REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by David H. Aizuss, MD, Chair:

1. CALLING FOR A MULTIFACETED APPROACH TO THE ILLICIT FENTANYL CRISIS

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-95.896 and H-95.940

At the 2024 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 202-I-24, "Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis," was introduced by the North American Spine Society. The second resolve of the resolution was referred and asked:

> "that our AMA continue to support efforts by federal, state and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds."

The remainder of Resolution 202-I-24 was adopted and is AMA Policy H-95.896, "Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis." Testimony was mixed during the meeting. Delegates highlighted that the AMA already has robust policy advocating for a public health focus to combat the drug overdose and death epidemic, including the need for the AMA to continue its public health approach to the epidemic. Testimony further emphasized the need to avoid stigmatizing drug use and to increase support for prevention, treatment and harm reduction initiatives. Testimony questioned the AMA's expertise to engage in areas traditionally handled by law enforcement. Delegates' testimony understandably reflected their concerns about the ongoing nature of the epidemic. Particular concern was raised about the multiple, toxic substances in the nation's illicit drug supply. This report provides relevant background, discusses issues raised by the resolution, cites AMA policy, and makes recommendations.

BACKGROUND

After more than a decade of deaths involving illegally-made fentanyl increasing at staggering rates year after year, fentanyl-related deaths decreased almost 27 percent nationally from 2023-2024, according to the Centers for Disease Control and Prevention (CDC).[1] Provisional CDC mortality data show that there were 77,677 drug-related deaths from January 2024-January 2025.[2] To put the decrease in context, the recent finding is similar to April 2019-April 2020 when 77,017 drug-related deaths were reported. The Board reflects that a public health emergency was first declared for the "opioid crisis" in 2017, when more than 70,000 Americans died from October 2016-2017. This is to say that the Board of Trustees (the Board) welcomes the decrease in overdose mortality, although we must also recognize the sobering reality that the epidemic of drug-related overdose deaths is far from over.

In the midst of the recent decreases of overall drug deaths, there are nuances related to the fact that polysubstance use—opioids and stimulants in combination—accounted for more than 46 percent of deaths in 2023.[3] Provisional CDC data, moreover, show that in the 12-month period from
January 2024-2025, deaths involving cocaine and methamphetamine also decreased slightly but remain at near-historic levels (21,297 and 28,753, respectively).[4] As discussed in more detail below, law enforcement has seized significant amounts of illicit drugs, but demand remains high. The Board highlights this data to caution that while illegally made fentanyl remains a national scourge, and other illicit substances remain a high concern, it is critical that neither the AMA nor public policy focus solely on one type of illicit substance to the detriment of acknowledging the multifaceted nature of the nation's drug overdose epidemic.[5]

Furthermore, while deaths have decreased, the Board also is well-aware that access to care for substance use disorders remains a challenge for most Americans. Patients with pain continue to face restrictions and barriers in accessing pharmacologic and non-pharmacologic treatment. And while harm reduction initiatives such as increased naloxone access have been highly effective,[6] there are ongoing concerns about access to sterile needle and syringe services programs,[7] as well as individuals' lack of knowledge about Good Samaritan state laws for layperson protections.[8] The reasons behind the drop in drug-related mortality also are multifaceted and unclear. When asked why drug-related deaths have decreased, Nora Volkow, MD, who directs the National Institute for Drug Abuse, pointed to several

possible reasons including: increased availability of naloxone; decreased fentanyl availability and purity; increased screening and public education of the benefits of medications for opioid use disorder (MOUD); and the sobering reality that "the most vulnerable people have died."[9] The Board does not disagree with Dr. Volkow's assessment, but with the exception of increasing naloxone and MOUD access, there is limited data to inform physicians and policymakers about which initiatives have been the most successful and should be expanded and which should no longer be pursued.

DISCUSSION

There are multiple reasons why the drug-related overdose and death epidemic persists. These include the toxicity of illegally made fentanyl, polysubstance use, unavailability of naloxone and other overdose reversal agents, lack of effective primary prevention efforts, and the ongoing challenge with obtaining (or maintaining) treatment for a substance use disorder. The primary focus of this report, however, is to identify what the AMA can or cannot do to "support efforts by federal, state and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds."

