI) including AI prescription services, be regulated and licensed by an appropriate body, as well as be developed with physician input and operated under direct physician supervision.

Your Reference Committee heard mixed testimony on Resolutions 238, 246, and 249. Testimony was largely supportive of the intent of these resolutions and opposed referral on the grounds that it would delay action on this important issue. Testimony also strongly underscored that AI should augment, not replace, the physician. Testimony noted that this issue is directly relevant to patient care, that physician oversight is essential, and that evidence should support the use of AI in clinical settings. Other testimony supported referral, noting that the issue is complex and warrants further study. Your Reference Committee also considered amendments proffered in relation to each of the resolutions. However, there was substantial support for the alternate resolution that was proposed, which preserved original language prohibiting the use of autonomous AI as an independent diagnostic or prescriptive tool or as a care management substitute for a physician, while preserving our AMA's ability to continue studying issues related to licensure and to engage in ongoing discussions with appropriate interested parties. Testimony emphasized the complexity and evolving nature of this issue and indicated that the alternate resolution offers a balanced approach by establishing policy in part, while also allowing continued study by AMA staff. Therefore, your Reference Committee recommends that Alternate Resolution 238 be adopted in lieu of Resolutions 238, 246, and 249.

(39) RESOLUTION 251 - MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS

RESOLVED, that our American Medical Association solely support the appointment and retention of federal health policy leaders with medical, scientific, public health, administrative, or health policy expertise relevant to their respective roles; whose official actions and policy leadership are consistent with AMA policy, evidence-based medical practice, evidence-informed public health practice, scientific integrity, transparent decision-making, vaccine confidence, disease surveillance; and who support the independence of federal scientific advisory processes; and be it further

RESOLVED, that our AMA work with relevant entities to provide education, counseling, and informational resources that align with AMA policy to federal candidates, nominees, or appointees for health policy leadership positions.

RESOLVED, that our American Medical Association (AMA) vocally oppose federal government nominees or appointees to health policy leadership positions who demonstrate a pattern of nonadherence to high-quality scientific evidence, including evidence-based vaccination policy, or who do not have appropriate medical or scientific qualifications; and be it further

RESOLVED, that our AMA work with relevant entities to provide good faith vaccine education, counseling, and informational resources to federal candidates, nominees, or appointees for health policy leadership positions who do not openly take evidence-based positions on vaccination.

Your Reference Committee heard mixed testimony for Resolution 251, with many speakers rising in support of adoption while a smaller, but still significant, number of speakers recommended that the resolution not be adopted, or that it be adopted with amendments. Your Reference Committee heard strong support from those who favored adoption for our AMA to take a more vocal stance against nominees and appointees to federal health policy leadership positions who lack necessary qualifications or espouse positions that are unsupported by science. Those who disagreed, while in some cases expressing their appreciation for the spirit of the resolution, argued that our AMA should focus on supporting the principles of science-based health policy, and that adopting a policy that calls on our AMA to take positions on individual nominees or candidates risks exposing our AMA to accusations of bias or partisanship, and could undermine our ability

to work with officials whose candidacy we opposed. Proposed amendments included striking the first Resolved clause altogether, amending the first Resolved clause to frame the issue in terms of our AMA supporting candidates rather than opposing them, and adding a new Resolved clause calling on our AMA to develop minimum standards for federal officials.

Your Reference Committee appreciates the thoughtful testimony it received from both sides of this issue and considered Resolution 251 at length. Your Reference Committee notes that our AMA is a nonpartisan, issues-based organization. At the same time, it is undeniable that high-ranking federal health policymakers impact the issues we are concerned with. Ultimately, your Reference Committee determined that adopting Resolution 251 with amendments addressing some of the problems identified by opponents of the resolution is the best course of action.

The amended language for the first Resolved clause proposed by your Reference Committee would establish that our AMA only support the appointment and retention of federal health policy leaders who have the requisite expertise for their expected roles and whose official actions are consistent with AMA policy and sound principles of science-based public health. This approach acknowledges the key role of federal officials in shaping public health policy without committing our AMA to advocacy practices that would often be counterproductive. The amended language for the second Resolved clause proposed by your Reference Committee clarifies and broadens the original language, while preserving the spirit of the original.

Therefore, your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

(40) RESOLUTION 253 — PROTECTION OF MEDICAID BENEFICIARIES FROM POLITICALLY MOTIVATED AND PROCEDURALLY DEFICIENT FEDERAL FUNDING DEFERRALS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 253 be adopted in lieu of Resolution 253.

PROTECTION OF MEDICAID BENEFICIARIES FROM FEDERAL FUNDING DEFERRALS

RESOLVED, that our AMA opposes withholding or deferral of Medicaid funding and other financial enforcement mechanisms in a manner that is arbitrary, disproportionate, inconsistent with established legal and administrative processes, or likely to cause undue disruption to patient care or state Medicaid program operations; and be it further

RESOLVED, that our AMA advocates that 1) federal enforcement actions utilize deferral or withholding of state Medicaid funding only after a thorough and transparent administrative process, in accordance with federal laws and regulations, that provides states with meaningful notice and opportunity for corrective action and administrative and judicial review protections; 2) CMS restore or release withheld or deferred Medicaid funds when such administrative processes have not been followed; and 3) CMS carefully balance the benefits and harms of new program integrity actions and minimize harm to Medicaid beneficiaries, participating physicians, hospitals and other providers, and state program operations; and be it further

RESOLVED, that our AMA requests that the relevant congressional committees conduct timely and appropriate oversight of the Administration's use of the Medicaid deferral mechanism. (Directive to Take Action)

RESOLVED, that our American Medical Association oppose any policy or practice, regardless of stated justification, that employs the withholding of Medicaid funds as a coercive instrument directed at state governments in ways that predictably injure patients and disrupt the continuity of care for vulnerable beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that CMS immediately restore withheld Medicaid funds to affected states pending the completion of any proper administrative or judicial review process, in order to prevent irreparable harm to patients currently dependent on Medicaid-funded services (Directive to Take Action); and be it further

RESOLVED, that our AMA request that the relevant congressional committees conduct immediate oversight of the Administration's use of the Medicaid deferral mechanism. (Directive to Take Action)

Your Reference Committee heard strong testimony on Resolution 253, which was proposed in response to the punitive withholding of large amounts of federal Medicaid funds in multiple states without due process. Commenters noted that in some cases federal funding has been withheld despite state compliance with federal requirements, and that there is a stark absence of process behind these federal actions. Some commenters characterized the withholdings as coercive and potentially politically motivated. While most speakers supported the resolution as written, an amendment was offered on the grounds that the original language is overly broad and could prevent the Centers for Medicare & Medicaid Services (CMS) from enforcing legitimate program integrity requirements.

