AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee B

Dale Mandel, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 02 — On-Site Physician Requirements for Emergency Departments
2. Board of Trustees Report 06 — Health Technology Accessibility for Aging Patients
3. Board of Trustees Report 09 — Corporate Practice of Medicine Prohibition
4. Resolution 205 — Native American Medical Debt
5. Resolution 218 — Time Sensitive Credentialing of New Providers with an Insurance Carrier

RECOMMENDED FOR ADOPTION AS AMENDED

6. Board of Trustees Report 01 — Assessing the Intersection Between AI and Health Care
7. Board of Trustees Report 04 — Addressing Work Requirements for J-1 Visa Waiver Physicians
8. Resolution 202 — Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis
9. Resolution 203 — Alternative Pathways for International Medical Graduates
10. Resolution 204 — Support for Physician-Supervised Community Paramedicine Programs
11. Resolution 206 — Protect Infant and Young Child Feeding
12. Resolution 207 — Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
13. Resolution 208 — Medicare Part B Enrollment and Penalty Awareness
14. Resolution 210 — Laser Surgery
15. Resolution 211 — Water Bead Injuries
16. Resolution 212 — Addressing the Unregulated Body Brokerage Industry
17. Resolution 213 — Sustainable Long-term Funding for Child Psychiatry Access Programs
18. Resolution 214 — Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access
19. Resolution 216 — Clearing Federal Obstacles for Supervised Injection Sites
20. Resolution 222 — Rollback on Physician Performance Measures
21. Resolution 229 — Supporting Penalties on Insurers Who Fail to Pay Doctors

RECOMMENDED FOR ADOPTION IN LIEU OF

22. Resolution 201 — Boarding Patients in the Emergency Room
    Resolution 230 — Addressing and Reducing Patient Boarding in Emergency Departments

RECOMMENDED FOR REFERRAL

23. Board of Trustees Report 03 — Reforming Stark Law's Blanket Self-Referral Ban
24. Resolution 226 — Information Blocking Rule

RECOMMENDED FOR REFERRAL FOR DECISION

25. Resolution 228 — Codification of the Chevron Deference Doctrine

RECOMMENDED FOR NOT ADOPTION

26. Resolution 221 — Medicare Coverage for Non-PAR Physicians

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

27. Resolution 215 — Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
28. Resolution 217 — Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
29. Resolution 219 — Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
30. Resolution 220 — MIPS Reform
31. Resolution 223 — Mandated Economic Escalators in Insurance Contracts
32. Resolution 225 — Elimination of Medicare 14-Day Rule
33. Resolution 227 — Medicare Payment Parity for Telemedicine Services
34. Resolution 231 — Establish Pregnancy as a Federal Qualifying Life Event Triggering a Special Enrollment Period

Amendments:
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 02 — ON-SITE PHYSICIAN REQUIREMENTS FOR EMERGENCY DEPARTMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 2 be adopted and the remainder of the Report be filed.

The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed:

1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open. (New HOD Policy)

2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care. (New HOD Policy)

Your Reference Committee heard mixed but mostly supportive testimony for the recommendations in Board of Trustees Report 2. Your Reference Committee heard two amendments. First, an amendment to the second recommendation would specify that an appropriate rural exception requires that a physician be available by phone at all times and in person within 30 minutes. Your Reference Committee feels that the language of the original recommendation is not incompatible with this proposed amendment and allows states more flexibility in crafting limited rural exceptions that meet their unique needs while still preserving physician-led care. Your Reference Committee also heard an amendment that would remove reference to AMA's potential support of federal legislation that might require a hospital with an ED to have a physician on-site and on duty who is primarily responsible for the emergency department at all times. Because the 24/7 physical presence of a physician is the preferred model of emergency care, and recognizing the value of federal legislation governing emergency departments, your Reference Committee feels it is appropriate that AMA be free to support potential federal legislation to that end. Therefore, your Reference Committee recommends that Board of Trustees Report 2 be adopted, and that the remainder of the Report be filed.

(2) BOARD OF TRUSTEES REPORT 06 — HEALTH TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 6 be adopted and the remainder of the Report be filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.:

That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition.

Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY

1. Our American Medical Association recognizes access to broadband internet as a social 6 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. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of Board of Trustees Report 6. Your Reference Committee heard that the recommendations in the Report amplify the message and recognition that equity in telehealth should expand beyond the population of older adults. Testimony reflected that the Report is a meaningful update to current AMA policy and reflects the increasing use of health technology and its impact on aging patients. Testimony specifically cited that, as the demographic of those over age 85 is rising due to medical advances prolonging life, ensuring those patients can interact with their physicians and other care givers is crucial. Testimony also supported the addition of electronic advanced care planning as a substantive addition to existing policy. Therefore, Your Reference Committee recommends that Board of Trustees Report 6 be adopted, and that the remainder of the Report be filed.

(3) BOARD OF TRUSTEES REPORT 09 — CORPORATE PRACTICE OF MEDICINE PROHIBITION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 9 be adopted and the remainder of the Report be filed.

The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA Policy H-215.981 entitled, “Corporate Practice of Medicine,” be amended by addition and the remainder of the report be filed:

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

2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine. (New HOD Policy)

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. (New HOD Policy)

4. At the request of state medical associations, our AMA 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. (Reaffirm HOD Policy)

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. (Directive to take action)

6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy ~~in clinical care~~ and operational authority ~~is~~ are preserved and protected. (Modify Current HOD Policy)

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. (New HOD Policy)

Your Reference Committee heard testimony uniformly in favor of adopting Board of Trustees Report 9. Testimony expressed concern about the detrimental impact that corporate investment has had on physician practices and health care generally, and thus noted that our AMA should do more to oppose the corporate practice of medicine. Testimony also highlighted that the Report should be adopted because, by not calling for a complete prohibition on corporate investment in physician practices, physicians wanting to pursue a partnership with a corporate investor are not prohibited from doing so. Testimony stressed that physicians must always maintain control of practice operations and clinical decision-making and emphasized the value of additional resources on the corporate practice of medicine doctrine to be developed by our AMA. Therefore, your Reference Committee recommends that Board of Trustees Report 9 be adopted, and that the remainder of the Report be filed.

(4) RESOLUTION 205 — NATIVE AMERICAN MEDICAL DEBT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 205 be adopted.

RESOLVED, that our American Medical Association support federal legislation requiring credit reporting agencies to remove information on the credit reports of Indian Health Service (IHS) beneficiaries that relate to debts or collections activities for medical services that should have been paid by the IHS. (New HOD Policy)

Your Reference Committee heard overwhelming testimony in favor of Resolution 205, with only one comment against adoption. Your Reference Committee heard that Resolution 205 would call on our AMA to advocate for federal legislation that would protect Native American patients from credit report penalties arising from unpaid medical bills that should have been covered by the Indian Health Service (IHS). Testimony noted that Native Americans are disproportionately affected by medical debt, which negatively impacts their credit scores and leads to increased reliance on high-risk loans. Your Reference Committee also heard that the IHS Purchased and Referred Care (PRC) program often fails to pay medical bills on time, leaving IHS patients burdened with medical debt that the agency is responsible for covering. This issue forces Indigenous patients to cover costs that should be federally funded, leading to both personal and financial harm. Further testimony highlighted that supporting policy changes for IHS beneficiaries would align with protections currently provided to veterans receiving care through the Department of Veterans Affairs, thereby fostering greater equity in credit reporting practices. Therefore, your Reference Committee recommends that Resolution 205 be adopted.