One of the defining aspects of the nation's drug overdose and death epidemic has been the deadly, polysubstance nature of illegally made fentanyl, including fentanyl analogs such as carfentanil and their presence in counterfeit medications. The data show how these illegally made fentanyls (IMFs) affect states across the nation, including spikes in adulterants such as xylazine,[10] which may be part of the so-called reduced purity of fentanyl in the past one to -two years. In addition to xylazine, the U.S. Drug Enforcement Administration (DEA) reported in its 2025 National Drug Threat Assessment (NDTA) that IMFs are also commonly mixed with heroin, acetaminophen, para-fluorofentanyl, 4-ANPP, fluorofentanyl, cocaine, methamphetamine, caffeine, and medetomidine.[11] Although many observers say that this epidemic began largely due to misuse of prescription opioids and heroin, the Board highlights that deaths involving cocaine and psychostimulants also were occurring at that time. As such, efforts to continue to detect which substances are present in a region—or local community—are essential to help support primary prevention and education efforts.

The ability to test and identify toxic substances in the illicit drug supply chain may help with reductions in distribution of deadly products. For example, for people who use drugs, the use of fentanyl test strips (FTS) has been shown to increase the use of harm reduction measures, such as having naloxone on hand when using, not using alone, using less, or discarding substances that were not what they expected.[12] FTS are just one of many types of drug checking technologies[13] which can potentially help limit the distribution within the drug-using community of deadly batches of drugs, but the Board cautions that there is not reliable data to suggest that the use of drug checking technologies is a viable strategy to prevent the distribution of illicit substances. Data also show how the use of emergency medical services data can be used to identify "hot spots" of overdose so as to try and ensure naloxone and other overdose prevention supplies are present in an area experiencing a rapid influx of overdoses.[14] In other words, while preventing the manufacturing, importation, and distribution of illegal drugs can be viewed as primarily the domain of law enforcement authorities, the public health initiatives that are part of the AMA's mission and expertise also can contribute to reducing use of illegal drugs.

In addition to the complicated, polysubstance nature of the drug supply, overall supply-side concerns remain high. Consider, for example, the following information concerning drug seizures:

- The NDTA reported that between 2019 and 2024, DEA seized 100,983 kilograms of fentanyl, and in 2024 alone, more than 61 million pills containing fentanyl were seized.
- Earlier this year, the DEA announced a "historic drug bust" capturing 396 kilograms of fentanyl pills; 11.5 kilograms of fentanyl powder; 1.5 kilograms of cocaine; 3.5 kilograms of heroin; and 7 pounds of methamphetamine.
- U.S. Customs and Border Protection (CBP) reported illicit fentanyl "seized at the border and ports of entry topping more than 27,000 pounds from October 2022 to the end of September 2023." CBP highlighted one operation where it combined intelligence from multiple agencies in 2023 that ultimately "led to over 900 seizures, including more than 13,000 pounds of precursor chemicals and more than 467 pill presses and pill molds to make fentanyl and fentanyl-laced pills, over 270 pounds of finished fentanyl in powder and laced-pills, plus an additional 1,162 pounds of methamphetamine and over 11,233 pounds of other drugs."
- Additional operations seized "more than 3,635 pounds of fentanyl, plus another 29,734 pounds of other narcotics to include 5,340 pounds of cocaine, more than 14,272 pounds of marijuana, and meth seizures topping 10,014 pounds."[15]

- In the first six months of 2025, "the DEA has seized approximately 44 million fentanyl pills, 4,500 pounds of fentanyl powder, nearly 65,000 pounds of methamphetamine, more than 201,500 pounds of cocaine, and made over 2,105 fentanyl-related arrests."[16]

The Board provides this detail to not only showcase the excellent work by law enforcement, but also to highlight the massive amount of illicit drug supply in the United States. Even with the staggering volume of illicit substances seized, 2023 data from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) show that among people aged 12 or older, in the past year, 61.8 million people used cannabis, 8.9 million people misused opioids, 8.8 million people used hallucinogens, and 2.6 million people used methamphetamine.[17] SAMHSA data also show that 627,000 people used IMFs, but that estimate may be very low as many individuals were likely unaware they were using an IMF. The Board supports these efforts by federal, state, and local government officials and agencies to take action to try and stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds. Yet, the Board is acutely aware that law enforcement activities are beyond the scope and mission of the AMA.