Your Reference Committee agrees that the withholding of federal Medicaid funding without appropriate process, or in a disproportionate manner, causes substantial harm to state Medicaid programs and, consequently, to patients and physicians. At the same time, your Reference Committee is concerned that overly broad policy could be read as dismissing the need for enforcement mechanisms to combat fraud and abuse in Medicaid. As supporters of the original resolution noted, ensuring program integrity and fighting genuine fraud in Medicaid is not what they are opposed to, but rather the improper use of enforcement mechanisms.

Your Reference Committee is proposing alternate language to clarify that arbitrary, disproportionate, or procedurally deficient withholding of federal Medicaid funding—which include the cases cited by supporters of the resolution—is what our AMA opposes, rather than program integrity enforcement or anti-fraud initiatives more broadly. Your Reference Committee believes this language is responsive to the urgency of the current situation and establishes a cogent policy for when it is appropriate for CMS to utilize its statutory authority to withhold or defer funding. Therefore, your Reference Committee recommends that Alternate Resolution 253 be adopted in lieu of Resolution 253.

RECOMMENDED FOR REFERRAL

(41) RESOLUTION 202 - USING AND DEFINING "UNSUPERVISED PRACTICE OF MEDICINE"

RECOMMENDATION:

Your Reference Committee recommends that Resolution 202 be referred.

RESOLVED, that our American Medical Association use the term "Unsupervised Practice of Medicine" (UPM) when describing statutory or regulatory efforts that allow nonphysician practitioners to diagnose, treat, and prescribe without physician oversight, and reaffirm that physician-led, team-based care with appropriate physician supervision remains the gold standard for patient safety and quality care (New HOD Policy); and be it further

RESOLVED, that our AMA incorporate the term "Unsupervised Practice of Medicine" in its advocacy materials, public communications, testimony, and educational resources, where appropriate, to clarify the distinction between physician licensure and nonphysician scope expansion (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to advocate for truth in advertising, transparency in professional identification, and clear communication to patients regarding differences in education, training, and licensure between physicians and nonphysician practitioners. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony for Resolution 202, with many commenters claiming that the term "unsupervised practice of medicine" improves clarity and accuracy in our AMA's advocacy on scope of practice issues. However, persuasive testimony for referral was also heard. Proponents of referring the resolution noted that the resolution raises many complicated and nuanced issues and would apply broadly across all of our AMA's advocacy efforts, public relations, and communications. Your Reference Committee agrees. The terminology used by the resolution is not universal and may mean different things in different jurisdictions. Furthermore, scope of practice issues are always evolving, and enshrining a single term could hamper our AMA's advocacy and community efforts with respect to emergent issues. Therefore, your Reference Committee recommends that Resolution 202 be referred for study.

(42) RESOLUTION 206 - OVERALL HOSPITAL QUALITY STAR RATINGS / CMS STAR RATINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 206 be referred.

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)

Your Reference Committee heard substantial testimony on Resolution 206 that was largely in favor of referral. Supporters of the resolution, including the author, felt that physician experience and clinical autonomy are important aspects of hospital quality not reflected in existing measures, and called for our AMA to develop physician-experience metrics that elevate physician voices. Several delegations, while supportive of the underlying goal, noted that issues in the resolution still need to be worked out and that referral would allow our AMA to get it right. Supporters of reaffirmation pointed to existing AMA policy calling for quality measures to be developed, evaluated, and implemented with input from our AMA and actively practicing physicians, and noted that there is currently no validated metric for measuring physician experience in the hospital setting, raising questions about how the resolution's proposals would be operationalized.

Your Reference Committee agrees that physician experience is a crucial factor in hospital quality, and that hospitals should create positive work environments that value physicians and prioritize their clinical judgment to avoid burnout and negative impacts on patient care. Given the strong interest in developing the physician-experience concept further, and the absence of an existing measure of physician experience in the hospital setting, your Reference Committee believes this issue would benefit from further study. Therefore, your Reference Committee recommends that Resolution 206 be referred.

(43) RESOLUTION 221 - UNIVERSAL NEWBORN CONGENITAL CYTOMEGALOVIRUS SCREENING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 221 be referred.

RESOLVED, that our American Medical Association support state legislation and policies requiring universal newborn screening for congenital cytomegalovirus (cCMV) (New HOD Policy); and be it further
RESOLVED, that our AMA support federal legislation and policies that expand newborn screening for congenital cytomegalovirus (cCMV) and increase funding for public awareness, prevention, and research related to congenital cytomegalovirus infection. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 221. Some commenters supported adoption, emphasizing the significance of early cCMV detection in enabling timely interventions, improving outcomes, and preventing missed opportunities for hearing loss surveillance and therapeutic treatment.

Other commenters questioned whether universal screening meets the established criteria for population-wide testing and raised issues regarding test accuracy, the management of asymptomatic cases, and uncertainties about the benefit of early identification in some infants. Testimony also urged support for and deference to existing processes for evaluating and implementing additions to newborn screening programs. Your Reference Committee also heard testimony supporting referral of the resolution for additional study, as well as suggestions that a science-based, inclusive policy for nationwide newborn screening—rather than disease-specific mandates—may be preferable.

Given the mixed testimony, the scientific and policy questions raised, and the need for further evaluation of the appropriate role of our AMA in newborn screening recommendations, your Reference Committee agrees that further study is warranted. Therefore, your Reference Committee recommends that Resolution 221 be referred.

(44) RESOLUTION 223 - ENSURING DUE PROCESS, TRANSPARENCY, AND HUMAN CLINICAL OVERSIGHT IN THE USE OF ARTIFICIAL INTELLIGENCE FOR HEALTH INSURANCE COVERAGE AND ELIGIBILITY DETERMINATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 223 be referred.

RESOLUTION 223 - ENSURING DUE PROCESS, TRANSPARENCY, AND HUMAN CLINICAL OVERSIGHT IN THE USE OF ARTIFICIAL INTELLIGENCE FOR HEALTH INSURANCE COVERAGE AND ELIGIBILITY DETERMINATIONS

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 attention to applicant-facing eligibility, underwriting, and enrollment decisions. (Directive to Take Action)

Your Reference Committee heard minimal testimony on Resolution 223. An amendment was proffered by the author and considered by the Reference Committee, but it was ultimately found to be an issue that warranted further study. Therefore, Your Reference Committee recommends that Resolution 223 be referred.