(5) RESOLUTION 218 — TIME SENSITIVE CREDENTIALING OF NEW PROVIDERS WITH AN INSURANCE CARRIER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be adopted.

RESOLVED, that our American Medical Association urge the US Department of Labor to establish uniform provider credentialing standards for Third Party Administrator’s (TPA's) serving ERISA Plans to include the following : that when a credentialing application is submitted, the insurance carrier must respond in writing within five business days whether the application is complete and acceptable, and if incomplete the carrier must send notice to the provider indicating what additional information is needed for completion of the process, and acknowledge the completion of a successfully completed application within ten business (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the US Department of Labor to require Third Party Administrators to send a written notice to applicants within 45 days, regarding their credentialing decision and after 45 days, an applicant is deemed to have been automatically credentialled and enrolled to be eligible for payment of services, even if the payer fails to acknowledge the applicant. (Directive to Take Action)

Your Reference Committee heard unanimous support for Resolution 218. Testimony highlighted the need for timely, uniform credentialing processes as described in the resolution. Your Reference Committee heard testimony that highlighted arbitrary and variable standards imposed by insurance companies, evidenced by delays of up to 9 months despite timely submission of all required documents. Your Reference Committee heard that current delays from varied carrier policies are detrimental to private practice viability and patient care. Testimony also emphasized the importance of credentialing for providers to establish a financial relationship with insurance carriers. Therefore, your Reference Committee recommends that Resolution 218 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) BOARD OF TRUSTEES REPORT 01 — AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Section "1) a)" be amended by addition and deletion to read as follows:

a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, ~~and~~ transparent, and evidence-based.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Section "1) g)" be amended by addition to read as follows:

g) Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Section "4) d)" be amended by addition to read as follows:

d) Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Section 5 be amended by addition to read as follows:

c) Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 01 be adopted as amended and the remainder of the Report be filed.

The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]

f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
g. Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician’s consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
        iv. Intended population and intended practice setting.
        v. Clear description of any limitations or risks for use, including possible disparate impact.
        vi. Description of how impacted populations were engaged during the AI lifecycle.
        vii. Detailed information regarding data used to train the model:
            1. Data provenance.
            2. Data size and completeness.
            3. Data timeframes.
            4. Data diversity.
            5. Data labeling accuracy.
        viii. Validation Data/Information and evidence of:
            1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
            2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
            3. Algorithmic validation.
            4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
            5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
            6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
            7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:
    1. Privacy.
    2. Security.
    3. Special considerations for protected populations or groups put at increased risk.
x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
   a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
   b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
      i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
      ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
      iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
      iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
      v. Data privacy.
      vi. Cybersecurity.
      vii. Physician liability associated with the use of generative AI tools.
   c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
   d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI

tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
f. Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
g. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b. User Education:
   i. Users should be provided with training specifically on generative AI. Education should address:
      1. Legal, ethical, and equity considerations.
      2. Risks such as data breaches and re-identification.
      3. Potential pitfalls of inputting sensitive and personal data.
      4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
   a. AI systems must have strong protections against input manipulation and malicious attacks.
   b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
   c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
   d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
   a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
   b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
   c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
   d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
    c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
    d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
    e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to 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. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the

physician who will be responsible for determining if the care is authorized.

f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

(New HOD Policy)

Your Reference Committee heard testimony largely in support of Board of Trustees Report 01. Testimony covered the report's comprehensive focus areas, including healthcare AI governance, transparency in AI applications, oversight of generative AI tools, physician liability, and AI-related privacy and security issues. Your Reference Committee has considered that this is a highly vetted report and includes amendments made in response to previous comments and concerns from prior AMA meetings. Several amendments were proposed, most of which your Reference Committee believes are consistent with the recommendations in the report and would provide additional clarity. These include amendments that would clarify that: clinical decisions influenced by AI must be made with a specified human who is qualified; the deployment of AI tools be evidence-based; and healthcare organizations, in addition to physicians, should engage with generative AI tools only when adequate information regarding the product is provided by the developers of those tools. In addition, your Reference Committee recommends including an amendment that would provide greater focus on addressing additional liability protections for physicians using AI-enabled technologies, as well as an amendment that would modify Recommendation B in the Preliminary Report to clarify the definition of "qualified human," per testimony received. While additional testimony was heard regarding disclosure to patients and physicians when AI is used in medical decision making, the use of confidential or proprietary information as prompts, and advocacy for the development of expert consensus guidelines, your Reference Committee recommends deferring to the language in the report at this time given that the current language has been well vetted. In making this recommendation, your Reference Committee considered that our AMA House of Delegates adopted Policy G-615.998 at the 2024 Annual Meeting, and that under this policy a task force is being formed that will focus on digital health, technology, informatics, and augmented/artificial intelligence. This task force, along with our AMA Councils, will be well positioned to consider these and other evolving and complex issues regarding AI and propose to the HOD revised or new policy as necessary to ensure that our AMA's advocacy on behalf of physicians and our patients remains impactful.

Therefore, your Reference Committee recommends that Board of Trustees Report 01 be adopted as amended and that the remainder of the Report be filed.

(7) BOARD OF TRUSTEES REPORT 04 — ADDRESSING WORK REQUIREMENTS FOR J-1 VISA WAIVER PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 4 be amended by addition and deletion to read as follows:

Our American Medical Association supports federal visa and visa waiver policies ~~that~~ to include time for administrative tasks, professional development opportunities, and other professional responsibilities within the federally mandated work week requirements for direct patient care~~, administrative tasks, professional development opportunities, and other professional responsibilities~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 4 be adopted as amended and the remainder of the Report be filed.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 217-I-23, and the remainder of the report be filed:

Our American Medical Association supports federal visa and visa waiver policies that include time within the federally mandated work week requirements for direct patient care, administrative tasks, professional development opportunities, and other professional responsibilities. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 4. Your Reference Committee heard that International Medical Graduates (IMGs) are working significant hours to ensure that they can provide patient care as well as gain professional development. Testimony noted that it was very difficult for IMGs to find enough time to accomplish all the personal and professional goals that they have due to their work hour requirements. Your Reference Committee heard that the work hour requirements that apply to J-1 waivers vary by state, regional commission, and federal agency. An amendment was provided and was supported by some commentors. However, testimony from the Board of Trustees emphasized the importance of maintaining the term support in this resolution. Testimony stated that maintaining the word support will provide staff with the ability to strategically advocate on this topic when the time is ripe to ensure that we do not negatively impact the passage of the Conrad 30 legislation, which must be renewed yearly. Therefore, the Reference Committee recommends that Board of Trustees Report 4 be adopted as amended, and that the remainder of the Report be filed.

(8) RESOLUTION 202 — ILLICIT DRUGS: CALLING FOR A MULTIFACETED APPROACH TO THE "FENTANYL" CRISIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 202 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association continue to support ~~advocate for~~ public education and awareness about the rapidly evolving US illicit drug epidemic ~~crisis~~ due to dangers of illegally made fentanyl and other toxic substances ~~carfentanil-laced products (Directive to Take Action)~~; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 202 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA continue to support efforts by ~~advocate that~~ federal, state and local government officials and agencies ~~implement measures~~ to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds (Directive to Take Action).~~;~~ ~~and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolves three through six of Resolution 202 be deleted.