The Board is also aware of efforts by multiple Administrations to try and stop the manufacturing, importation, and distribution of illicit fentanyl and other toxic substances. This includes investing in additional detection equipment at ports and other border locations; international diplomacy; prosecutions of those involved with drug cartels; and more.[18] Many local DEA offices have been active in seizing IMF pills and illegal use of pill presses that contributed to the 79 million fake pills containing fentanyl seized in 2023.[19] The AMA commends the DEA and other agencies for these efforts as well as law enforcement and other efforts to enhance the use of detection equipment at ports and land borders. Physicians, on the other hand, do not have the expertise to curb importation of illicit drugs into this country.

A MULTIFACETED APPROACH TO THE NATION'S OVERDOSE AND DEATH EPIDEMIC

The Board emphasizes that while we do not believe we have the expertise to properly advise the DEA, CBP, or other law enforcement agencies about interdiction activities, we also are limited in our expertise to meaningfully advise on issues related to international cooperation between law enforcement agencies, investigators, and intelligence gathering. The Board highlights, however, that there is much the AMA can do to directly help end the nation's drug-related overdose and death epidemic. The Board further stresses that the AMA remains committed to focusing its advocacy, public health initiatives, and educational offerings on those elements that will: (1) increase access to evidence-based care for individuals with a substance use disorder or mental illness; (2) remove barriers to care for patients with pain, including pharmacologic and non-pharmacologic options when recommended by their physician; and (3) advocate for evidence-based harm reduction initiatives, including naloxone access, syringe services programs, Good Samaritan laws, and other policies to save lives and reduce the spread of infectious disease.

As part of the AMA's multifaceted campaign to end the nation's overdose and death epidemic, AMA advocacy has helped reduce the prior authorization burden on physicians and patients to access MOUD. This advocacy includes ensuring that nearly all states have removed prior authorization for at least one form of MOUD.[20] AMA advocacy also has resulted in increased access to MOUD via telemedicine,[21] as well as reduced barriers for youth and others to be treated in an opioid treatment program. AMA advocacy further has helped most states enhance their Good Samaritan overdose protection laws,[22] although the Board continues to encourage state medical associations to use AMA model state legislation to decriminalize possession of drug checking equipment, harm reduction supplies (e.g., fentanyl test strips), and provide comprehensive civil and criminal protections to all those at the scene of an overdose event to support calling for help or providing direct assistance. While these policies may not directly address manufacturing, importation, or distribution, they serve as important tools to save lives from overdose.

Saving lives from overdose also requires states to have comprehensive 911 Good Samaritan laws. Generally, these laws provide civil and criminal protection for individuals who call or assist others when there is an overdose event. Data show that approximately half of overdoses have a bystander present,[23] but the rate has increased in recent years.[24] Research shows positive effects of these laws on saving lives from overdose.[25] Similar to the discussion regarding drug checking technologies above, the Board is not aware of data to suggest that 911 Good Samaritan laws would have a meaningful impact on the manufacturing, importation, or distribution of illicit substances, but the Board nonetheless highlights this harm reduction intervention as an area where public health and law enforcement can work more closely together.

AMA POLICY

AMA policy is clear in its support for "public education and awareness about the rapidly evolving US illicit drug epidemic due to dangers of illegally made fentanyl and other toxic substances." (Policy H-95.896, "Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis") The AMA also, "recognizes that emerging drugs of abuse, especially new psychoactive substances, are a public health threat." (Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use") AMA policy also already includes clear support for federal, state and local government action to not only address emerging trends in illicit drug use, but to take action to identify those drugs and take action to mitigate harms. (Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use") Consistent with the AMA's public health focus and expertise, AMA policy broadly supports education, prevention, and treatment efforts. (Policy D-95.987, "Prevention of Drug-Related Overdose") Increased education also is central to AMA policy to address emerging drug trends. (Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use")

With respect to law enforcement, AMA policy is generally silent on specific law enforcement actions related to the importation, manufacturing, or distribution of illicit substances. Rather, AMA policy more specifically focuses on not criminalizing individuals with a substance use disorder. (Policy H-95.901, "Drug Policy Reform") AMA policy also supports "the removal of fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia." (Policy D-95.987, "Prevention of Drug-Related Overdose") Similarly, AMA policy strongly supports broad Good Samaritan protections (Policy D-95.977, "911 Good Samaritan Laws") and the "decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking." (Policy H-95.900, "Supporting Harm Reduction") The Board is confident that these policies provide the AMA with a robust foundation on which to continue its public health advocacy.