(45) RESOLUTION 225 - REQUIRING PERIODIC FACE-TO-FACE VISITS BY BOARD-CERTIFIED SPECIALISTS WHO DELEGATE VISITS TO NON-PHYSICIAN PRACTITIONERS FOR NURSING HOME PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 225 be referred.

RESOLVED, that our American Medical Association support federal legislation or regulation to require a minimal standard for specialist care for patients in nursing homes, such that, when a board-certified medical specialist delegates visits to nonphysician practitioners in a nursing home setting, the physician specialist must personally conduct a face-to-face evaluation of the patient either in person or via telehealth no less than every third visit. (New HOD Policy)

Your Reference Committee heard mixed testimony for Resolution 225. While some testimony supported adoption of the resolution, opposing testimony noted that the resolution as written raised concerns surrounding discouraging specialist participation in nursing home coverage arrangements and creating operational and enforcement difficulties and questioned the validity of required an evaluation every third visit. Further testimony offered amendments, including expanding the resolution to physicians generally rather than specialists, and still others recommending referral for further study. Given the diversity of opinions on this resolution and the potential for unintended consequences of

adopting policy without due consideration, your Reference Committee favors referral. Therefore, your Reference Committee recommends that Resolution 225 be referred.

(46) RESOLUTION 236 - EXTENDING AND EXPANDING THE AMA TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP TO ENSURE ACCESS AND REGULATORY CLARITY IN GENDER-AFFIRMING CARE

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve clause of Resolution 236 be referred with a report back at I-26.

RECOMMENDATION B:

Your Reference Committee recommends that the first, third, fourth, and fifth resolve clauses of Resolution 236 be adopted.

RESOLVED, that our American Medical Association extend and expand the work of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to include a formalized and sustained focus on legislative and regulatory actions to protect access to and education in gender-affirming care (Directive to Take Action); and be it further

RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a comprehensive, centralized digital resource hub—modeled on the Reproductive Health Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026 Interim Meeting, including but not limited to:

1. State-specific legal summaries and regulatory guidance;
2. Shield law analyses and cross-state practice considerations;
3. Privacy and HIPAA compliance best practices;
4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
5. Documentation and informed consent templates consistent with evolving legal standards;
6. Coding, billing, and reimbursement guidance;
7. Institutional policy templates and sample protocols;
8. Educational and training resources for undergraduate and graduate medical education;
9. Telehealth and interstate licensure guidance; and
10. Information regarding legal assistance and physician defense resources (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen its advocacy efforts at the federal and state levels to oppose criminalization and punitive actions against physicians providing evidence-based gender-affirming care and to support legal protections safeguarding the patient

physician relationship, with guidance by the Task Force (Directive to Take Action); and be it further

RESOLVED, that our AMA identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe, evidence-based, and medically appropriate health care (Directive to Take Action); and be it further

RESOLVED, that our AMA report annually to the House of Delegates regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes. (Directive to Take Action)

Your Reference Committee heard extensive testimony for Resolution 236. Your Reference Committee heard that many delegations and specialty groups are concerned by urgent and evolving threats to the patient-physician relationship posed by legislative and regulatory actions targeting gender-affirming care. Your Reference Committee also heard that supporters view the extension and expansion of the AMA Task Force—and creation of centralized resources—as crucial steps to guide physicians, advance advocacy, and support patient access to evidence-based care.

Your Reference Committee also heard that the landscape surrounding gender-affirming care is rapidly changing, legally complex, and controversial. Your Reference Committee heard various proposed amendments, including suggestions to restructure the Task Force into an ad hoc advisory committee, and clarify reporting requirements. However, your Reference Committee also heard from our Board of Trustees that they would like additional time to study the asks contained in the second resolve and ensure that these are in harmony with the existing recommendations from the Task Force, which your Board has extended. Your Reference Committee appreciates the importance of allowing this additional information to inform next steps.

Your Reference Committee appreciates that the issues raised by Resolution 236 are incredibly important, complex, and sensitive. Furthermore, your Reference Committee acknowledges that the resolution makes asks that require careful deliberation and consideration and have significant implications for our AMA. Your Reference Committee recognizes the complexity of the landscape, the variation in testimony, the multiple offered amendments, the diversity in opinions for implementation, and the fact that a Task Force on this issue could wade into topics, duties, and financial obligations that require further study. Therefore, your Reference Committee recommends that the second resolve of Resolution 236 be referred with a report due back at the 2026 Interim Meeting of the House of Delegates, and the remainder of the Resolution be adopted.

(47) RESOLUTION 241 - STRENGTHENING OUR AMA EFFORTS TOWARD CPOM PROHIBITION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 241 be referred for report back at I-26.

RESOLUTION 241 - STRENGTHENING OUR AMA EFFORTS TOWARD CPOM PROHIBITION

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

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 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:

"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)

Your Reference Committee heard testimony establishing that Board of Trustees Report 25 and Resolution 241 serve complementary but distinct purposes and accordingly considered them separately. Testimony regarding Resolution 241 was generally favorable, though commentors were divided between recommending adoption and recommending referral. Those favoring referral emphasized that the corporate practice of medicine policy proposed in Resolution 241, while important, is highly complex and warrants careful deliberation prior to adoption, further noting that Resolution 241 would make sweeping changes to existing AMA policy, portions of which may warrant retention.

Your Reference Committee concurs that corporate intrusion on the practice of medicine is a matter of urgent concern. It likewise recognizes that Resolution 241 proposes sweeping revisions to a policy that was designed to serve as guidance to physicians navigating relationships with corporate entities, and that Resolution 241 is significant in scope and considerable in nuance. Given the highly complex nature of physician practice arrangements, before this policy is adopted, care must be taken to ensure that it does not produce unintended consequences, for example by imposing undue restrictions on practice arrangements that are functioning effectively and which preserve physician autonomy. Your Reference Committee therefore recommends that Resolution 241 be referred for report back at I-26.

(48) RESOLUTION 242 - REDUCING EMERGENCY DEPARTMENT BOARDING THROUGH PAYMENT REFORM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 242 be referred.

