DISCLAIMER
The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee G

Robert Dannenhoffer, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 22 – Comprehensive AMA Policy Publication Regarding Employed Physicians
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2016 House Policies
3. Council on Medical Service Report 4 – Expanding Medicare Coverage of Medical Nutrition Therapy
4. Council on Medical Service Report 7 – Private Insurance Coverage of Anti-Obesity Medications
5. Resolution 704 – Advocating Against Automatic Refill Requests
6. Resolution 708 – Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
7. Resolution 711 – Oppose Denials Based on Origin of Referral
8. Resolution 712 – Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions
9. Resolution 715 – Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA

RECOMMENDED FOR ADOPTION AS AMENDED

10. Board of Trustees Report 20 – Mitigating the Impact of Excessive Prior Authorization Processes
11. Council on Medical Service Report 9 – Nonprofit Status
12. Resolution 701 – The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
13. Resolution 702 – Physicians Who Do Not Practice in Hospital Setting
14. Resolution 703 – Parity in Pricing for Anti-Obesity Medications
15. Resolution 705 – Recognizing Physicians as Sexual Assault Forensic Examiners
16. Resolution 706 – Discharge Summaries from Skilled Nursing Facilities
17. Resolution 709 – Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
18. Resolution 710 – Parity in Access to Evidence-Based Obesity Treatment
19. Resolution 713 – Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
20. Resolution 714 – Physician Case Log Portability

RECOMMENDED FOR REFERRAL

21. Council on Medical Service Report 6 – Study of Practice Models for Physicians Performing Procedures Across State Lines
22. Resolution 707 – Malpractice Insurance for Employed Physicians
23. Resolution 717 – Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

24. Resolution 716 – Equal Opportunity for Payment for “On Call” Duty

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 22 -
COMPREHENSIVE AMA POLICY PUBLICATION
REGARDING EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Board of Trustees Report 22 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 22 is adopted and remainder of Report filed.

The Board of Trustees recommends that the first directive of Policy D-225.971, Comprehensive AMA Policy Publication Regarding Employed Physicians, be rescinded as having been accomplished by this report and that the remainder of the report be filed.

Your Reference Committee heard limited, but supportive, testimony on this report. Thus, your Reference Committee recommends that recommendations in Board of Trustees Report 22 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 -
COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF
2016 HOUSE POLICIES

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 1 is adopted and remainder of Report filed.

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

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

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - EXPANDING MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 4 is adopted and remainder of Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 116-A-25 and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognize the benefits and support the use of medical nutrition therapy (MNT) – delivered by a Registered Dietitian Nutritionist, as defined in §1861(v)(2) of the Social Security Act and credentialed by the Commission on Dietetic Registration and in ongoing support with the patient's physician – for the purpose of managing and treating chronic health conditions for which there is evidence of efficacy. (New HOD Policy)
2. That our AMA support the expansion of Medicare coverage and exemption from budget neutrality for evidence-based intensive behavioral and nutritional interventions, including medical nutrition therapy (MNT). (New HOD Policy)
3. That our AMA reaffirm Policy H-160.906, which defines the role that physicians should have within team-based health care as well as guidelines and a model in the development of physician-led team-based care. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-385.905, which supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in Merit-based Incentive Payment System with incentive payments, or implements positive annual physician payment updates. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 4. Testimony indicated that medical nutrition therapy plays a significant role in the treatment of multiple metabolic diseases and should therefore be appropriately covered by Medicare. While one individual expressed their reservations with the exemption of Medicare coverage for medical nutrition therapy from budget neutrality, there was no other testimony on this issue. One individual proffered an amendment to add two recommendations to support equitable coverage of the treatment of eating disorders, which are classified as "serious mental illnesses." The Council on Medical Service noted that the amendment was not germane to the report since the issue falls outside the scope of the referred resolution. A preponderance of testimony supported the report as written with no testimony supporting the amendments. Therefore, your Reference Committee

recommends that recommendations in Council on Medical Service Report 4 be adopted and remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 7 - PRIVATE INSURANCE COVERAGE OF ANTI-OBESITY MEDICATIONS

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 7 is adopted and remainder of Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Subclauses 1e and 1g of Resolution 230-A-25, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support:
    a. Potential innovative payment arrangements to help individuals afford treatment for emerging anti-obesity medications (AOMs);
    b. Pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management, such as glucagon-like peptide-1 and glucose-dependent insulinotropic polypeptide-based medications;
    c. The long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability;
    d. Equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity.