CONCLUSION

In conclusion, the AMA continues to have deep concerns about the ongoing, multifaceted nature of the nation's drug overdose and death epidemic. The AMA supports law enforcement's efforts to curb manufacturing, importation and distribution of IMFs and other deadly substances. The AMA also will continue to focus its efforts on public health and policy interventions where we have expertise and can have a meaningful impact on improving care and saving lives. Existing AMA policy provides more than sufficient guidance for the AMA to continue its public health advocacy.

At the same time, while the AMA is clear-eyed about supply-side concerns, including manufacturing, importation and distribution of IMFs, those are areas outside the scope of the AMA as well as beyond our expertise. As noted in this report, there are areas where public health and law enforcement can work together, and the AMA will continue to share its medical perspectives on substance use disorders and evidence-based approaches to treatment and prevention to inform public safety strategies, such as 911 Good Samaritan overdose protection statutes. This does not mean, however, that we have expertise on the specific focus of this report, i.e., how to "stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds." The Board, therefore, recommends the AMA continue its public health advocacy while making clear the AMA's support for appropriate law enforcement activities, including opportunities for partnership where it has potential to advance public health.

RECOMMENDATIONS

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

1. That our American Medical Association amend Policy H-95.896 to read:

    1. Our American Medical Association continue to support public education and awareness about the rapidly evolving US illicit drug epidemic due to dangers of illegally made fentanyl and other toxic substances.

    2. <u>That our American Medical Association (AMA) continue to support efforts that respect human life and minimize harm by federal, state and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds</u>.

3. That our AMA continue to monitor trends in polysubstance use, including the potential for drug checking technologies to assist public health officials in identifying how such technologies can lead to public health interventions, such as rapid deployment of naloxone and other overdose reversal agents.

4. That our AMA encourage state medical associations and national medical specialty societies to support legislative and other efforts to strengthen state 911 Good Samaritan Overdose statutory protection consistent with AMA policy.

2. That our AMA reaffirm Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use."

Fiscal Note: Less than $500.

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2. LASER SURGERY

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **RECOMMENDATIONS ADOPTED**
REMAINDER OF REPORT FILED
See Policies H-475.980 and H-475.989

This American Medical Association (AMA) Board of Trustees Report arises from Resolution 210-I-24, which was introduced by the American Academy of Ophthalmology and was referred. It asked the following:

> 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; 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."

Testimony centered on the amendment to Policy H-475.989, "Laser Surgery," and was generally supportive of strengthening our existing policy. Perspectives varied, however, on the correct approach. Multiple alternative amendments were offered that would clarify who should and should not be permitted to perform laser surgery, ultimately leading to a decision for referral.

Resolution 210-I-24 also asked our AMA to amend Policy H-475.980, "Addressing Surgery Performed by Optometrists." These amendments, however, focused only on correcting a typographical error and were not the basis of discussion. While the resolution was referred in its entirety, the primary focus of this report will be on H-475.989, "Laser Surgery," as this was the genesis of the referral. This report provides relevant background, discusses AMA policy, and makes recommendations.

BACKGROUND

Scope of practice is a priority issue for the AMA, state medical associations, and national medical specialty societies. Every year, legislation is introduced in state legislatures that would allow non-physicians to provide care or perform procedures that are considered the practice of medicine often without physician supervision. This year the AMA tracked hundreds of bills related to scope of practice, including legislation that would allow non-physicians, such as optometrists, to perform surgery, including laser surgery. The AMA, working alongside our state medical association and national medical specialty society colleagues, has strongly advocated in opposition to these bills.

Resolution 210-I-24 sought to clarify AMA Policy H-475.989, "Laser Surgery," which currently specifies that laser surgery should only be performed by (1) individuals licensed to practice medicine and surgery or (2) those categories of practitioners currently licensed by the state to perform surgical services. Since optometrists are licensed to perform surgery in twelve states, the amendment proposed in Resolution 210-I-24 by the American Academy of Ophthalmology added qualifying language "appropriately trained" to the second category of practitioners to clarify that these individuals must be both licensed to perform surgical services and appropriately trained to do so—the implication being that optometrists are not appropriately trained to perform laser surgery. The proposed amendment was also deemed necessary to provide consistency between this policy and Policy H-475.980, "Addressing Surgery Performed by Optometrists," which expressly states that our AMA support legislation prohibiting optometrists from performing surgical procedures, including laser surgery.