RESOLVED, that our American Medical Association advocates for the Centers for Medicare & Medicaid Services (CMS) and other payors to tie admitted patients' hospital reimbursement to emergency department boarding performance, including payment reductions or creation of a lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to Take Action); and be it further

RESOLVED, that our AMA adopts policy and advocates for making emergency department boarding metrics mandatory quality measures incorporated into value-based payment programs, rather than reporting-only requirements without financial consequence. (Directive to Take Action)

Your Reference Committee heard extensive testimony on Resolution 242, with strong agreement that ED boarding is a serious and worsening problem that harms patients. However, there was a clear split between those favoring adoption with an amendment and those favoring referral. Supporters urged adoption, including a proposed amendment to protect physicians from being pressured to alter medically appropriate admission, timing, or disposition decisions to avoid boarding penalties, arguing that existing policy lacks teeth. A substantial majority of testimony, however, supported referral.

Testimony favoring referral shared the concern about boarding harms but cautioned that the resolution's central mechanism, tying hospital reimbursement to a boarding threshold, is untested and could shift pressure onto physicians and reduce physician reimbursement without addressing the system-wide drivers of boarding, including inpatient bed availability, post-acute capacity, behavioral health infrastructure, and staffing. Testimony noted that boarding is a hospital-wide and often community-wide problem. Further testimony highlighted that behavioral health patients and rural and urban facilities face distinct challenges, and that any payment-based approach would require careful guardrails that the resolution does not contain.

Your Reference Committee further notes that our AMA is actively engaged on this issue and that a Board of Trustees report on emergency department boarding, following Board of Trustees Report 04-I-25, is due at the 2026 Interim Meeting. Your Reference Committee believes the concerns raised by Resolution 242 are best addressed through that ongoing work. Therefore, your Reference Committee recommends that Resolution 242 be referred, to be combined with the forthcoming report.

RECOMMENDED FOR NOT ADOPTION

(49) RESOLUTION 245 - STATE REGULATION OF NON-PREEMPTED "NON-CENTRAL MATTERS" OF ERISA PLANS—RUTLEDGE V. PCMA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 245 be not adopted.

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

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)

Your Reference Committee received mixed testimony for Resolution 245. Though some supportive testimony was received, very convincing testimony noted the legal inaccuracies that are espoused in Resolution 245. Testimony noted that the *Rutledge* Supreme Court case mentioned in Resolution 245 did not fundamentally change ERISA preemption and subsequent cases interpreting *Rutledge* have made this clear. Further testimony noted that our AMA ERISA experts already gave the requested education presentation to the PPPS earlier at this meeting and our AMA gave a similar educational presentation to the entire Federation this year. Testimony also highlighted that our AMA has also developed an extensive issue brief discussing *Rutledge*, subsequent cases interpreting *Rutledge*, and how different state legislative strategies might be treated under *Rutledge* and subsequent cases, including credentialing and recoupment. The issue brief is available on the AMA website and the issue brief is regularly updated to reflect new cases interpreting *Rutledge* and/or ERISA preemption of state law. The issue brief was just updated in May. Given the legal precedence and the past and ongoing work that our AMA has undertaken in this space your Reference Committee agrees with the testimony that was provided in opposition to this Resolution. Therefore, your Reference Committee recommends that Resolution 245 not be adopted.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(50) RESOLUTION 204 - D-400.982 REVISION

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-400.982, D-385.945, D-390.922, and D-400.981 be reaffirmed in lieu of Resolution 204.

RESOLVED, that our American Medical Association reaffirm D-400.982:

1. Our American medical Association will increase media awareness around the 20 24 AMA Annual Meeting about the need for Medicare payment reform eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up it's public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare payment reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of current inadeq uacies of Medicare payments. (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA will report back quarterly to the House of Delegates via open forum on these Medicare Payment Reform initiatives. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 204. Supporters of adoption stressed the vital importance of Medicare physician payment reform and argued that quarterly updates to the House of Delegates on our AMA's Medicare payment reform initiatives will increase transparency. Supporters of reaffirmation note that our AMA has extensive policy on Medicare payment reform and is heavily engaged in advocacy and operational work on the issue. This work includes the Fix Medicare Now grassroots campaign, the Characteristics of a Rational Medicare Payment System principles, and the AMA National Advocacy Conference, and ongoing legislative advocacy on permanent MEI-based updates, budget neutrality reform, MIPS reform, and APM expansion. With respect to transparency, the Board of Trustees provides biannual reports on our AMA's efforts, as well as additional updates when events dictate. Multiple commenters question whether quarterly reporting requirements will be overly burdensome without meaningfully advancing transparency compared to the existing schedule.

Your Reference Committee believes that existing AMA policies already address the issues raised by Resolution 204 and shares the concerns raised about a quarterly reporting schedule. Your Reference Committee notes that reports take time to generate and are subject to internal review processes, and notes that a quarterly schedule will not provide sufficient turnaround time for the Board of Trustees and AMA staff to produce high quality reports with new meaningful information. Our AMA maintains extensive policy and active advocacy on Medicare physician payment reform, and the Board of Trustees already reports to the House biannually, with additional updates as events dictate. Therefore, your Reference Committee recommends that existing AMA policies D-400.982, D-385.945, D-390.922, and D-400.981 be reaffirmed in lieu of Resolution 204.

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

Advocacy and Action for a Sustainable Medical Care System D-385.945

1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

Physician Payment Reform and Equity D-390.922

Our American Medical Association will implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

Increasing Transparency of AMA Medicare Payment Reform Strategy D-400.981

1. Our American Medical Association will provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.

2. Our AMA will share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.

(51) RESOLUTION 205 - REPEAL OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-400.982, H-385.905, H-390.838, H-478.986, D-390.949, and D-395.999 be reaffirmed in lieu of Resolution 205.

RESOLVED, that our American Medical Association support full repeal of the Merit-Based Incentive Payment System (MIPS) (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for immediate administrative relief in MIPS, including expanded low-volume and hardship exemptions for rural and small practices, shortened/streamlined reporting requirements, and reduction of reporting complexity until MIPS is repealed. (Directive to Take Action)

Your Reference Committee heard testimony for Resolution 205 that was split between commenters supporting adoption and those supporting reaffirmation of existing AMA policies. Supporters of adoption point to the harmful impacts of the Merit-based Incentive Payment System (MIPS), which are disproportionately borne by small and rural practices. However, supporters of reaffirmation argue that existing AMA policies adequately respond to the harms of MIPS, and further argue that our AMA should maintain a flexible policy that can accommodate advocacy for either the full repeal of MIPS or for MIPS reform, depending on the circumstances and the legislative environment.

Your Reference Committee believes that existing AMA policy adequately addresses the concerns raised by Resolution 205. Therefore, your Reference Committee recommends that existing AMA policies D-400.982, H-385.905, H-390.838, H-478.986, D-390.949, and D-395.999 be reaffirmed in lieu of Resolution 205.

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.