    (New HOD Policy)
2. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-110.959, which supports efforts to ensure patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, that all patients have access to all prescription drugs necessary to treat their illnesses, and physicians have the freedom to prescribe the most appropriate drug and method of delivery. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy D-330.954, which supports the Centers for Medicare & Medicaid Services (CMS) negotiating pharmaceutical pricing for all applicable medications covered by CMS, AMA working toward the elimination Medicare prohibition on drug price negotiation, and indicates the AMA's support for federal

legislation giving the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-150.953, which recognizes obesity as a complex health disorder, urges all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and appropriate federal agencies work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity. (Reaffirm HOD Policy)

Your Reference Committee heard unanimously supportive testimony on Council on Medical Service Report 7. Testimony indicated that the report satisfied the intent of the resolution and approached the complex and dynamic topic of anti-obesity medication coverage with alacrity. Therefore, your Reference Committee recommends that recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

(5) RESOLUTION 704 - ADVOCATING AGAINST AUTOMATIC REFILL REQUESTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 704 be adopted.

HOD ACTION: Resolution 704 is adopted.

RESOLVED, that our American Medical Association communicate effectively with large pharmacy chains and conglomerates for the purpose of explaining the unnecessary administrative burden of automatic, non-patient-initiated refill requests and petitioning them to require all medication refill requests use a patient directed “opt-in” approach (Directive to Take Action); and be it further

RESOLVED, that our AMA petition the Centers for Medicare & Medicaid Services to restrict participating pharmacies from sending medication refill requests to physicians unless the patient “opts-in” to using the refill request. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 704, with several delegations emphasizing that automatic pharmacy-generated refill requests create unnecessary administrative burden, disrupt workflow, and often occur without patient involvement. Testimony supported an opt-in approach to ensure patient engagement and improve safety, with one delegation raising concerns about potential impacts on access for contraception and proposed an amendment to address those concerns. There was no other testimony in support of the amendment and concerns were expressed that the proposed language could increase administrative burden further without improving access to contraception. Therefore, your Reference Committee recommends that Resolution 704 be adopted.

(6) RESOLUTION 708 - OPPOSE IMPOSITION OF FEES ON PHYSICIANS FOR ELECTRONIC PAYMENT TRANSFERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 708 be adopted.

HOD ACTION: Resolution 708 is adopted.

RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid Services (CMS) to issue a legally-binding rule compliant with the Administrative Procedure Act with a notice and comment period preventing the use of virtual credit cards or imposition of electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Resolution 708, with multiple delegations emphasizing that fees on electronic payments reduce physician payment and increase administrative burden. Testimony urged adoption to secure enforceable Centers for Medicare & Medicaid Services action, noting that existing policy has been insufficient to address ongoing fee practices and therefore providing testimony against reaffirmation. Your Reference Committee recommends that Resolution 708 be adopted.

(7) RESOLUTION 711 - OPPOSE DENIALS BASED ON ORIGIN OF REFERRAL

RECOMMENDATION:

Your Reference Committee recommends that Resolution 711 be adopted.

HOD ACTION: Resolution 711 is adopted.

RESOLVED, that our American Medical Association advocate against prior authorization denials based solely upon the referring physician or appropriately licensed clinician. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on Resolution 711, with multiple delegations stating that denials based solely on the referring physician create administrative barriers, delay care, and harm patients. Testimony emphasized the realities of team-based care and the need for decisions based on medical necessity. Several delegations opposed reaffirmation, noting gaps in current policy. Therefore, your Reference Committee recommends that Resolution 711 be adopted.

(8) RESOLUTION 712 - ADDRESSING THE COMMODITIZATION OF MEDICINE THROUGH RECOGNITION OF THE FULL SCOPE OF PHYSICIAN WORK AND CONTRIBUTIONS

RECOMMENDATION:

Your Reference Committee recommends Resolution 712 be adopted.

HOD ACTION: Resolution 712 is adopted.

RESOLVED, that our American Medical Association advocate that health systems, hospitals, other physician employers, and third-party payors recognize that the profession of medicine is not a commoditized entity, is fundamentally anchored in the patient-physician relationship, and should not be reduced solely to productivity measures (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage employers of physicians to utilize productivity benchmarks, performance expectations, and compensation structures that recognize and integrate the full scope of physician work, including clinical, administrative, educational, and operational responsibilities that may not be fully captured by traditional productivity metrics (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for regulatory, employer, and practice models that provide both employed and independent physicians with appropriate time, resources, compensation, support, and recognition for non-billable work that is essential to patient care, physician well-being, and health system function. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 712. Several delegations provided testimony in favor of the original resolution. There was an amendment offered by an individual; however, there was no further testimony on this amendment. As such, your Reference Committee took this as support for the original language and recommends that Resolution 712 be adopted.