~~RESOLVED, that our AMA support federal legislation that would help Customs and Border Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit medications (New HOD Policy); and be it further~~

~~RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which criminalizes the use of a biological agents to cause death, disease, or other harm), request our government to determine if expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further~~

~~RESOLVED, that our AMA encourage our government to clarify if, and in what circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their precursors, should be considered chemical weapons as defined by The Chemical Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it further~~

~~RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may be used as a WMD and what steps healthcare workers, hospital systems and first-responders should take to prepare for such an event. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 202 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 202 be changed to read as follows:

CALLING FOR A MULTIFACETED APPROACH TO THE ILLICIT FENTANYL CRISIS

RESOLVED, that our American Medical Association advocate for public education and awareness about the rapidly evolving US illicit drug crisis due to dangers of fentanyl and carfentanil-laced products (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that federal, state and local government officials and agencies implement measures to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal legislation that would help Customs and Border Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit medications (New HOD Policy); and be it further

RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which criminalizes the use of a biological agents to cause death, disease, or other harm), request our government to determine if expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage our government to clarify if, and in what circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their precursors, should be considered chemical weapons as defined by The Chemical Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it further

RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may be used as a WMD and what steps healthcare workers, hospital systems and first-responders should take to prepare for such an event. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 202. Your Reference Committee heard that our AMA has considerable, existing policy advocating for a public health focus to combat the drug overdose and death epidemic, including strong support for increased education, research, prevention, treatment, harm reduction efforts, and removing the stigma associated with drug use and substance use disorders (SUDs). Testimony highlighted the need for our AMA to take a public health approach to this Resolution to avoid stigmatizing drug use and to increase support for harm reduction initiatives such as naloxone access. Testimony emphasized that our AMA's most appropriate role is to support public health efforts and that law enforcement should be left to law enforcement. Testimony also noted the ongoing nature of the epidemic, including how there are multiple, toxic substances in the nation's illicit drug supply. Testimony noted that AMA advocacy is incredibly broad and effectively addresses the polysubstance nature of the epidemic without having to name every new substance. Therefore, your Reference Committee recommends that Resolution 202 be adopted as amended.

(9) RESOLUTION 203 — ALTERNATIVE PATHWAYS FOR INTERNATIONAL MEDICAL GRADUATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association provides an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the ~~A-25~~ I-25 meeting (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA develop educational resources related to alternate licensing models for the AMA HOD and other interested parties ~~stakeholders~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 203 be amended by deletion to read as follows:

RESOLVED, that our AMA widely distribute the Commission's report and relevant educational content to all AMA members ~~and other interested stakeholders~~ (Directive to Take Action).~~; and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth resolve of Resolution 203 be deleted.

~~RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA study our existing policy pertaining to state licensure processes, including alternate licensing pathways, and recommend updates to such policies, as appropriate, to help inform advocacy efforts by state medical societies. (Directive to Take Action)~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 203 be adopted as amended.

RESOLVED, that our American Medical Association provides an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the A-25 meeting (Directive to Take Action); and be it further

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA develop educational resources related to alternate licensing models for the AMA HOD and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, that our AMA widely distribute the Commission's report and relevant educational content to all AMA members and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA study our existing policy pertaining to state licensure processes, including alternate licensing pathways, and recommend updates to such policies, as appropriate, to help inform advocacy efforts by state medical societies. (Directive to Take Action)

Your Reference Committee heard about the importance of the Advisory Commission on Additional Licensing Models and the work that it is undertaking to try and unify and ease the licensure pathway for international medical graduates (IMGs). Testimony noted how difficult it can be for IMGs to receive a license to practice medicine in the United States, even if they have already received extensive training abroad. Testimony also noted the importance of a more uniform approach to this licensure pathway among the states. However, your Reference Committee also heard that it is the undertaking of the Commission to provide information about the Commission and its ongoing work to interested parties and states. Moreover, testimony noted that since the recommendations of the Commission are not complete and will continue to be developed over the course of multiple years, our AMA should not commit to changing our existing policies based on the work of the Commission. Further testimony noted that due to the ongoing work of the Commission, an informational report would be more beneficial to our House if it were presented at the Interim 2025 meeting of the House of Delegates to provide more time for the Commission to develop their recommendations and for staff to appropriately review the work of the Commission in alignment with our existing AMA policy. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

(10) RESOLUTION 204 — SUPPORT FOR PHYSICIAN-SUPERVISED COMMUNITY PARAMEDICINE PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support federal and state efforts to strengthen ~~establish, expand,~~ and provide coverage for community paramedicine programs ~~supervised by physicians~~, especially in rural or underserved areas, so long as these programs do not decrease funding for physician payment. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 204 be amended by addition of a second resolve clause to read as follows:

RESOLVED, that our American Medical Association only support community paramedicine programs that preserve physician-led team-based care.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 204 be adopted as amended.

RESOLVED, that our American Medical Association support federal and state efforts to establish, expand, and provide coverage for community paramedicine programs supervised by physicians, especially in rural areas. (New HOD Policy)

Your Reference Committee heard unanimous testimony in support of Resolution 204. Your Reference Committee received testimony that highlighted the important role of community paramedicine programs in improving access to care and limiting unnecessary trips to emergency departments. However, some testimony highlighted the need to preserve physician-led teams in these programs. Additionally, amendments were proffered to ensure that funding for physician payment was not decreased because of the establishment of these programs. Further testimony noted the importance of guaranteeing that other underserved communities were included in this advocacy work. Therefore, your Reference Committee recommends that Resolution 204 be adopted as amended.

(11) RESOLUTION 206 — PROTECT INFANT AND YOUNG CHILD FEEDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 206 be amended by addition to read as follows:

RESOLVED, that our American Medical Association support public and private payer coverage of medically necessary donor human breast milk (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

RESOLVED, that our American Medical Association support Medicaid coverage of donor human breast milk (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for an adequate supply and consistent sources of infant milk formula. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of Resolution 206, with no opposing testimony offered. Your Reference Committee heard that AMA policy recognizes that breastfeeding is the optimal form of nutrition for most infants and promotes strategies to increase breastfeeding, and further, that in alignment with this policy, the American Academy of Pediatrics supports the use of donor human milk for high-risk

infants and calls for policies to provide high-risk infants access to donor human milk based on medical necessity, not financial status. Your Reference Committee further heard that in 2011, the U.S. Surgeon General called for strategies to address obstacles to the availability of safe, banked, donor human milk for fragile infants. Your Reference Committee heard support for having mechanisms in place that allow for the accessibility of safe and sufficient nutrition for infants and that our AMA should advocate for such a supply. An amendment was offered to support coverage of donor human milk only in cases of medical necessity. Testimony noted that this was an important addition due to supplier concerns. Additional testimony emphasized the importance of requiring this benefit from all payers. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

(12) RESOLUTION 207 — ACCOUNTABILITY FOR G-605.009: REQUESTING A TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP TASK FORCE UPDATE AND GUIDANCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 207 be deleted.