3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

Merit-based Incentive Payment System (MIPS) Update H-385.905

Our American Medical Association supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in (MIPS) with incentive payments, or implements positive annual physician payment updates.

MIPS and MACRA Exemption H-390.838

Our American Medical Association will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Merit-Based Incentive Programs H-478.986

Our AMA will advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.

Preserving Patient Access to Small Practices Under MACRA D-390.949

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Reducing MIPS Reporting Burden D-395.999

Our American Medical Association will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician’s choosing) within the calendar year.

(52) RESOLUTION 210 - ELIMINATING PRESCRIPTION DRUG ADHERENCE (PDA) AS A QUALITY METRIC TIED TO PHYSICIAN RATINGS OR COMPENSATION

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-180.976 and D-450.958 be reaffirmed in lieu of Resolution 210.

RESOLVED, that our American Medical Association advocate against the use of patient Prescription Drug Adherence (PDA) as a quality metric tied in any manner to physician ratings or compensation. (Directive to Take Action)

Your Reference Committee heard support both for adoption of Resolution 210 and for reaffirmation of existing policy. Supporters of adoption argued that this quality measure is onerous and largely outside physician control, and that the existing cited policies are too narrow, contending that the principles should apply broadly to all medications rather than being limited to pain-related measures. Supporters of reaffirmation noted that existing AMA policy already directs advocacy against the use of adherence-related measures in physician assessment, payment, and survey programs, and supports quality metrics based on factors that physicians and health plans can reasonably control. Testimony also highlighted the strength and breadth of existing AMA policy in this area.

Your Reference Committee agrees that physicians should not be held accountable through ratings or compensation for patient adherence, which is largely outside their control, and finds that existing AMA policy is sufficient to allow our AMA to address the concerns raised. Therefore, your Reference Committee recommends that existing AMA policies D-180.976 and D-450.958 be reaffirmed in lieu of Resolution 210.

Minimum Payer Communication Quality Standards D-180.976

1. Our AMA advocates for payer minimum quality standards to include immediate access to a live representative during business hours.
2. Our AMA advocates 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.

Pain Medicine and Patient Adherence in Quality Care Assessment D-450.958

1. Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys.

2. Our AMA 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.

(53) RESOLUTION 211 - PREVENTING HOSPITAL-BASED 340B PROGRAMS FROM UNFAIRLY COMPETING WITH INDEPENDENT PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy H-110.985 be reaffirmed in lieu of Resolution 211.

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)

Your Reference Committee heard mixed testimony for Resolution 211. Testimony provided by the author in opposition to reaffirmation emphasized the need for broader 340B reform and argued that the current structure has created an uneven playing field. However, the majority of testimony supported reaffirmation of existing policy, expressing concern that expanding the program in this manner would be impracticable and would not address the underlying flaws of the 340B program. Testimony also noted concerns about the assumptions underlying the resolution and whether the proposed approach would meaningfully improve patient care. Testimony emphasized that our AMA already has strong policy on 340B that broadly addresses these concerns. Your Reference Committee agrees that, although 340B remains in need of reform, reaffirmation of existing AMA policy is the most appropriate recommendation. Therefore, your Reference Committee recommends that existing AMA policy H-110.985 be reaffirmed in lieu of Resolution 211.

340B Drug Discount Program H-110.985

Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; (2) will support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; (3) recognizes the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients; (4) will support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well

as standalone community practices; and (5) will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program; and (6) supports 340B programs funded by HRSA grants provided 340B funds are utilized for the care of low-income and underserved patients as legislatively intended.

(54) RESOLUTION 214 - MEDICAL STUDENT LOANS SHOULD NOT BE CAPPED

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-305.924 and H-305.925 should be reaffirmed in lieu of Resolution 214.

RESOLVED, that our American Medical Association oppose the caps on medical student debt as a result of the H. R. 1 - One Big Beautiful Bill Act. (New HOD Policy)

Your Reference Committee heard substantial testimony on Resolution 214, with many commenters supporting adoption of the resolution or adoption with amendments to keep the language broad and avoid tying it to a specific law. Most commenters agreed that imposing arbitrary caps on federal student loans does not address the high costs of medical education or the issue of student debt. However, others noted that increasing loan amounts does not resolve the debt crisis either, and more structural changes, such as shortening the duration of medical school, are needed.

Additional commenters also supported reaffirmation, noting that our AMA has already actively opposed caps on federal student loans, sent multiple advocacy letters, and engaged Congress and regulatory agencies to preserve student access to education financing and flexible repayment programs.

Your Reference Committee agrees that our AMA is already engaged in substantial work in the student loan space. Our AMA is actively engaged with Congress on the issue, including through comments on proposed changes to federal student loans in H.R. 1 (the "One Big Beautiful Bill Act") and recommending that Congress exempt physicians from student loan restrictions in a March 2026 Statement for the Record on "Advancing the Next Generation of America's Health Care Workforce." Our AMA also has continued to actively engage with the Department of Education, including by commenting on proposed changes to the Public Service Loan Forgiveness (PSLF) Program and by responding to proposals to cap federal student loans and minimize loan repayment pathways. These examples demonstrate that existing policy already supports a positive advocacy approach that is responsive to the concerns raised in Resolution 214.

Moreover, your Reference Committee notes that our existing AMA policy advocates for "federal student loan limits that accurately reflect the cost of attendance of graduate medical education programs." This approach is desirable because a lack of loan limits may remove medical school guardrails that prevent schools from arbitrarily and steeply raising their tuition prices. Your Reference Committee notes that our AMA also supports

ensuring that tuition remains in check. Your Reference Committee wants to ensure that as many people as possible can afford medical school. However, the Committee believes that exiting policy better achieves this goal.

Therefore, your Reference Committee recommends that existing AMA policies H-305.924 and H-305.925 be reaffirmed in lieu of Resolution 214.

Restore and Enhance Federal Loan Programs for Medical Education H-305.924

1. Our American Medical Association will continue to advocate for federal student loan limits that accurately reflect the cost of attendance of graduate medical education programs.
2. Our AMA will continue to support diverse and beneficial repayment plans for federal student loans, including income-based repayment plans that are favorable to individuals who took out loans for graduate medical education.
3. Our AMA will continue to advocate for the protection of the Public Service Loan Forgiveness (PSLF) Program for physicians.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and
    b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness

programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
    d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;

e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
    g. Adding the ability to refinance Federal Consolidation Loans.
    h. Eliminating the cap on the student loan interest deduction.
    i. Increasing the income limits for taking the interest deduction.
    j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
    k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.
    l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
    a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
    b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
    c. share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
    f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,

g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
j. Monitor the denial rates for physician applicants to the PSLF.
k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs

and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.