(9) RESOLUTION 715 - OPPOSE THE LEGAL POSITION THAT VIRTUAL CREDIT CARDS ARE A LEGAL METHOD OF PAYMENT UNDER HIPAA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 715 be adopted.

HOD ACTION: Resolution 715 is adopted.

RESOLVED, that our American Medical Association will advocate that a vendor or clearinghouse that offers a multi-payer platform may not create separate payer-specific enrollment mechanisms into standard adopted HIPAA transactions (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate that a health plan may not use a vendor for electronic transactions that unnecessarily create duplicate administrative work for physician practices by creating a separate mechanism of enrollment in the same standard transaction for different health plans. (Directive to Take Action)

Your Reference Committee heard uniformly supportive testimony on Resolution 715. The author and multiple delegations emphasized that virtual credit cards impose unnecessary fees on physicians for receiving payment, reducing already limited payment. Testimony reinforced longstanding AMA policy supporting no-fee electronic funds transfer and opposing excessive payment processing fees, underscoring that physicians should not have to pay to get paid. One individual proposed additional amendments regarding HIPAA compliance, but there was testimony provided against the amendments and all other testimony largely supported the resolution as written. Therefore, your Reference Committee recommends that Resolution 715 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) BOARD OF TRUSTEES REPORT 20 – MITIGATING THE IMPACT OF EXCESSIVE PRIOR AUTHORIZATION PROCESSES

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 20 be amended by addition to read as follows:

2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians including, if feasible, a potential class action lawsuit.

RECOMMENDATION B:

Your Reference Committee recommends that Recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 20 is adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

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

1. That the referred resolve clause of Resolution 704-A-25 not be adopted.

2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians including, if feasible, a potential class action lawsuit.

3. That existing AMA policies H-320.939, "Prior Authorization and Utilization Management Reform", D-320.974, "Insurer Accountability When Prior Authorization Harms Patients", and H-320.950, "Eliminating Precertification" be reaffirmed.

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

1. That the referred resolve clause of Resolution 704-A-25 not be adopted.
2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians.
3. That existing AMA policies H-320.939, “Prior Authorization and Utilization Management Reform”, D-320.974, “Insurer Accountability When Prior Authorization Harms Patients”, and H-320.950, “Eliminating Precertification” be reaffirmed.

Your Reference Committee heard mixed, but mostly supportive testimony on Board of Trustees Report 20. There was confusion regarding which of the original resolve clauses were referred, which was clarified by the Board. In response to testimony asking for a class action lawsuit to be explored, the Board offered an amendment to recommendation 2, noting that the report did not conclusively determine that a class action lawsuit was impossible, only that it would be difficult. Subsequent testimony supported this amendment. Therefore, your Reference Committee recommends that recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 9 - NONPROFIT STATUS

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation in Council on Medical Service Report 9 be amended by addition to read as follows:

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a "community benefit" that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status.
5. Our AMA advocates for the development of ~~a~~ transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
6. Our AMA advocates for transparency and consistency regarding ~~the expansion of~~ governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.

7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 9 is adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL POLICIES, H-155.954

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

including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

1. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

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

Your Reference Committee heard overall supportive testimony on Council on Medical Service Report 9, highlighting its relevance and timeliness. There were amendments offered in testimony to broaden the scope of the report. The Reference Committee agreed with the Council's response highlighting that several of the topics recommended for addition were addressed in the body of the report and concurred with testimony to include only the amendment regarding consideration of social drivers of health when determining community benefits. Your Reference Committee believes this language broadens the recommendations while remaining in scope of the original report and thus recommends that recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

(12) RESOLUTION 701 - THE CRISIS IN THE AVAILABILITY OF PRIMARY CARE: HALT THE REQUIRED PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 701 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~will~~ advocate ~~for the immediate discontinuation of required participation~~ to exempt practices from mandatory participation in value-based programs (VBP), including associated reporting requirements and penalties, when such practices meet one or more criteria indicating limited capacity to participate. This includes but is not limited to small practice size, lower Medicare fee-for-service revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless the physician or practice voluntarily elects to participate. ~~arrangements for practices with ten or fewer physicians, regardless of practice revenue.~~ (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 701 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 701 be changed to read as follows:

PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS

HOD ACTION: Resolution 701 is adopted as amended.