Ophthalmologists may use lasers to perform delicate eye surgeries to treat eye conditions such as glaucoma, cataracts, diabetic retinopathy, macular degeneration, retinal tears or detachment, and to perform refractive surgery, such as LASIK. Policy H-475.989, "Laser Surgery," however, addresses laser surgery more broadly, not just laser surgery on the eyes. In fact, there are multiple types of lasers that are used in a variety of surgical procedures across many physician specialties. For example, laser surgery is often used by dermatologists for scar revision, treatment of vascular lesions, tattoo removal, hair removal, or for ablative or non-ablative cutaneous rejuvenation. Other surgical specialties regularly use lasers in place of a scalpel in their surgical procedures. Depending on the type of laser and indication, some laser procedures may be performed by non-physicians who are appropriately trained and working under the direct supervision of a physician. Since lasers, which use focused, coherent light beams to remove, cut, burn or vaporize tissue, can cut as easily as a knife, laser procedures are considered medical procedures and included in the AMA's definition of surgery (Policy H-475.983).

Given the wide range of laser use by many physician specialties, several amendments were offered during testimony to further clarify the language around who should or should not be able to perform laser surgery. In general, these amendments would have added qualifiers to the physician language while also modifying the language around "other categories of practitioners." For example, one amendment suggested language that laser surgery should only be performed by "appropriately trained physicians:" removing the reference to other practitioners entirely. Another amendment would have largely retained the language of the original resolution but would have defined the term licensed physician as only "Doctor of Medicine or Doctor of Osteopathy." Finally, another amendment would have

allowed laser surgery to only be performed by "appropriately trained licensed physicians or by individuals appropriately trained and under the supervision of a physician."

DISCUSSION

The Board of Trustees (the Board) understands the concerns that prompted Resolution 210-I-24 and the concerns raised by those who testified on this issue and agrees that Policy H-475.989, "Laser Surgery," should be amended to more clearly align with our AMA policy on surgery, physician-led care, and the definition of physician.

First, the Board notes three policies that are particularly relevant to the discussion of who should and should not perform surgery, including physicians and other categories of practitioners: Policy H-475.983, "Definition of Surgery," Policy H-480.981 "Cryotherapy, Therapeutic Ultrasound and Diathermy," and Policy H-410.950, "Pain Management."

First, Policy H-475.983, "Definition of Surgery," unequivocally states that surgery is the practice of medicine and that lasers, or instruments used to cut, burn, vaporize, or freeze, or otherwise alter tissue by thermal or light-based means is considered surgery. This policy also includes language on point related to the qualifications of physicians performing laser surgery, specifically that "…patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards."

Policy H-480.981 "Cryotherapy, Therapeutic Ultrasound and Diathermy," provides guidance on language around the qualifications of both physicians and other categories of practitioners who may perform surgery under the supervision of a physician. This policy addresses specific surgical modalities and the use of such modalities by appropriately trained physicians or individuals practicing under the supervision of a physician. This policy states that the application of heat or cold can be used as a therapeutic modality to cause tissue destruction and specifies that when they are used in such a manner, "the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician."

Similarly, Policy H-410.950, "Pain Management," which is related to interventional pain management, also provides relevant language around the training required to perform and supervise these procedures, which can include surgical techniques using a laser. This policy informs the Board's recommendations and specifies that:

> Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations.

Our AMA's robust policy on scope of practice is also relevant here and clearly supports physician-led care and appropriate physician supervision of non-physicians. For example, Policy H-160.949, "Practicing Medicine by Non-Physicians," states that, "[o]ur AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;" and "through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine."

In addition to these policies, Policy H-405.969, "Definition of Physician," and Policy H-405.951, "Definition and Use of the Term Physician," are also relevant to this discussion. To ensure alignment with these policies, the Board recommends adding qualifying language to Policy H-475.989, "Laser Surgery," defining physician as "Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency." The Board also recommends adding language that physicians "must meet appropriate professional standards."

Finally, the Board wants to make clear that per Policy H-475.980, "Addressing Surgery Performed by Optometrists," our AMA opposes optometrists performing surgical procedures, including laser surgery, and encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies on surgery and laser surgery.