25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

(55) RESOLUTION 215 - OPPOSE MEDICARE EFFICIENCY ADJUSTMENTS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-400. 972, H-390.849, and D-400.982 be reaffirmed in lieu of Resolution 215.

RESOLVED, that the American Medical Association support all efforts, whether by legislation or regulation, to restrict the use of arbitrary new factors such as the efficiency adjustment used in the 2026 Medicare Physician Payment Schedule. (New HOD Policy)

Your Reference Committee received testimony for Resolution 215 that noted strong opposition to the newly introduced “efficiency adjustment” in the 2026 Medicare Physician Fee Schedule, and support for strong AMA advocacy against such arbitrary payment reductions. Though mixed testimony was received, multiple commenters noted support for reaffirmation, with some emphasizing recent AMA advocacy efforts demonstrate that existing policy already supports a strong response to the efficiency adjustment.

Your Reference Committee notes that our AMA has spoken out repeatedly against the efficiency adjustment, including in a September 2025 comment letter to CMS Administrator Mehmet Oz. More broadly, the principles espoused by our AMA in its Medicare payment reform efforts effectively argue against the arbitrary efficiency adjustment cuts. Given these efforts, your Reference Committee believes that existing AMA policy is sufficient to allow for targeted advocacy against the efficiency adjustments alongside support for structural Medicare payment reforms. Therefore, your Reference Committee recommends that existing AMA policies H-400.972, H-390.849, and D-400.982 be reaffirmed in lieu of Resolution 215.

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both

absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.

9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reform. that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.

d. Not require budget neutrality within Medicare Part B.
e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
h. Use adequate risk adjustment methodologies.
i. Incorporate incentives large enough to merit additional investments by physicians.
j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
m. Include ongoing evaluation processes to monitor the success of the reform. in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare

Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

(56) RESOLUTION 217 - ENSURING PROPORTIONAL ACCOUNTABILITY FOR HOSPITAL EXPENDITURES ATTRIBUTED TO MEDICARE ACOS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy H-160.915 be reaffirmed in lieu of Resolution 217.

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services establish policies requiring hospitals that receive substantial expenditures attributable to ACO-assigned beneficiaries to enter defined participation and financial accountability agreements with the relevant ACO contracting entity (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that, absent such defined participation and accountability agreements, hospital expenditures for ACO-assigned beneficiaries not be included in total cost of care reconciliation calculations under the Medicare Shared Savings Program or other advanced alternative payment models (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enhanced transparency of hospital facility spending attributable to ACO-assigned beneficiaries within benchmarking and reconciliation methodologies (Directive to Take Action); and be it further

RESOLVED, that our AMA to study and report on policy mechanisms to ensure equitable financial accountability for hospital expenditures attributed to Medicare ACOs, including mechanisms addressing site-of-service payment differentials and facility fee impacts. (Directive to Take Action

Your Reference Committee heard mixed testimony on Resolution 217, with some testimony supporting adoption, others supporting adoption with amendments, and still others arguing for reaffirmation. The commenters supporting reaffirmation noted that our AMA's Accountable Care Organization Principles, established in existing AMA policy, thoroughly address the concerns raised by Resolution 217.

Your Reference Committee heard additional testimony from the author, who argued that existing policy leaves a specific gap as CMS moves to place more physicians in downside-risk arrangements. The author's concern is that physicians in these arrangements are held

financially accountable for hospital expenditures, the largest component of total Medicare spending, despite lacking direct governance authority or operational control over them.

Your Reference Committee appreciates the author's testimony but continues to believe that existing AMA policy thoroughly addresses the concerns raised by Resolution 217. The AMA's Accountable Care Organization Principles, establish that ACOs must be physician-led with governance separate and independent from any hospital governing board, that ACO spending benchmarks be risk-adjusted, that quality and cost methodologies use appropriate attribution consistent with AMA quality reporting principles, and that physicians retain decision-making authority over ACO operations and the distribution of shared savings. These principles directly speak to the concern that physicians should be held accountable only for spending and quality they can control. Therefore, your Reference Committee recommends that existing AMA policy H-160.915 be reaffirmed in lieu of Resolution 217.

Accountable Care Organization Principles H-160.915

Our American Medical Association adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first:
    a. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.
    b. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
    c. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.

d. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and

resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
8. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
9. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
10. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
11. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
12. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.
13. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment;

and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

14. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
15. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.
16. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
17. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
18. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

(57) RESOLUTION 220 - REVERSE CMS CUTS TO FACILITY-BASED PRACTICE EXPENSE PAYMENTS FOR PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-400.972, H-390.849, D-400.982, D-330.891, H-385.916, and D-405.965 be reaffirmed in lieu of Resolution 220.

RESOLVED, that our American Medical Association write and promote federal legislation to reverse CY 2026 Physician Fee Schedule (CME-1832-F) reductions to facility-based practice expenses payments for physicians – retroactive to 01/01/2026 – and codify future payment updates by linking these payments to the Medicare Economic Index (MEI). (Directive to Take Action)

Your Reference Committee received testimony for Resolution 220 that revealed strong opposition to reductions to facility-based practice expenses payment for physicians included in the 2026 Medicare Physician Fee Schedule. While many commenters

supported adoption on this basis, others noted that our AMA has extensive and robust Medicare payment policy that encompasses the asks of this resolution, and that our AMA is already actively engaged in advocacy efforts opposing this policy. An example of this work can be seen in the September 2025 comment letter on the 2026 Medicare Physician Fee Schedule proposed rule. Your Reference Committee believes that existing AMA policy is sufficient to allow for advocacy against the specific cuts that are the focus of the resolution alongside broader Medicare payment advocacy efforts. Therefore, your Reference Committee recommends that existing AMA policies H-400.972, H-390.849, and D-400.982, D-330.891, H-385.916, and D-405.965 be reaffirmed in lieu of Resolution 220.

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative

office visits, concomitant office procedures, and/or future procedures.

6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reform. that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reform. in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

Transparency of Facility Fees for Hospital Outpatient Department Visits D-330.891

1. Our American Medical Association advocates for legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at hospital outpatient department designated clinics.
2. Our AMA advocates the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service.

Reimbursement for Office-Based Surgery Facility Fees H-385.916

Our American Medical Association urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities.

Root Cause Analysis of the Causes of the Decline of Private Medical Practice D-405.965

Our AMA will 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.