ADOPTED LANGUAGE:

NEW TITLE: PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS

RESOLVED, that our American Medical Association advocate to exempt practices from mandatory participation in value-based programs (VBP), including associated reporting requirements and penalties, when such practices meet one or more criteria indicating limited capacity to participate. This includes but is not limited to

small practice size, lower Medicare fee-for-service revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless the physician or practice voluntarily elects to participate. (Directive to Take Action)

RESOLVED, that our American Medical Association will advocate for the immediate discontinuation of required participation in value-based programs (VBP) arrangements for practices with ten or fewer physicians, regardless of practice revenue. (Directive to Take Action)

Your Reference Committee heard supportive testimony for Resolution 701. Testimony suggested that the resolution could contribute to small practice viability by ensuring reasonable applications of value-based programs. One delegation proffered an amendment highlighting the complex designations of small practices and that a limited capacity to participate might not be limited to practice size but could include location, Medicare revenue, or professional shortage areas. Additional testimony supported the amended language and suggested a corresponding title change so that the resolution apply to all small practices regardless of specialty. Therefore, your Reference Committee recommends that Resolution 701 be adopted as amended with a title change.

(13) RESOLUTION 702 - PHYSICIANS WHO DO NOT PRACTICE IN HOSPITAL SETTING

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association amend D-230.981 as follows:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation.

(Modify Current HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Resolution 702 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association amend D-230.981 as follows:

1. **Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.**
2. **Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.**
3. **Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation.**

(Modify Current HOD Policy)

RESOLVED, that our American Medical Association amend D-230.981 as follows:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. Our AMA advocate that hospital privileges not be a requirement for insurance network participation.

(Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 702, with the suggestion of a clarifying amendment. The proposed amendment broadened the language to include both federal and state advocacy efforts and was supported by the authors of the resolution. Testimony was supportive of the intent of the original resolution as well as the amended language since these requirements can create burdens on physicians and can also reduce access to care for patients; therefore, your Reference Committee recommends that Resolution 702 be adopted as amended.

(14) RESOLUTION 703 - PARITY IN PRICING FOR ANTI-OBESITY MEDICATIONS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 703 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Resolution 703 be changed to read as follows:

MEDICATION PRICING PARITY

HOD ACTION: Resolution 703 is adopted as amended.

ADOPTED LANGUAGE:

NEW TITLE: MEDICATION PRICING PARITY

RESOLVED, that our American Medical Association actively oppose preferential pricing strategies by pharmaceutical manufacturers that offer discounted medications exclusively to telehealth or online providers, as such practices undermine the established physician-patient relationship and the continuity of care. (Directive to Take Action)

RESOLVED, that our American Medical Association actively oppose preferential pricing strategies by pharmaceutical manufacturers that offer discounted medications exclusively to telehealth or online providers, as such practices undermine the established physician-patient relationship and the continuity of care. (Directive to Take Action)

Your Reference Committee heard universal support for Resolution 703. Testimony indicated that while telehealth is a valuable tool, it should not replace, disincentivize, or fragment in-person care. Furthermore, testimony highlighted that a title change may be warranted so that the resolution can apply to all medications. Therefore, your Reference Committee recommends that Resolution 703 be adopted with a change in title.

(15) RESOLUTION 705 - RECOGNIZING PHYSICIANS AS SEXUAL ASSAULT FORENSIC EXAMINERS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 705 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

1. Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:
    a. receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;
    b. preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;
    c. notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
    d. be informed of these rights and the policies governing the sexual assault evidence kit; and
    e. access to emergency contraception information and treatment for pregnancy prevention free of charge.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased patient access to Sexual Assault Medical ~~Nurse~~ Forensic Examiners~~, and other trained and qualified clinicians, in the emergency department~~ for sexual assault medical forensic examinations.
5. Our AMA will advocate at the state and federal level for;

a. the timely processing of all sexual examination kits upon patient consent;
b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
c. additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of ~~Sexual Assault Nurse Examiner and~~ Sexual Assault Medical Forensic Examiners ~~providers~~. (Modify Current AMA Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 705 be adopted as amended.