CONCLUSION

The Board agrees that Policy H-475.989, "Laser Surgery," should be amended to more clearly align with AMA policy on surgery, physician-led care, and the definition of physician. After carefully examining this policy along with the varying perspectives offered by the author of the original resolution and those who testified at the House of Delegates, the Board offers the following recommendations.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 210-I-24 and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-475.989, "Laser Surgery," to read:

    1. Our American Medical Association adopts the policy that laser surgery should be performed only by ~~individuals~~ licensed physicians (defined as individuals who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency)~~to practice medicine and surgery~~ who meet appropriate professional standards, or by those categories of practitioners who are appropriately trained, credentialed, and currently licensed by the state to perform surgical services, and are working under the direct supervision of a physician who possesses appropriate training and privileges in performance of the procedure being supervised. ~~currently licensed by the state to perform surgical services.~~

2. 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".

    Fiscal Note: Less than $500.

APPENDIX

AMA POLICY

H-475.980, "Addressing Surgery Performed by Optometrists"

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-475.988, "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-475.988, "Laser Surgery".

H-475.983, "Definition of Surgery"

Our American Medical Association adopts the following definition of "surgery" from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body

cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.

H-475.989, "Laser Surgery"
Our American Medical Association adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services.

Our AMA encourages state medical associations to support state legislation and rulemaking in support of this policy.

H-480.981, "Cryotherapy, Therapeutic Ultrasound and Diathermy"
Our American Medical Association recognizes that the application of heat or cold is a therapeutic modality used by a variety of practitioners. When these modalities are used and are expected to cause tissue destruction, the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician.

H-410.950, "Pain Management"
Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing."

H-35.989, "Physician Assistants"

1. Our American Medical Association opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which:
    a. would unreasonably expand the professional scope of practice of the supervising physician;
    b. cannot be performed safely and effectively by the physician assistant, or
    c. would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to their physician assistant.
5. Our AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

H-160.906, "Models / Guidelines for Medical Health Care Teams"

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

   Patient-Centered:
   a. The patient is an integral member of the team.
   b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
   c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
   d. Team members are expected to adhere to agreed-upon practice protocols.
   e. Improving health outcomes is emphasized by focusing on health as well as medical care.
   f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
   g. Safety protocols are developed and followed by all team members.

   Teamwork:
   h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
   i. All practitioners commit to working in a team-based care model.
   j. The number and variety of practitioners reflects the needs of the practice.
   k. Practitioners are trained according to their unique function in the team.
   l. Interdependence among team members is expected and relied upon.
   m. Communication about patient care between team members is a routine practice.
   n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

   Clinical Roles and Responsibilities:
   o. Physician leaders are focused on individualized patient care and the development of treatment plans.
   p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
   q. Care coordination and case management are integral to the team's practice.
   r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

   Practice Management:
   s. Electronic medical records are used to the fullest capacity.
   t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
   u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
   v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

H-160.947, "Physician Assistants and Nurse Practitioners"
Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

H-160.949, "Practicing Medicine by Non-Physicians

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S).

H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner"

Our American Medical Association endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"
Our American Medical Association endorses the following principles:

1. Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.
2. Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.
3. Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.
4. Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.
5. Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards.
6. Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

H-405.969, "Definition of a Physician"

1. Our American Medical Association affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. Our AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according, according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

H-405.951, "Definition and Use of the Term Physician"

1. Our American Medical Association Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
3. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician.
4. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician.
5. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
6. Our AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
7. Our AMA ensures that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
8. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
9. Our AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
10. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

3. STARK LAW SELF-REFERRAL BAN

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-385.940

At the 2024 Interim Meeting, the House of Delegates (HOD) referred Board of Trustee Report 3, "Stark Law Self-Referral Ban," which recommended the following be adopted in lieu of Resolution 227-I-23:

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." (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)

The Reference Committee heard mixed testimony concerning BOT 03-I-24. The Reference Committee heard that the Stark law has contributed to creating an uneven playing field for physician practices which 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, the Reference Committee recommended that BOT 03-I-24 be referred, and the HOD concurred.

BACKGROUND

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or the physician may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in federal health care programs.

AMA POLICY AND ADVOCACY

The AMA has longstanding policy on the issue of self-referral by physicians. AMA Policy H-140.861, "Physicians' Self-Referral," states that physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services, when they have a financial interest in that facility.

In a similar vein, the AMA has well developed policy regarding physician ownership and referral for imaging services. AMA Policy D-270.995, "Physician Ownership and Referral for Imaging Services," states that the AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary services exception to physician self-referral laws, including as they apply to imaging services.