(58) RESOLUTION 224 - CLARITY OF SIGNAGE: DISTINGUISHING URGENT CARES FROM EMERGENCY ROOMS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy H-160.888 be reaffirmed in lieu of Resolution 224.

RESOLVED, that our American Medical Association advocate for federal regulatory or legislative action that would require clear and standardized signage for urgent care centers to distinguish them from hospital emergency departments. (Directive to Take Action)

Your Reference Committee received testimony for Resolution 224 that reflects strong support for the need for clear, standardized signage to distinguish urgent care centers from emergency departments, citing risks of patient confusion, delayed care, and safety concerns. However, multiple commenters, while acknowledging these concerns, argue that existing AMA policy directly addresses the issues raised by Resolution 224. Through this existing policy, our AMA establishes principles that explicitly prohibit urgent care centers from using the word “emergency” or “ED” in their name, advertisements, or descriptions of care, and directs our AMA to support patient education on the differences between urgent care centers and emergency departments.

Your Reference Committee agrees that existing policy directly covers the asks of this resolution. Therefore, your Reference Committee recommends that existing AMA policy H-160.888 be reaffirmed in lieu of Resolution 224.

Urgent Care Centers H-160.888

1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
    a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community.

b. UCCs must transfer a patient's medical records to their primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.
d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made.
e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted.
f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers.
g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided.

2. Our AMA will work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending.
3. Our AMA supports patient education including notifying patients if their physicians are providing extended hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, asking for their patients to notify their physician or usual source of care before seeking UCC services, and encouraging patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services

(59) RESOLUTION 227 - STANDBY CAPACITY PAYMENTS AND HEALTH IT FOR HOSPITALS IN RURAL AREAS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-290.970, H-290.951, D-305.967, H-480.937, H-478.980, H-350.937, D-478.994, D-478.996, H-465.972, and D-465.998 be reaffirmed in lieu of Resolution 227.

RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of H.R. 1, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas (Directive to Take Action); and be it further

RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 227. Commenters generally agreed on the urgent challenges facing rural health care and highlighted the importance of policies supporting telehealth and other health IT, standby capacity payments for rural providers, and safety net programs. Additional testimony was received that supported amending the resolution, arguing that it should be broadened to encompass more rural health care services, such as emergency care. A few commenters opposed the resolution, arguing that the resolved clauses are unclear or would be difficult to implement. Finally, some comments proposed reaffirmation in lieu of adoption, identifying multiple existing policies for each clause of the resolution that address the issues raised.

Your Reference Committee agrees that the challenges facing rural health care are daunting. However, our AMA already has an extensive body of policy responding to these challenges, including policies that support capacity payments for rural hospitals, increasing access to health IT in rural communities, mitigating cuts to safety net programs that disproportionately impact rural communities, and more.

These policies have enabled strong advocacy on rural issues by our AMA, including endorsing legislation focused on rural issues such as the Rural Residency Planning and Development Act, the Specialty Physicians Advancing Rural Care Act, and the Connected

Maternal Online Monitoring Act, and developing maternal health recommendations. Our AMA has also undertaken extensive work in the student loan space in response to H.R. 1 including commenting on House Concurrent Resolution 14, commenting on H.R.1, commenting on the PSLF proposed changes, commenting on the proposed rule surrounding student loan changes, and creating a resource guide to explain the changes in the student loan space. Additionally, as some commenters noted, our AMA has done extensive educational and operational support work on rural issues. In particular, our AMA was very active in shaping state applications for Rural Health Transformation Program (RHTP) funding, and continues to lead on issues relating to the RHTP.

Therefore, your Reference Committee recommends that existing AMA policies D-290.970, H-290.951, D-305.967, H-480.937, H-478.980, H-350.937, D-478.994, D-478.996, H-465.972, and D-465.998 be reaffirmed in lieu of Resolution 227.

Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts D-290.970

1. Our American Medical Association publicly denounces cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025").
2. Our AMA 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. Our AMA will 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. Our AMA will report back to the AMA's House of Delegates at A-26.

Preservation of Medicaid H-290.951

1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility.
2. Our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education

(GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American

Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will:
    a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
    b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
    c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

Addressing Equity in Telehealth and Health Technology H-480.937

1. Our American Medical Association recognizes access to broadband internet as a social determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
3. Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
4. Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.
5. Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
6. Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
7. Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
8. Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
9. Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
10. Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.

11. Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access.

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

Improving Healthcare of Minority Communities in Rural Areas H-350.937

1. Our AMA encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas.
2. Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life.
3. Our AMA encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas.
4. Our AMA will advise organizations of the importance of minority health in rural areas.
5. Our AMA will channel existing policy for telehealth to support improved broadband internet access in minority communities in rural areas to increase the availability of telemedicine where clinically appropriate.
6. Our AMA supports minority health in rural areas through programming, equity initiatives, and other representation efforts.
7. Our AMA encourages the development of strategies and mechanisms for communities to share resources and best practices to serve their rural minority populations.

Health Information Technology D-478.994

Our AMA will:

(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);

(2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;

(3) support initiatives to ensure interoperability among all HIT systems; and

(4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

Information Technology Standards and Costs D-478.996

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

Payment Models to Sustain Rural Hospitals H-465.972

1. Our American Medical Association believes that rural hospitals are essential to the communities they serve. To ensure that these hospitals have adequate support to remain open and financially viable, our AMA will continue to work with interested national medical specialty societies and state medical associations to:
    a. support and monitor novel payment models for rural hospitals and encourage uniform reporting; and

b. support educating patients, physicians, and non-physician practitioners on alternative payment models for rural hospitals.

2. Our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care.
3. Our AMA will work to vigorously oppose Medicaid cuts as they significantly impact at-risk rural hospitals.

Addressing Payment and Delivery in Rural Hospitals D-465.998

1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
    a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
    b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
    c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
    d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
    e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
    f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.
5. Our AMA supports educating patients, physicians, and non-physician practitioners on the impact of Medicare Advantage plans on rural hospitals and encourages all payers to provide adequate payment to support the financial stability of rural hospitals.

(60) RESOLUTION 231 - PROTECTING AND PROMOTING LONG TERM CARE WORKFORCE AMIDST IMMIGRATION CHALLENGES

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-360.998 and D-255.980 be reaffirmed in lieu of Resolution 231.