~~RESOLVED, that our AMA's work on the Task Force continues for a minimum of three years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 207 be amended by addition and deletion to read as follows:

2h. Work with interested parties to encourage the development of institution-level guidance and protection ~~publish public-facing guidance for what is medically allowable~~ for physicians practicing in states with restrictions potentially ~~impeding on~~ interfering with the patient-physician relationship. (Modify Current HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

RESOLVED, that our American Medical Association's Task Force to Preserve the Patient-Physician Relationship will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed (Directive to Take Action); and be it further

RESOLVED, that our AMA's work on the Task Force continues for a minimum of three years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it further

RESOLVED, that our AMA amend G-605.009 with the addition of text as follows:

2h. Work with interested parties to publish public-facing guidance for what is medically allowable for physicians practicing in states with restrictions potentially impeding on the patient-physician relationship. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was overall supportive of the Task Force to Preserve the Patient-Physician Relationship and of efforts to protect the patient-physician relationship from laws that restrict medical care. Your Reference Committee heard testimony in support of the Reference Committee recommendation to require the Task Force to report annually on its progress and in support of an amendment to direct the Task Force to encourage the development of institution-level guidance for physicians practicing in states that restrict medical care.

Your Reference Committee also heard testimony that provided information on the Task Force activities. For example, your Reference Committee heard about informational report (BOT 21-I-24) that has been provided to this House. Informational report (BOT 09-I-23) was also provided at last year's Interim Meeting, and – as directed by policy – updates will be provided annually. As outlined in its report, the Task Force has been working diligently to carry out the directives adopted by this House. The Task Force has met virtually and in-person and has tapped national experts and government officials to help examine key issues for the Task Force to focus its efforts on – including legal issues, EMTALA, shield laws, workforce, and education issues, and more.

In addition, testimony noted existing resources, including "Know your State's Abortion Laws" guides for medical providers from the Abortion Defense Network. These guides align with the ask in Resolution 207 that our AMA publish state specific guidance about the legal boundaries of state abortion laws. Our AMA has supported the development of these resources and a hotline for medical professionals to ask additional questions about the current state of the law, seek individualized legal advice, or find representation in civil or criminal cases. Our AMA is also in the process of conducting research and producing resources on the impact of abortion laws on the physician workforce and on strategy and message development. The Task Force is in the process of developing additional deliverables as well.

Your Reference Committee heard testimony that opposed requiring the Task Force to operate for a certain number of years and an amendment was offered to strike the second resolved clause accordingly. The testimony emphasized that it would be premature to extend the Task Force mandate to 2029 and that such a directive would be overly prescriptive. Your Reference Committee agrees that the Task Force should be able to continue its important work and that a timeline for the Task Force should be evaluated at a later time after the Task Force has reported on its progress. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended.

(13) RESOLUTION 208 — MEDICARE PART B ENROLLMENT AND PENALTY AWARENESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the fourth resolve of Resolution 208 be deleted.

~~RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

RESOLVED, that our American Medical Association review the current penalties for declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services (CMS), and advocate for changes to improve awareness of the risk and financial burdens associated with discontinuing coverage before reaching age 65 (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in insurance coverage or permanent increases in Part B premiums (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enhanced public awareness regarding the risks of not enrolling in Medicare Part B, and support making information about these risks more accessible and widely available to prevent lifetime penalties (Directive to Take Action); and be it further

RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 208. Your Reference Committee heard testimony that emphasized the need to increase awareness and simplify Medicare Part B enrollment to prevent lifelong penalties and support for seniors receiving necessary healthcare coverage. Testimony noted that the current Medicare enrollment process is complex and that penalties for late enrollment can place significant financial strain on seniors, especially those with limited incomes. An amendment was offered stemming from concerns about the legal and logistical complexities of auto-enrolling individuals in a program that requires premium payments, as this could unintentionally impact financial autonomy and create additional costs for

those not wishing to participate. Your Reference Committee heard that our AMA's framework for auto-enrollment advocacy has historically been aligned with Medicaid programs, where individuals are auto-enrolled only if they are eligible for coverage options that come at no cost to them after the application of subsidies, as exemplified in AMA Policy H-165.823, Options to Maximize Coverage under the AMA Proposal for Reform. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(14) RESOLUTION 210 — LASER SURGERY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 210 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by ~~individuals licensed to practice medicine and surgery or by those categories of practitioners appropriately trained~~ licensed physicians or by individuals who are appropriately trained, under the supervision of a physician, and currently licensed by the state to perform surgical services (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 210 be adopted as amended.

RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners appropriately trained and currently licensed by the state to perform surgical services (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-475.980 Addressing Surgery Performed by Optometrists to read:

1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery."

2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of Resolution 210, however several amendments were offered. One amendment aimed to clarify that only licensed physicians are considered appropriately trained clinicians licensed by the state to perform surgical services. Your Reference Committee believes that this amendment creates redundancy within policy H-475.989, which already specifies that "laser surgery should be performed only by individuals licensed to practice medicine and surgery." Another amendment, recognizing that Resolution 210 was proposed with ophthalmology in mind, suggested specifying that policy H-475.989 only applies to laser surgery "of the eyeball." However, because policy H-475.989 was crafted to apply to all forms of laser surgery, your Reference Committee believes that this amendment would inappropriately narrow its scope. A final amendment proposed specifying that laser surgery may be performed by "appropriately trained licensed physicians or individuals appropriately trained and under the supervision of a physician." Your Reference Committee understands that laser surgery is used by many different medical specialties and that some non-physicians practicing on physician-led teams within certain specialties may be trained to perform laser surgery under the supervision of a physician. This amendment avoids redundancy and aligns with the intent of the existing policy while creating safeguards to ensure and clarify that AMA can only support laser surgery done by non-physicians if the individual is appropriately trained and practicing on a physician-led team. Therefore, your Reference Committee recommends that Resolution 210 be adopted as amended.

(15) RESOLUTION 211 — WATER BEAD INJURIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 211 be <u>amended by deletion</u> to read as follows:

RESOLVED, that our AMA ~~continue to~~ urge Congress to enact legislation to classify water bead products as banned hazardous items to protect consumers, particularly children, from associated risks (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 211 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association urge the U.S. Consumer Product Safety Commission (CPSC) to promptly promulgate and enforce stringent performance and labeling requirements for water bead toys and toys containing water beads to effectively mitigate associated health hazards (New HOD Policy); and be it further

RESOLVED, that our AMA continue to urge Congress to enact legislation to classify water bead products as banned hazardous items to protect consumers, particularly children, from associated risks (New HOD Policy); and be it further

RESOLVED, that our AMA encourage businesses that sell gel blasters to make appropriate and safe protective eye wear available and encourage its use to their customers and to distribute educational materials on the safe use of gel guns (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development of national safety standards for gel blasters that include requirements for product design modifications such as lower velocity limits, safer projectile designs, or integrated safety mechanisms to reduce the risk of eye injuries. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 211. Your Reference Committee heard that water beads can be dangerous for children and have the potential to cause significant damage if they expand inside the body after ingestion, inhalation or insertion into ears, and can cause potential bowel obstruction, choking, or other injuries. Testimony also noted the significant dangers associated with water beads being used as projectiles, including eye injuries. Your Reference Committee heard that adoption of Resolution 211 would be a welcome addition to our AMA's broad range of public health policies, especially with respect to protecting children and young adults. An amendment was proposed to correct a misstatement in the second resolve with respect to our AMA continuing to support pending legislation in Congress that would classify water bead products as banned hazardous items, but our AMA has not supported such legislation; your Reference Committee agrees with this amendment. Therefore, your Reference Committee recommends that Resolution 211 be adopted as amended.