HOD ACTION: Resolution 705 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

SEXUAL ASSAULT SURVIVORS, H-80.999

1. **Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.**
2. **Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:**
   a. **receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;**
   b. **preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;**
   c. **notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;**
   d. **be informed of these rights and the policies governing the sexual assault evidence kit; and**
   e. **access to emergency contraception information and treatment for pregnancy prevention free of charge.**
3. **Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.**

4. **Our AMA will advocate for increased patient access to Sexual Assault Medical Forensic Examiners for sexual assault medical forensic examinations.**
5. **Our AMA will advocate at the state and federal level for;**
    a. **the timely processing of all sexual examination kits upon patient consent;**
    b. **timely processing of "backlogged" sexual assault examination kits with patient consent; and**
    c. **additional funding to facilitate the timely testing of sexual assault evidence kits.**
6. **Our AMA supports the implementation of a national database of Sexual Assault Medical Forensic Examiners.**

(Modify Current AMA Policy)

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

SEXUAL ASSAULT SURVIVORS, H-80.999

1. Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:
    a. receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;
    b. preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;
    c. notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
    d. be informed of these rights and the policies governing the sexual assault evidence kit; and
    e. access to emergency contraception information and treatment for pregnancy prevention free of charge.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group

established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will advocate for increased patient access to Sexual Assault ~~Nurse~~ Forensic Examiners~~, and other trained and qualified clinicians,~~ in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for;

   a. the timely processing of all sexual examination kits upon patient consent;
   b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
   c. additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of ~~Sexual Assault Nurse Examiner and~~ Sexual Assault Medical Forensic Examiners ~~providers~~.

(Modify Current AMA Policy)

Your Reference Committee heard mostly supportive testimony for Resolution 705. Testimony indicated that the resolution enhances existing policy by ensuring the AMA is aligned with currently accepted terminology. One individual proposed several amendments, suggesting that the updates more accurately capture the limited credentialling of sexual assault nurse examiners (SANEs), trauma informed care may be performed outside of the emergency department, and medical forensic examinations constitute a broader term not solely representative of sexual assault examinations. The author testified in support of the amendment recognizing that trauma informed care may be performed outside the emergency department but clarified that SANE is a form of sexual assault forensic examiner (SAFE) and was correctly categorized. Furthermore, the author agreed that there is a distinction between medical forensic examinations and sexual assault examinations and proposed a compromised amendment utilizing the current Department of Defense terminology "sexual assault medical forensic examinations". Your Reference Committee agrees that the compromised language most effectively updates AMA policy and concurs with the author that SANEs are a form of SAFEs and were correctly identified. Furthermore, your Reference Committee recognizes that sexual assault may occur outside of the emergency department, and, therefore, recommends that Resolution 705 be adopted as amended.

(16) RESOLUTION 706 - DISCHARGE SUMMARIES FROM SKILLED NURSING FACILITIES

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association educate physicians ~~their members~~ as to Centers for Medicare & Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 706 be amended by addition of a new resolve clause to read as follows:

RESOLVED, that our AMA advocate that CMS enforce its existing regulations on timely and comprehensive discharge summaries.

RECOMMENDATION C:

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

HOD ACTION: Resolution 706 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association educate physicians as to Centers for Medicare & Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

RESOLVED, that our AMA advocate that CMS enforce its existing regulations on timely and comprehensive discharge summaries.

RESOLVED, that our American Medical Association educate their members as to Centers for Medicare & Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP). (Directive to Take Action)

Your Reference Committee heard limited testimony in support of the intent of Resolution 706, but with two amendments offered. Testimony supported the goal of the resolution to improve continuity of care and communication during transition from skilled nursing facilities to outpatient settings and suggested an amendment to clarify where the proposed education should be targeted. A second amendment was proposed to ask the AMA to advocate that the Centers for Medicare & Medicaid Services enforce existing guidelines. Your Reference Committee did not believe that the second part of the proposed amendment for the new resolve clause, which read "as policies without implementation or accountability mechanisms often fail to improve real-world practice" was necessary to include, as it was mostly narrative and will not significantly impact the potential action the AMA would take. Therefore, your Reference Committee recommends that Resolution 706 be adopted as amended.

(17) RESOLUTION 709 - REQUIRING TRANSPARENCY AND ACCOUNTABILITY WHEN INSURERS AND THIRD-PARTY ADMINISTRATORS REQUIRE UTILIZATION REVIEW, THEREBY PRACTICING MEDICINE

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 709 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction ~~New York State~~ and therefore, accountable to ~~New York State authorities~~ appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 709 be adopted as amended.

HOD ACTION: Resolution 709 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA),

and allow for accountability should the decision be called into question (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction and therefore, accountable to appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RESOLVED that our American Medical Association amend their Policy H-285.939 as follows:

MANAGED CARE MEDICAL DIRECTOR LIABILITY, H-285.939
Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine.

1. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions.

2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations.