In addition, the AMA has adopted principles emphasizing that, in regard to their involvement with Accountable Care Organizations (ACOs), the physician's primary ethical and professional obligation is the well-being and safety of the patient. AMA Policy H-160.915, "Accountable Care Organization Principles," emphasizes in Clause 5 that federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs.

Also, Policy H-385.914, "Stark Law and Physician Compensation," calls on the AMA to oppose and continue to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

Finally, AMA Code of Medical Ethics 9.6.9, "Physician Self-Referral," states that, in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility.

In May – July 2025, the AMA advocated to the Office of Management and Budget, U.S. Department of Justice, the HHS Centers for Medicare & Medicaid Services (CMS), and U.S. Department of Health and Human Services that these agencies promulgate a "rural exemption" to the Stark law's Site-of-Service requirements and the In-Office Ancillary Services Exception. These recent advocacy efforts were undertaken in furtherance of current AMA policy and in response to the AMA members' expressed desire at the 2024 Interim Meeting for stronger support to eliminate the Stark law's unfair barriers to competition on physician practices.

DISCUSSION

The Board recognizes the challenges the Stark law may pose to many physician practices. The Board also recognizes that restrictions on self-referral may be a contributing factor to market consolidation. Current AMA policy, however, generally addresses the concerns expressed in Resolution 227-I-23. For example, AMA policy opposes and advocates against the misuse of the Stark law and regulations to cap or control physician compensation. Resolution 227-I-23, the genesis of BOT Report 03-I-24 and this report, indicated that the Stark law provides a "blanket ban on self-referral practices." This, however, is not the case. The Stark law contains numerous exceptions, which if met, allow physicians to self-refer, e.g., when physicians self-refer to risk-bearing arrangements. Most importantly for the purposes of this report, the Stark law has a broad exception for both ownership interests and compensation arrangements that applies specifically to physician practices—the in-office ancillary services exception. Regarding any contributing factor the Stark law may have on consolidation, the AMA has extensive policy addressing issues raised by consolidated hospital markets and advocates aggressively with the goal of preventing further consolidation and restoring competition in those markets.

CONCLUSION

The Board considered the views expressed at the AMA's 2024 Interim Meeting urging stronger support for eliminating the Stark law's unfair barriers to competition on physician practices. With these considerations in mind, the Board's recommendations serve to more effectively target those Stark law restrictions that place an unfair barrier on independent physician practices, remove the inaccurate reference to a Stark law blanket ban on self-referral, and ensure alignment with AMA policy including AMA Code of Ethics Policy 9.6.9.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 227-I-23 and BOT 03-I-24 and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs.

2. That our AMA supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral."

3. That our AMA supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

Fiscal Note: Less than $500.

4. ADDRESSING AND REDUCING PATIENT BOARDING IN EMERGENCY DEPARTMENTS (EDS)

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-130.957

At the 2024 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted alternate Resolution 201 which resulted in Policy D-130.957, "Addressing and Reducing Patient Boarding in Emergency Departments (EDs)," which directs the AMA as follows:

1. Our American Medical Association will 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.
2. Our AMA supports 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.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports 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.
5. 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.
6. Our AMA will report back to the House of Delegates at the 2025 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.

Note: This report is in response to the request in the sixth clause of Policy D-130.957. It was prepared in July, 2025, based on approval deadlines; therefore, more recent developments may not be reflected.

BACKGROUND AND PREVIOUS AMA ADVOCACY

A "boarded patient" is one who remains in the ED after being admitted or placed into observation status, which can contribute to ED crowding.[1] ED boarding is on the rise and is widely considered a crisis, with harmful impacts on patients, hospital staff, public safety, and health care costs.[2] Over 90 percent of EDs routinely report crowded conditions.[3] Patients can wait days, or even weeks after a physician has decided to admit them waiting for an inpatient bed to become available. The Emergency Medical Treatment and Labor Act (EMTALA) is a factor in ED boarding,

since in emergency medicine uniquely anyone who presents to the ED with an emergency must be treated or stabilized, regardless of their insurance status or ability to pay. The causes of ED boarding are multifactorial with health system-wide dysfunction that impedes ED throughput and drives multiple adverse effects as shown in this American College of Emergency Physicians (ACEP) diagram.

Recent developments are summarized below.