(16) RESOLUTION 212 — ADDRESSING THE UNREGULATED BODY BROKERAGE INDUSTRY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 212 be amended by addition and deletion to read as follows:

Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations; (2) will support ~~collaborate with interested organizations to actively advocate for the passage of~~ federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate for legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted as amended.

RESOLVED, that our American Medical Association amend existing policy H-460.890, "Improving Body Donation Regulation," by addition to read as follows:

Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations.; (2) will collaborate with interested organizations to actively advocate for the passage of federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

Your Reference Committee heard strong supportive testimony on Resolution 212. Testimony highlighted current gaps in federal and state oversight that allow body brokers to operate with minimal accountability, raising significant ethical concerns and public health risks. Testimony strongly supported our AMA's role in aiding states in enforcing minimum standards that would prevent the misuse and exploitation of donor bodies. Testimony particularly addressed the unregulated practices of non-living tissue body banks. A minor amendment was offered to support the passage of federal legislation to broaden our AMA's advocacy on this issue. Therefore, your Reference Committee recommends that Resolution 212 be adopted as amended.

(17) RESOLUTION 213 — SUSTAINABLE LONG-TERM FUNDING FOR CHILD PSYCHIATRY ACCESS PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 213 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate that the federal government work to achieve adequate and sustained funding for ~~of~~ access to child psychiatry consultation programs~~, such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access Program~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 213 be adopted as amended.

RESOLVED, that our American Medical Association advocate that the federal government work to achieve adequate sustained funding of child psychiatry consultation programs, such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access Program. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 213. Your Reference Committee heard that the Child Psychiatry Access Programs (CPAP) model helps to meet the needs of, and support primary care providers in, managing pediatric patients with psychiatric illnesses. Testimony noted that despite strong efforts to increase the number of child and adolescent psychiatrists, the demand exceeds the supply. Your Reference Committee heard that due to the success of CPAPs, Health Resources and Services Administration (HRSA) issued several grants for states to develop and implement these programs, however, it was noted that funding will run out for many states in 2026. Your Reference Committee also heard that Resolution 213 should be adopted with an amendment to delete reference to specific programs funded under discretionary appropriations and to make the language broader to provide flexibility to support more comprehensive physician workforce policy and to prevent conflicts with efforts to increase residency slots in mental health. Your Reference Committee agrees that the proffered amendment would provide more flexibility to AMA staff in working with Congress and should be adopted. Therefore, your Reference Committee recommends that Resolution 213 be adopted as amended.

(18) RESOLUTION 214 — ADVOCATING FOR EVIDENCE-BASED STRATEGIES TO IMPROVE RURAL OBSTETRIC HEALTH CARE AND ACCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that third resolve of Resolution 214 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team ~~advanced practice providers~~ and improve perinatal health outcomes in rural communities (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted as amended.

RESOLVED, that our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit (New HOD Policy); and be it further

RESOLVED, that our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and advanced practice providers and improve perinatal health outcomes in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities (New HOD Policy).

Your Reference Committee heard strong supportive testimony in favor of Resolution 214. Your Reference Committee heard that patients may seek obstetric care in a number of non-obstetric settings and therefore, it is important to ensure that the larger physician workforce, especially those physicians who are often required to provide prenatal and postpartum care in rural facilities, are trained and prepared to provide this medical care. Testimony also noted that in many rural areas that lack regular and reliable access to physician specialists and subspecialists, non-specialist physicians must manage this care and thus need access to teleconsultations. Your Reference Committee also heard that this Resolution aligns with ongoing AMA advocacy in this space and that our AMA put out maternal health recommendations to Congress and the Administration acknowledging the importance of increased training and access to teleconsultations within the context of a physician led team. However, your Reference Committee also heard about the importance of aligning the terminology that we use for nonphysician practitioners with our policy compendium. Further testimony noted the importance of ensuring that this care takes place as part of a physician led team. Therefore, your Reference Committee recommends that Resolution 214 be adopted as amended.

(19) RESOLUTION 216 — CLEARING FEDERAL OBSTACLES FOR SUPERVISED INJECTION SITES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for elimination of federal obstacles ~~policies that empower states to determine the legality of~~ to the development of overdose prevention sites ~~supervised injection facilities (SIFs)~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 216 be changed to read as follows:

CLEARING FEDERAL OBSTACLES FOR OVERDOSE PREVENTION SITES

RESOLVED, that our American Medical Association advocate for federal policies that empower states to determine the legality of supervised injection facilities (SIFs). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 216. Your Reference Committee heard that it is important to help remove barriers to more states being able to implement a pilot overdose prevention site. Testimony noted that decisions about overdose prevention sites should be left to the states and that the federal government should not be able to dictate the existence of these sites. Additional testimony noted that these sites are an important harm reduction measure, and that this resolution addresses a gap in existing AMA policy. However, one commentator suggested that adopting the resolution would create the appearance of AMA suggesting that illicit drug use can be done safely. Nevertheless, significantly more testimony was in favor of the resolution. Moreover, an amendment was offered that suggested a change in terminology from “supervised injection facility” to “overdose prevention site.” Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

(20) RESOLUTION 222 — ROLLBACK ON PHYSICIAN PERFORMANCE MEASURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association will continue to advocate ~~make public statements calling~~ for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will support ~~seek~~ legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 222 be deleted.

~~RESOLVED, that our AMA will include the following action on a national level, including but not limited to:~~

~~-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and~~

~~-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

RESOLVED, that our American Medical Association will make public statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED, that our AMA will seek legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED, that our AMA will include the following action on a national level, including but not limited to:

-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and

-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)

Your Reference Committee heard support for Resolution 222. Your Reference Committee heard that many existing performance measures lack scientific validation and burden physicians without improving patient care. Testimony argued that these mandates often redirect resources away from patient interaction. Further testimony noted that many current measures for quality reporting do not accurately capture the true quality of patient care. An amendment was offered that provided a more focused and strategic approach to addressing concerns regarding unproven performance measures that negatively impact physicians. The amendment captures our AMA's ongoing role in supporting legislative efforts that address unproven performance measures in the Merit-based Incentive Payment System (MIPS) and includes significant reforms, such as freezing performance thresholds, eliminating punitive payment penalties, requiring timely quarterly feedback from the Centers for Medicaid and Medicare Services, and simplifying reporting processes to reduce administrative burdens on physicians. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

(21) RESOLUTION 229 - SUPPORTING PENALTIES ON INSURERS WHO FAIL TO PAY DOCTORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association will advocate for passage of legislation that imposes penalties on insurers that fail to pay doctors within 30 days when doctors win for a claim brought to the federal Independent Dispute Resolution (IDR) process ~~(i.e. No Surprises Enforcement Act that has currently been introduced to the U.S. House of Representatives)~~.

RECOMMENDATION B:

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

RESOLVED, that our American Medical Association will advocate for passage of legislation that imposes penalties on insurers that fail to pay doctors within 30 days when doctors win for a claim brought to the federal Independent Dispute Resolution (IDR) process (i.e. No Surprises Enforcement Act that has currently been introduced to the U.S. House of Representatives)

Your Reference Committee heard support for Resolution 229. Your Reference Committee heard about the need for both Congress and the Administration to ensure that the Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA) functions as Congress intended. However, your Reference Committee heard that the reference to specific legislation should be removed since the legislation referenced in the Resolution has already been changed to the Enhanced Enforcement of Health Coverage Act. Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(22) RESOLUTION 201 — BOARDING PATIENTS IN THE EMERGENCY ROOM
RESOLUTION 230 — ADDRESSING AND REDUCING PATIENT BOARDING IN EMERGENCY DEPARTMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of Resolutions 201 and 230.