3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

(Modify Current HOD Policy)

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA), and allow for accountability should the decision be called into question (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in New York State and therefore, accountable to New York State authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further

RESOLVED that our American Medical Association amend their Policy H-285.939 as follows:

MANAGED CARE MEDICAL DIRECTOR LIABILITY, H-285.939
Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine.
1. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical

directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions.
2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations.
3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.
(Modify Current HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 709, with many calling out the inappropriate reference to a specific state in the second resolve clause. There were several amendments proposed to address these concerns. Other testimony emphasized that utilization review decisions reflect medical judgment and should be recognized as the practice of medicine, requiring transparency and accountability. Those providing testimony highlighted the need for disclosure of reviewer identity, licensure, and credentials, and supported amendments to ensure national applicability. Therefore, your Reference Committee recommends that Resolution 709 be adopted as amended.

(18) RESOLUTION 710 - PARITY IN ACCESS TO EVIDENCE-BASED OBESITY TREATMENT

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 710 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of ~~anti-obesity~~ medications for anti-obesity indications ~~(Section 1927(d)(2) of the Social Security Act), and further advocate that all state Medicaid programs be required to include FDA-approved anti-obesity medications on their formularies as a condition of federal matching funds~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends Resolution 710 be amended by addition of a new resolve clause to read as follows:

RESOLVED, that our AMA affirm that treatment decisions for patients with obesity — including the sequencing and selection of pharmacologic therapy, behavioral intervention, and bariatric or metabolic surgery — should be made through individualized, evidence-based, shared decision-making between the physician and patient, free from payer-imposed treatment hierarchies or mandatory sequencing requirements. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 710 be adopted as amended.

HOD ACTION: Resolution 710 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association promote policies and recommend to all public and private health insurance plans to provide coverage parity for evidence-based obesity treatments, including chronic weight management medications, bariatric and metabolic surgery, intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular disease without exclusionary carve-outs, annual or lifetime caps specific to obesity,

or "fail first"/step therapy requirements not applied to comparable chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of medications for anti-obesity indications (New HOD Policy); and be it further

RESOLVED, that our AMA oppose as discriminatory any insurance practice that terminates, reduces, or restricts coverage to evidence-based obesity treatment or insurer-defined weight loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned with individualized, evidence-based clinical decision-making as well as advocate for federal and state regulation prohibiting such practices (New HOD Policy); and be it further

RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery coverage, and advocate for the elimination of such requirements at the federal and state level. (New HOD Policy)

RESOLVED, that our AMA affirm that treatment decisions for patients with obesity — including the sequencing and selection of pharmacologic therapy, behavioral intervention, and bariatric or metabolic surgery — should be made through individualized, evidence-based, shared decision-making between the physician and patient, free from payer-imposed treatment hierarchies or mandatory sequencing requirements. (New HOD Policy)

RESOLVED, that our American Medical Association promote policies and recommend to all public and private health insurance plans to provide coverage parity for evidence-based obesity treatments, including chronic weight management medications, bariatric and metabolic surgery, intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular disease without exclusionary carve-outs, annual or lifetime caps specific to obesity, or "fail first"/step therapy requirements not applied to comparable chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of anti-obesity medications (Section 1927(d)(2) of the Social Security Act), and further advocate that all state Medicaid programs be required to include FDA-approved anti-obesity medications on their formularies as a condition of federal matching funds (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose as discriminatory any insurance practice that terminates, reduces, or restricts coverage to evidence-based obesity treatment or insurer-defined weight loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned with individualized, evidence-based clinical decision-making as well as advocate for federal and state regulation prohibiting such practices (New HOD Policy); and be it further

RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery coverage, and advocate for the elimination of such requirements at the federal and state level. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony for Resolution 710. Testimony indicated that obesity continues to be a significant challenge for much of the population and that emerging therapies may help address it. The Council on Medical Service raised concerns about the second resolve clause and proposed revised language, noting that requiring state Medicaid programs to include anti-obesity medications (AOMs) on their formularies as a condition of federal matching funds could create unintended fiscal consequences. Additional testimony agreed with the Council's amendment. Online testimony from an individual proposed an amendment to the fourth resolve clause, suggesting that surgery should not automatically be treated as the preferred next step before adequate trials of modern medical therapy. However, your Reference Committee heard testimony at the in-person hearing offering an alternate amendment that supported the original language of the fourth resolve clause and adding a new fifth resolve clause. There was subsequent testimony in support of these proposed amendments. Therefore, your Reference Committee recommends that Resolution 710 be adopted as amended.