RESOLVED, that our American Medical Association oppose administrative or regulatory actions that exacerbate staffing shortages or threaten access to long term care when such actions are not accompanied by adequate workforce supply and training, immigration pathways, and funding support (New HOD Policy); and be it further

RESOLVED, that our AMA support immigration policies that protect, retain, and expand the long-term care workforce, including timely work authorization, efficient visa processing, and protections against abrupt workforce disruptions for immigrant health care workers. (New HOD Policy)

Your Reference Committee heard extensive testimony in support of Resolution 231, with commenters noting that disruptions to the long-term care workforce negatively impacts physicians, patients, and the health care system more broadly. However, additional testimony noted that, while our AMA engages in extensive advocacy efforts relating to easing immigration barriers for physicians and International Medical Graduates (IMGs), the resolution is not physician-focused but addresses immigration barriers faced by nurses, home health aides, and other direct care workers. Reaffirmation of existing policy relating to the workforce shortages was proposed.

Your Reference Committee appreciates that understaffing among nurses, health aides, and other health care workers is a major issue facing our healthcare system. Your Reference Committee recognizes that staffing shortages exist in long-term care and that these important individuals provide life affirming care that is largely non-clinical. In principle, the Committee is aligned with the spirit of the resolution and notes that existing AMA policy states that our AMA will work to “enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions.” The Committee further notes, when feasible, our AMA already undertakes this work. For example. H.R. 7961, which the AMA worked hard to get introduced, would exempt physicians and health care workers involved in direct patient care from the $100,000 H-1B fee. However, the Committee notes that our AMA’s focus in the immigration space must remain on the critical physician shortages that exist across our country and which only our IMG colleagues can ease, as was noted in testimony.

Therefore, your Reference Committee recommends that existing AMA policy D-360.998 and D-255.980 be reaffirmed in lieu of Resolution 231.

The Growing Nursing Shortage in the United States D-360.998

1. Our American Medical Association recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields.
2. Our AMA encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients.
3. Our AMA encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process.
4. Our AMA will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions.
5. Our AMA will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(61) RESOLUTION 234 - PHYSICIAN UNITY IN ADVOCACY REGARDING PHYSICIAN REIMBURSEMENT

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-400.982, H-400.972, and H-390.849 be reaffirmed in lieu of Resolution 234.

RESOLVED, that our American Medical Association reaffirm that physician payment reform should prioritize the sustainability of the entire physician workforce and the protection of patient access to care (New Hod Policy); and be it further

RESOLVED, that our AMA adopt policy stating that physicians and physician organizations should refrain from advocating for reductions in reimbursement specifically targeted at other physician specialties or physician groups (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage physician organizations to pursue payment reform through approaches that improve overall fairness, adequacy, and stability of physician reimbursement rather than redistribution among physician specialties (Directive to Take Action); and be it further

RESOLVED, that our AMA affirm that physicians should advocate collectively against reimbursement cuts affecting any group of physicians and support efforts to protect the financial sustainability of all physician practices in order to preserve patient access to care. (New HOD Policy)

Your Refence Committee heard mixed testimony for Resolution 234. Your Reference Committee heard testimony in favor of adopting the resolution, opposing the resolution altogether, amending the resolution, and reaffirming existing policy.

Testimony noted that our AMA has a robust body of Medicare payment policy, is engaged in ongoing, extensive advocacy on Medicare payment issues, and is a leader on Medicare payment reform. Our AMA is already working to unite physicians and bring the House of Delegates together. For example, our AMA's principles for Medicare reform, Characteristics of a Rational Medicare Payment System, have been endorsed by over 70 national medical specialty societies and medical organizations and all 50 state medical associations and the District of Columbia. Additionally, H.R. 8163, the "Provider Reimbursement Stability Act" just unanimously passed a significant Ways and Means markup this month. This important piece of legislation garnered widespread support within the House of Medicine and is a prominent example of the importance of ensuring that our AMA policy benefits the whole House. Though your Reference Committee understands that there are gaps in payment between specialties it also acknowledges the significant and ongoing work within our AMA to minimize payment gaps and to work across all states and specialties to ensure that all physicians can thrive. Your Reference Committee notes the significant importance of ensuring that our AMA policy supports the whole House of Medicine and allows our AMA to continue to be an important and neutral convener on this topic.

Given our AMA's unique, central role in ongoing conversations within the House of Medicine regarding Medicare payment reform, your Reference Committee recommends that existing AMA policies D-400.982, H-400.972, and H-390.849 be reaffirmed in lieu of Resolution 234.

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.

3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely

information on developments in Medicare physician payment reform.

14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

RECOMMENDED FOR FILING

(62) BOARD OF TRUSTEES REPORT 37 - AMA POLICIES ON GENDER AFFIRMING CARE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 37 be filed.

Your Reference Committee heard substantial testimony regarding Board of Trustees Report 37 and the events that prompted its development. Many commenters expressed concern regarding our AMA's prior public statement on gender affirming care and its consistency with existing AMA policy. At the same time, your Reference Committee heard appreciation for the Board of Trustees' willingness to acknowledge those concerns, provide additional clarification regarding AMA policy, and engage in a transparent discussion with the House of Delegates.

Your Reference Committee appreciates the Board's efforts to summarize our AMA policies that form the foundation of our AMA's position on gender affirming care and to clarify that the prior statement was not intended to alter existing AMA policy. Your Reference Committee also notes the Board's testimony indicating its intent to revise the report, by deletion and addition, on page 3, lines 30-31, and appreciates the Board's responsiveness to concerns raised during testimony regarding that characterization.

Your Reference Committee further heard testimony expressing a desire for continued communication from the Board regarding this matter, including the processes that will be used to ensure future public statements accurately reflect existing AMA policy and receive appropriate expert review prior to release. Given the importance of these issues to physicians and patients, your Reference Committee encourages the Board of Trustees to continue providing updates to the House of Delegates regarding its ongoing work in this area and any further efforts to communicate AMA policy on gender affirming care. Your Reference Committee thanks the Board of Trustees for this informational report and recommends that Board of Trustees Report 37 be adopted as amended.

Your Reference Committee, in concurrence with of the Board of Trustees, notes that the report has been corrected, on page 3, lines 30 through 31, by striking “According to” and all that follows through “the consensus” and inserting “The consensus”. Therefore, your Reference Committee, in accordance with the Board of Trustees, recommends that Board of Trustees Report 37 be filed.

This concludes the report of Reference Committee B. I would like to thank Elie Azrak, MD, Karl Napekoski, MD, Chris Paprzycki, MD, Sherif Zaafran, MD, Anne Langguth, MD, Matthew Jared, MD, and all those who testified before the Committee.

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Amendments

If you wish to propose an amendment to an item of business, scan the QR code below:

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