ADDRESSING AND REDUCING PATIENT BOARDING IN EMERGENCY DEPARTMENTS

RESOLVED, that our American Medical Association (AMA) collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding (Directive to Take Action); and be it further

RESOLVED, that our AMA support appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased state and federal assistance to address the systemic factors contributing to emergency department boarding (Directive to Take Action); and be it further

RESOLVED, that our AMA support other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions (Directive to Take Action); and be it further

RESOLVED, that our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care (Directive to Take Action).

RESOLUTION 201

RESOLVED, that our American Medical Association immediately collaborate with stakeholders such as hospitals, insurance companies, CMS, and joint commission to resolve this issue (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and appropriate care for patients and the emergency room and those admitted but still physically located in the emergency room to decrease patient harm and physician and nurse burnout. (Directive to Take Action)

RESOLUTION 230

RESOLVED, that our American Medical Association strongly advocate that hospitals and health systems prioritize strategies to reduce emergency department boarding (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased state and federal funding to address the underlying causes of emergency department boarding (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness about the negative impacts of emergency department boarding and propose solutions (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the inclusion of emergency department boarding metrics in hospital quality measures and accreditation standards (New HOD Policy); and be it further

RESOLVED, that our AMA will report back to the House of Delegates at the 2025 Annual Meeting on progress addressing and reducing patient boarding in emergency departments (Directive to Take Action).

Your Reference Committee heard testimony in support of the spirit of Resolutions 201 and 230. Your Reference Committee heard that boarding patients in emergency rooms is a systemic problem that has a detrimental impact on both patients and physicians. Multiple amendments were offered. Additional testimony highlighted concerns about prescriptive staffing ratios and offered amendments to negate this issue. Testimony stressed that boarding patients in emergency rooms is an emergent problem that harms patients and contributes to physician burnout. Testimony also supported the joint consideration of Resolution 201 and Resolution 230 given their similarities and a well-supported Alternate Resolution was offered that combined the content in both Resolutions. Therefore, your Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of Resolutions 201 and 230.

RECOMMENDED FOR REFERRAL

(23) BOARD OF TRUSTEES REPORT 03 — STARK LAW SELF-REFERRAL BAN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 3 be referred.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed.

1. That our American Medical Association reaffirm AMA Policies H-140.861, "Physicians Self-Referral," D-270.995, "Physician Ownership and Referral for Imaging Services," and H-385.914, "Stark Law and Physician Compensation," be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 3. Your Reference Committee heard that the Stark law has contributed to creating an uneven playing field for physician practices who must go to great lengths to avoid violating the Stark law's prohibition on self-referral. Other testimony noted that the Report should go further to remove burdens on physician practices that large, consolidated entities do not face. Testimony recommended referral for stronger support to eliminate the Stark law's unfair barrier to competition on physician practices. Therefore, your Reference Committee recommends that Board of Trustees Report 3 be referred.

(24) RESOLUTION 226 — INFORMATION BLOCKING RULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 226 be referred.

RESOLVED, that our American Medical Association supports the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy); and be it further

RESOLVED, that our AMA supports the requirement of review of report and result information by the ordering physician or physician surrogate prior to release of medical information to the patient (New HOD Policy); and be it further

RESOLVED, that our AMA supports expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for expansions to the harm exception to the Information Blocking Rule and for the requirement of review by the ordering physician or surrogate prior to the application of the Information Blocking Rule provisions. (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 226. Testimony indicated that any limits on patients' access to their medical records must be undertaken only at the request of the patient to avoid violation of the HIPAA patient right of access and the Information Blocking Rules. However, testimony also noted that requiring physician review of every result would unnecessarily increase physician burden. Testimony emphasized the need to differentiate between delay of normal results versus abnormal results with serious implications. Some testimony opposed the delay of results only when directed by a patient. Your Reference Committee believes that given the level of complexity and variety of concerns heard throughout testimony, further study is the most appropriate course of action to sufficiently address this issue. Therefore, your Reference Committee recommends that Resolution 226 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(25) RESOLUTION 228 – CODIFICATION OF THE CHEVRON DEFERENCE DOCTRINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 228 be referred for decision.

RESOLVED, that our American Medical Association support codification of the Chevron deference doctrine at the federal and state levels, which would:

a. generally leave reasonable interpretation of ambiguous regulatory statutes to the purview of the executive branch, including agencies comprised of scientific and medical experts evaluating robust evidence and

b. generally prioritize legislative oversight and modification of ambiguous regulatory statutes and agency rules, instead of deferring to the judicial branch for this function.

Your Reference Committee heard mixed testimony on Resolution 228. In support, your Reference Committee heard that in June 2024, the U.S. Supreme Court overturned the 40-year-old Chevron Deference Doctrine, under which courts would defer to Agency interpretation of ambiguous legislation. Moreover, your Reference Committee heard that healthcare, public health, scientific, and technological regulations are best left to subject-matter and technical experts within the Agencies. Further testimony was heard that noted that the demise of Chevron sets a dangerous precedent for the gradual erosion of regulations governing environmental, healthcare, public health, and civil rights policy. Testimony noted that this legal change could threaten our AMA's advocacy on a myriad of healthcare and public health priorities.

However, your Reference Committee also heard that this resolution could have negative consequences for our AMA's advocacy efforts. Your Reference Committee heard that the Supreme Court's decision may present opportunities for our AMA to challenge certain regulations, especially under Medicare, that negatively impact physician payment. Further testimony noted that our AMA is currently examining various regulations where legal challenges might be possible. Your Reference Committee heard that calling for the codification of the Chevron Deference Doctrine is too vague since Chevron deference is a judicial doctrine, not a legislative mandate, and codifying "deference" itself seems to contradict its purpose. . Your Reference Committee also heard concerns that establishing a statutory requirement that ambiguous statutes should always be decided by Executive Branch Agencies could result in unchecked Executive authority, which might not align with our AMA's advocacy in opposition to certain Agency interpretations or implementation of rules.

Your Reference Committee considered testimony that offered alternative language than what is in the resolution, as well as testimony raising concerns that adopting Resolution 228 would have significant implications for our AMA's advocacy agenda and strategy. Your Reference Committee agrees with testimony that our Board is in a better position to weigh the pros and cons of this resolution and should be referred for study or referred for

decision. Having heard testimony that this issue is urgent, your Reference Committee recommends that a referral for decision would be a more expedient way to address this matter. Therefore, your Reference Committee recommends that Resolution 228 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(26) RESOLUTION 221 — MEDICARE COVERAGE FOR NON-PAR PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 221 not be adopted.