(19) RESOLUTION 713 - REDUCING PRIOR AUTHORIZATION DELAYS TO IMPROVE ACCESS TO NEUROMODULATION AND NON-OPIOID PAIN THERAPIES

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 713 be deleted:

~~RESOLVED, that our AMA advocate for standardized, transparent, and expedited prior authorization processes across payers, including response timelines that do not exceed 72 hours for non-urgent requests and 24 hours for urgent requests (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 713 be adopted as amended.

HOD ACTION: Resolution 713 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated (Directive to Take Action); and be it further

RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non-opioid pain care (New HOD Policy); and be it further

RESOLVED, that our AMA encourage further research on the impact of insurance-related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status. (Directive to Take Action)

RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for standardized, transparent, and expedited prior authorization processes across payers, including response timelines that do not exceed 72 hours for non-urgent requests and 24 hours for urgent requests (Directive to Take Action); and be it further

RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non-opioid pain care (New HOD Policy); and be it further

RESOLVED, that our AMA encourage further research on the impact of insurance-related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status. (Directive to Take Action)

Your Reference Committee heard limited testimony on Resolution 713, with one individual speaking in favor of adoption with amendment. There was no testimony to support reaffirmation. Testimony emphasized that prior authorization delays uniquely affect chronic pain care by limiting access to evidence-based non-opioid therapies and may worsen outcomes or increase reliance on opioids. The testimony supported removing prescriptive timeline language. Therefore, your Reference Committee recommends that Resolution 713 be adopted as amended.

(20) RESOLUTION 714 - PHYSICIAN CASE LOG PORTABILITY

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 714 be amended by addition and deletion to read as follows:

RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, that ensures timely access to these files but takes into consideration operational realities, verification processes, and patient privacy safeguards ~~not to exceed five (5) business days~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

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

HOD ACTION: Resolution 714 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further

RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, that ensures timely access to these files but takes into consideration operational realities, verification processes, and patient privacy safeguards (Directive to Take Action); and be it further

RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)

RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further

RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, not to exceed five (5) business days (Directive to Take Action); and be it further

RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 714. One delegation provided testimony in favor of the resolution and proposed an amendment to lengthen the five-business day timeline, but no alternative timeline was suggested. Since no timeline was offered to replace the five-business days cited in the original resolution, your Reference Committee presents language that it believes captures the intent of the need for an extension; however, the Reference Committee would be open to further amendments if a specific timeline would be more appropriate. Your Reference Committee recommends that Resolution 714 be adopted as amended.

RECOMMENDED FOR REFFERAL

(21) COUNCIL ON MEDICAL SERVICE REPORT 6 - STUDY OF PRACTICE MODELS FOR PHYSICIANS PERFORMING PROCEDURES ACROSS STATE LINES

RECOMMENDATION:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 6 be referred.

HOD ACTION: Council on Medical Service Report 6 is referred.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 711-A-25 and the remainder of the report be filed:

1. That our American Medical Association (AMA) supports the following principles for physicians employed by ambulatory surgical centers (ASC) or office-based laboratories (OBL) who may travel from their primary practice location to provide patient care:
    a. A transfer agreement with a physician or physician group licensed in the patient's state should be arranged to address in-person care needs that may arise from a patient receiving care from a physician with no admitting privileges to the local hospital.
    b. A referral system with a local physician, physician practice, or other facility for appropriate treatment should be established if a patient's conditions or symptoms are beyond the scope of services provided by the ASC or OBL.
    c. Transfer agreements and backup plans should be coordinated between physicians.
        i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician that would be among those receiving the patient must give explicit consent to the agreement to provide follow-up care.
        ii. When patient transfer is required, a direct hand off of the patient and patient records should be completed.
        iii. Transfer and referral agreements should be evidence-based and risk-based to balance access to care and patient safety.
    d. Protocols for ensuring continuity of care with physicians in the local community should be established.
    e. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.
    f. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements.

    (New HOD Policy)
2. That our AMA reaffirm Policy H-475.984, which lists Core Principles for Office-Based Surgery Regulations, with a focus on Core Principle #4 which states that physicians

performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or to maintain an emergency transfer agreement with a nearby hospital. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Council on Medical Service Report 6. Online testimony had limited support, while in-person testimony favored referral. Questions were raised as to whether this report should be referred to specifically include considerations for both rural and reproductive healthcare. The Council on Medical Service offered amendments to address the concerns raised; however, testimony continued to support referral. Your Reference Committee recommends that recommendations in Council on Medical Service Report 6 be referred.