RESOLVED, that our American Medical Association support federal legislation that would provide Medicare enrollees with the ability to receive partial reimbursement towards the cost of receiving treatment from the physician of their choice, regardless of whether that physician participates in Medicare. (New HOD Policy)

Your Reference Committee heard considerable testimony in opposition to Resolution 221. Your Reference Committee heard support for the intent to increase patient choice, but testimony raised concerns about potential redundancy with existing policies. Additional testimony noted that our AMA already has policies supporting patient choice, including the Medicare Patient Empowerment Act, and recommended that our AMA continue our advocacy with our existing policies rather than adopting new ones. Further testimony expressed opposition based on Medicare's current allowances for non-participating providers, and noted concerns that the resolution may not reflect current Medicare rules and limits around non-PAR physician reimbursement, as outlined by CMS. For additional information on this issue please see our AMA's Medicare Participation Options Toolkit and our AMA's Medicare Participation Guide, and our AMA's Frequently Asked Questions Regarding Medicare Participation Options. Therefore, your Reference Committee recommends that Resolution 221 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(27) RESOLUTION 215 — ADVOCATING FOR FEDERAL AND STATE INCENTIVES FOR RECRUITMENT AND RETENTION OF PHYSICIANS TO PRACTICE IN RURAL AREAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that existing AMA policies H-465.988, H-465.981, H-305.925, and D-305.958 be reaffirmed in lieu of Resolution 215.

RESOLVED, that our American Medical Association advocate for increased federal and state funding for loan forgiveness for physicians who commit to practice and reside in rural and underserved areas for a meaningful period of time (Directive to Take Action); and be it further

RESOLVED, that our AMA urge Congress and State legislatures to establish retention bonus programs for physicians who maintain practice in rural areas for extended periods, with increasing bonuses for longer commitments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the expansion and sustainable funding of residency and graduate medical education slots in rural areas, as well as opportunities for exposure to rural health care such as through clinical rotations in rural areas, to increase the likelihood of physicians practicing in these communities after training. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 215. Your Reference Committee heard that it is extremely important to ensure that physicians who work in rural and underserved communities are properly supported and provided with the resources necessary to practice in these communities. Testimony noted the cost of medical school and the importance of loan forgiveness programs as well as the need to ensure that medical students and residents are provided rotations and residency positions in rural communities to help build a connection to the work and ensure that these areas have access to physicians. However, your Reference Committee also heard that our AMA has consistently advocated for additional loan forgiveness avenues and increased funding for residency slots. Testimony also highlighted that our AMA is consistently advocating for sustainable working environments for physicians across the board, including those that practice in rural areas. This advocacy includes requests for proper payment, access to needed resources, pipeline programs and more. Additionally, your Reference Committee heard that more providers are needed in the Indian Health Service and notes that our AMA recently passed policy that addresses helping to create sustainable pipelines for physicians in the Indian Health Service. Your Reference Committee also notes that our AMA has actively worked on this issue and has sent multiple advocacy letters out on this topic. (See some of our AMA advocacy work on this topic here, here, here, here, here, here, here, and here). Further testimony noted that Resolution 215 is already abundantly covered by existing AMA policy and advocacy work. Therefore, your Reference

Committee recommends that existing AMA policies H-465.988, H-465.981, H-305.925, and D-305.958 be reaffirmed in lieu of Resolution 215.

H-465.988 - Educational Strategies for Meeting Rural Health Physician Shortage

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:

a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will:
    a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
    b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

H-465.981 - Enhancing Rural Physician Practices

1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

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

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.

D-305.958 - Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy

1. Our American Medical Association will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.

2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.

3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.
5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.
6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to:
    a. Support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty.
    b. Investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

(28) RESOLUTION 217 — EXPAND ACCESS TO SKILLED NURSING FACILITY SERVICES FOR PATIENTS WITH OPIOID USE DISORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-95.955 be reaffirmed in lieu of Resolution 217.

RESOLVED, that our American Medical Association advocate for legislative and regulatory action to ensure patients are not being denied appropriate admission to skilled nursing facilities based on practices of denying admission solely on the diagnosis of opioid use disorder or prescriptions for active medications for opioid use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for and support legislation and regulatory action to ensure adequate reimbursement of skilled nursing facilities that recognizes the complexity of care, treatment and resources required for opioid use disorder treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased access to medications for opioid use disorder in long-term care pharmacies and address the barriers to access to methadone in long-term care for use in the treatment of opioid use disorder. (Directive to Take Action)

Minimal but mixed testimony was received for Resolution 217. Your Reference Committee heard that there has been a consistent struggle for patients with opioid use disorder (OUD) when admission to a skilled nursing facility (SNF) is recommended. Testimony noted that a history of OUD or being prescribed appropriate medical treatment for OUD should not be a barrier to receiving necessary care at a SNF. Further testimony highlighted the fact that denying admission to these facilities based solely on an OUD diagnosis, or actively taking medications for OUD, exacerbates the stigma surrounding addiction and denies patients access to the comprehensive care they need. Your Reference Committee

received one suggestion to refer this resolution for further study however, opposing testimony noted that this issue does not need to be studied and noted that not accepting a patient needing physical rehabilitation services because they are on medication for OUD is discrimination. Further testimony noted that our AMA already has existing policy that addresses caring for individual with OUD in SNFs. Therefore, your Reference Committee recommends that existing AMA policy D-95.955 be reaffirmed in lieu of Resolution 217.

Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD) D-95.955

1. Our American Medical Association advocates to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder.
2. Our AMA advocates that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, at skilled nursing facilities.
3. Our AMA advocates that Medicare and Medicaid, including managed care organizations, remove barriers to coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, in skilled nursing facilities.

(29) RESOLUTION 219 — ADVOCATE TO CONTINUE REIMBURSEMENT FOR TELEHEALTH / TELEMEDICINE VISITS PERMANENTLY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-480.965 and D-480.963 be reaffirmed in lieu of Resolution 219.

RESOLVED, that our American Medical Association advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 219. Your Reference Committee heard testimony that emphasized telehealth's role in improving access to care, particularly for rural and underserved communities, and highlighted its sustained value since the COVID-19 pandemic. Testimony also reflected the increasing importance of advocating for a permanent telehealth solution for Medicare beneficiaries and patients with private insurance plans, as the COVID-19 telehealth waivers are set to expire on December 31st of this year. However, strong testimony, that was supported by others, recommended reaffirmation of existing AMA policy. This testimony noted that our AMA already has policy that directly addresses the concerns raised by Resolution 219 concerning access and reimbursement for telehealth. Your Reference Committee also heard about our AMA's tireless advocacy efforts in this realm in the form of supporting bi-partisan legislation and commenting, when appropriate, through the regulatory rule making process. Therefore, Your Reference Committee recommends that existing AMA Policies D-480.965 and D-480.963 be reaffirmed in lieu of Resolution 219.

D-480.965 - Reimbursement for Telehealth

Our American Medical Association will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians.

D-480.963 -COVID-19 Emergency and Expanded Telemedicine Regulations

1. Our American Medical Association will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2.
2. Our AMA will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:
    a. Provide equitable coverage that allows patients to access telehealth services wherever they are located.
    b. Provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.
3. Our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients.
4. Our AMA supports the use of telehealth to reduce health disparities and promote access to health care.

(30) RESOLUTION 220 — MIPS REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-400.982, H-385.905, and D-395.999 be reaffirmed in lieu of Resolution 220.

RESOLVED, that our American Medical Association advocate for the repeal of the Medicare Merit-Based Incentive Payment System (MIPS) and replacement with 1) a practicing physician-designed program that has far less administrative burdens and 2) only adopts measures that have been shown to measurably improve patient outcomes. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 220. Your Reference Committee heard that MIPS has become overly complex, placing excessive administrative demands on physicians and detracting from direct patient care. Testimony noted that the existing Surgical Care MIPS Value Pathway (MVP) demonstrates the system's flaws, as it groups unrelated specialties together and lacks relevant, clinically meaningful measures. However, your Reference Committee also heard strong testimony noting that our AMA

already has policy that addresses the concerns raised in this resolution. Existing AMA policy already focuses on securing sufficient Medicare physician payment to ensure access to care and emphasizes reducing the financial and reporting burdens that MIPS places on physicians. These existing AMA policies advocate for reforms such as positive payment updates, eliminating budget neutrality, and reducing the administrative load associated with MIPS reporting. Your Reference Committee also heard that our AMA is actively advocating in this area. For example, our AMA, in collaboration with 50 state medical associations, the District of Columbia, and 76 national medical specialty societies, has developed legislation to replace key elements of MIPS with a new Data-Driven Performance Payment System (DPPS). This includes freezing performance thresholds, eliminating the tournament model, and simplifying reporting to reduce the negative impacts on small and rural practices (see here and here). Therefore, your Reference Committee recommends that existing AMA policies D-400.982, H-385.905, and D-395.999 be reaffirmed in lieu of Resolution 220.

D-400.982 – AMA Efforts on Medicare Payment Reform

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.

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

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.

D-395.999 - Reducing MIPS Reporting Burden

Our AMA 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.

(31) RESOLUTION 223 — MANDATED ECONOMIC ESCALATORS IN INSURANCE CONTRACTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-400.990 be reaffirmed in lieu of Resolution 223.

RESOLVED, that our American Medical Association advocates through legislation or regulation for the mandatory insertion of an economic escalator provision in all commercial insurance contracts to account for economic inflation or a decline in Medicare Physician Fee Schedule (PFS). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 223. Your Reference Committee heard that linking commercial reimbursement to Medicare's declining rates without adjustments for inflation creates financial strain for physician practices, particularly as operational costs continue to rise. Additional testimony argued that economic escalators could perpetuate unsustainable cost-shifting and fail to address underlying reimbursement issues and recommended that instead innovative reimbursement models such as value-based care and bundled payments, which align payments with patient outcomes, should be promoted. Your Reference Committee also heard strong testimony in favor of reaffirming existing AMA policy. This testimony noted that existing AMA policy already supports uncoupling commercial fee schedules from Medicare's declining payment rates and advocates for inflation-based adjustments to ensure physician payment schedules reflect both the rising costs of care and the value of services provided. Testimony also highlighted the work that our AMA is already doing in this space including advocating to ensure that commercial payers adopt payment models that better align with the costs and value of care, rather than relying solely on Medicare's outdated fee structure. Therefore, your Reference Committee recommends that existing AMA Policy D-400.990 be reaffirmed in lieu of Resolution 223.

D-400.990 - Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule

1. Our American Medical Association shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule and to maintain a level of payment that is sustainable, reflects the full cost of practice, and the value of the care provided, and includes inflation-based updates.
2. Our AMA will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment Schedule.

(32) RESOLUTION 225 — ELIMINATION OF MEDICARE 14-DAY RULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-330.903 be reaffirmed in lieu of Resolution 225.

RESOLVED, that our American Medical Association actively lobby the federal government to readdress and change laboratory date of service rules under Medicare, e.g. the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that complex laboratory services performed on pathologic specimens collected from an inpatient hospital procedure be paid separately from inpatient bundled payments, consistent with Outpatient rules. (Directive to Take Action).

Your Reference Committee heard minimal but mixed testimony on Resolution 225. Your Reference Committee heard testimony in support of reaffirming existing policy. Testimony reflected that existing policy on this subject accomplishes the spirit of this resolution and the testimony noted that the resolution's slightly modified language does not provide any substantive changes to our existing policy. Your Reference Committee would like to encourage interested parties to contact our AMA staff who would be happy to help state or specialty societies address this issue. Therefore, your Reference Committee recommends that existing AMA policy D-330.903 be reaffirmed in lieu of Resolution 225.

D-330.903 - Elimination of Laboratory 14-Day Rules Under Medicare

Our AMA will actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

(33) RESOLUTION 227 — MEDICARE PAYMENT PARITY FOR TELEMEDICINE SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-480.969 and D-480.965 be reaffirmed in lieu of Resolution 227.

RESOLVED, that our American Medical Association advocate for Medicare to reimburse providers for telemedicine-provided services at an equal rate as if the services were provided in-person. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 227. Your Reference Committee heard about telemedicine's role in expanding access to care and promoting continuity across various care settings. Testimony noted that Medicare payment parity is essential for sustaining telemedicine services and fairly compensating

physicians. However, additional testimony suggested exploring flexible reimbursement models to account for telemedicine's unique cost structure while still recognizing the value of physician expertise and time. Your Reference Committee also heard testimony that clarified that the value of telehealth services paid for by Medicare is something that cannot be advocated for by AMA staff since discussions related to the value of those codes occur at the AMA/Specialty Society RVS Update Committee (RUC) meetings following deliberations by the various specialty society members that utilize those services. Testimony further noted the strong existing policy that our AMA already has that addresses the heart of Resolution 227. Therefore, your Reference Committee recommends that existing AMA Policies D-480.969 and D-480.965 be reaffirmed in lieu of Resolution 227.

D-480.969 - Insurance Coverage Parity for Telemedicine Service

1. Our American Medical Association will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

D-480.965 - Reimbursement for Telehealth

Our American Medical Association will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians.

(34) RESOLUTION 231 - ESTABLISH PREGNANCY AS A FEDERAL QUALIFYING LIFE EVENT TRIGGERING A SPECIAL ENROLLMENT PERIOD

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy H-165.828 be reaffirmed in lieu of Resolution 231.

RESOLVED, that our American Medical Association actively advocate that the United States Department of Health and Human Services and Congress establish pregnancy as a qualifying life event for a Special Enrollment Period in the Affordable Care Act Marketplace. (Directive to Take Action)

Your Reference Committee heard strong testimony in favor of adoption of Resolution 231. Your Reference Committee heard that in light of the U.S.'s high maternal mortality rate

and the gaps in access to maternal care, a woman needs immediate access to pregnancy care when she becomes pregnant, but the U.S. Department of Health and Human Services (HHS) has declined to change current regulations to allow this, and that active advocacy efforts by our AMA are needed. However, your Reference Committee also heard testimony that Resolution 231 should not be adopted because our AMA already has policy supporting inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. Your Reference Committee heard that this policy was adopted in 2021 and is included in policy H-165.828 as subparagraph 8. Your Reference Committee notes that this existing AMA policy is broader and more flexible because it allows for appropriate advocacy to take place across a range of entities instead of restricting this advocacy to HHS. Further, your Reference Committee heard that our AMA has actively advocated for this policy. For example, in a 2023 letter to the Administrator of the Centers for Medicare & Medicaid, our AMA stated that pregnancy should be a qualifying life event. In addition, your Reference Committee heard that in a 2022 letter, our AMA stated that "our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace." While acknowledging the importance of this issue, in light of existing policy H-165.828 and the actions to implement this policy that our AMA has already taken, your Reference Committee recommends that existing AMA policy H-165.828 be reaffirmed in lieu of Resolution 231.

Health Insurance Affordability H-165.828

1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Rachel Kyllo, MD, Robert Dannenhoffer, MD, Anuradha Reddy, MD, Michael Medlock, MD, Deborah Fuller, MD, Rebekah Bernard, MD, and all those who testified before the Committee.

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