(22) RESOLUTION 707 - MALPRACTICE INSURANCE FOR EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 707 be referred.

HOD ACTION: Resolution 707 is referred.

RESOLVED, that our American Medical Association support a requirement for employers to purchase only occurrence malpractice insurance policies for their employed physicians, fellows, and residents. (New HOD Policy)

Your Reference Committee heard mixed testimony that supported the spirit of Resolution 707 but recommended that this resolution be referred in order to carefully consider the language. Most testimony agreed that malpractice insurance is an important issue, especially for employed physicians and young physicians. Testimony asked for a future report to consider the impact on private practices, explore potential resolutions for entities that have collapsed, and explore differences in coverage options between states. Hearing the concerns raised, the Reference Committee believes that this topic could benefit from further study and thus recommends referral.

(23) RESOLUTION 717 - ADVOCACY FOR A FAILURE-PROOF NATIONAL CENTRALIZED ELECTRONIC TRANSACTION CLEARINGHOUSE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 717 be referred.

HOD ACTION: Resolution 717 is referred with report back at A-27.

RESOLVED, that our American Medical Association advocate for implementation of the standard national health plan identifier (HPID) that all transactions must be communicated directly with the health plan (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for the implementation of a national centralized electronic healthcare transaction clearinghouse that would allow physician practices, other providers, health plans, clearinghouses, health IT vendors, state and federal regulators, digital health products, and consumer apps to maintain only one standard direct connection through which all electronic transactions can flow seamlessly, securely, and at low cost to any other participant guided by a transaction ID and a standard identifier such as a health plan identifier (HPID) and/or national provider identifier (NPI). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 717. There was support for the resolution, emphasizing the need for a standardized national clearinghouse and identifier framework to reduce fragmentation and administrative burden, particularly for small and independent practices. Further testimony supported the intent but recommended study, and the Council on Medical Service testified in opposition to the resolution, noting that the AMA previously supported rescission of the Health Plan Identifier after significant operational and implementation problems emerged and that the Centers for Medicare & Medicaid Services is pursuing more effective modern interoperability approaches. Your Reference Committee believes this topic could benefit from further study and thus recommends that Resolution 717 be referred.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(24) RESOLUTION 716 - EQUAL OPPORTUNITY FOR PAYMENT FOR "ON CALL" DUTY

RECOMMENDATION:

Your Reference Committee recommends that Policies H-130.948, D-130.963, and D-130.965 be reaffirmed in lieu of Resolution 716.

HOD ACTION: Resolution 716 is referred.

RESOLVED, that our American Medical Association will work with relevant stakeholders to advocate that all physicians, whether employed or independent, should be paid for “on call” responsibilities, whether or not patient care is separately billed. (Directive to Take Action)

Your Reference Committee heard testimony on Resolution 716 that mostly supported reaffirmation. One delegation in support of the resolution as written highlighted that inadequate payment and resource support for “on call” inpatient and emergency care has led to a lack of specialists required to treat patients. However, the author agreed that reaffirmation of existing policy is the most prudent approach as there is sufficient AMA policy that addresses this resolution. The author reiterated support for reaffirmation at the in-person hearing in addition to other testimony supporting reaffirmation. Your Reference Committee agrees that there is ample policy that covers the resolution and recommends that Policies H-130.948, D-130.963, and D-130.965 be reaffirmed in lieu of Resolution 716.

ON-CALL PHYSICIANS H-130.948
Our AMA:
(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that

are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.
(CMS Rep. 3, I-99; Reaffirmation A-00; Modified: Sub. Res. 217, I-00; Reaffirmation I-01; Reaffirmation A-07; Appended and Reaffirmed: CMS Rep. 1, I-09; Modified: Res. 818, I-17; Reaffirmed: Res. 824, I-24)

ON-CALL AND EMERGENCY SERVICES PAY D-130.963
Our AMA will develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services.
(Res. 818, I-17)

ON-CALL COVERAGE MODELS D-130.965
Our American Medical Association will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to

unrealistic and unduly burdensome on-call demands, and educate AMA physician members regarding these options. (Res. 722, A-13; Reaffirmed: CMS Rep. 01, A-23)

This concludes the report of Reference Committee G. I would like to thank Anna Brown, MD, MPhil, Bill David, MD, PhD, Rafael Haciski, MD, Debra Lupeika, MD, Man-Kit Leung, MD, Brian Privett, MD, and all those who testified before the Committee.

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