- November 2022: The AMA, ACEP and 33 other organizations signed a letter to President Biden declaring ED boarding a national public health emergency.
- May 2023: 42 members of Congress authored a letter to then-Health and Human Services (HHS) Secretary Xavier Becerra expressing concern about the nationwide patient boarding crisis and urging HHS to convene a multi-stakeholder taskforce to develop solutions.
- December 2023: Secretary Becerra responded with a letter charging the Agency for Healthcare Research and Quality (AHRQ) with convening a multistakeholder roundtable.
- October 2024: AHRQ held a summit to address ED boarding and issued a report in January 2025. Solutions included enhanced measurement and public reporting; aligning payment and incentive policies; facilitating telehealth and care transfers; diversion strategies, especially for behavioral health (BH) patients; and supports for staff dealing with boarding.
- December 2024: AHRQ issued a Special Emphasis Notice that describes its "strong and continued interest in receiving health services research grant applications for addressing ED boarding and hospital crowding." In the notice, AHRQ recognizes that boarding harms patients and is linked to higher mortality rates, increased medical errors, longer hospital stays, increased health care costs, staff burnout, ED violence, and strain that ripples through entire health care systems and communities. AHRQ solicited applicants for related research grant opportunities, stating it is particularly interested in supporting research focusing on financial and regulatory pressure, throughput, data measurement and tracking, workforce solutions, resources and toolkits, and/or the patient experience.
- April 2025: A RAND research report *Strategies for Sustaining Emergency Care in the United States* included several recommendations to address ED boarding including "smoothing" elective admissions; allocating funds to ED care and broader care for substance use disorders and mental health conditions; compensating EDs commensurate with the level of indigent care they provide; investing in expanding primary care capacity; using strategies for efficient inpatient and observation discharge; protecting health care workers by enforcing hospital anti-violence policies and increasing the legal consequences for violence against health care workers; Medicaid expansion and payment parity with Medicare; fixing the No Surprises Act flaws so payers must pay in full any independent dispute resolution judgments to the prevailing physicians within a preset time frame; and advocating for state or federal ED boarding policies that provide financial incentives and/or penalties for hospitals to address ED boarding.
- July 2025: At its annual Quality Conference, CMS hosted a panel session on hospital boarding. Solutions included boarding metrics in value-based programs, enhanced BH interventions, reductions in prior authorization (PA) and other administrative burdens, and improving post-acute care transfers. AMA advocacy was cited in materials.

RECENT AMA ADVOCACY

The AMA is committed to addressing ED boarding directly and advocating for enhanced federal and state supports to address its root causes and impacts on clinical staff, as outlined below.

The Addressing Boarding and Crowding in the ED (ABC-ED) Act of 2025

The AMA recently sent letters to the House and Senate in support of the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act of 2025" (H.R. 2936/S. 1974). This bipartisan legislation would offer multiple solutions to the multifaceted ED boarding problem by enabling public health data modernization grants to support the development of real-time hospital bed capacity tracking systems, establishing public-facing dashboards to promote accountability and transparency, and promoting pilot programs through the Center for Medicare and Medicaid Innovation to support emergency department redesign, interdisciplinary staffing, improved infrastructure, and better transitions of care for patients who are older adults or experiencing psychiatric emergencies. These populations are particularly vulnerable to extended emergency department stays and would benefit greatly from tailored care models and improved coordination between emergency and post-acute care settings.

Addressing Root Causes: Improving Health Care Infrastructure to Reduce Avoidable ED Visits

Measurement and Public Reporting Efforts

Measurement is a potential tool to assist with improving the complex boarding problem. CMS is in the process of updating and improving how it measures boarding in the Hospital Outpatient Quality Reporting Program (HOQPR). In 2024, CMS removed the Admit Decision Time to ED Departure Time for Admitted Patients measure from the HOQPR because it was in the process of developing an improved measure. The Admit measure was also penalizing EDs and physicians for factors outside of their direct control. However, CMS has maintained the Left Without Being Seen (LWBS) Measure in HOPQR, which relates to boarding and crowding. Research indicates that boarding reduces the throughput of non-boarded patients, thereby directly affecting LWBS rates.

To improve how CMS is addressing boarding in the HOPQR, CMS has contracted with the Yale Center for Outcomes Research and Evaluation (Yale CORE) to develop an Equity of Emergency Care Capacity and Quality (ECCQ) measure. CMS placed the measure on the 2024-2025 measure under consideration list. It was reviewed by the Pre-Rulemaking Measure Review Hospital Committee during the 2024-2025 cycle for the Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency Hospital (REH) Quality Reporting Program. The AMA submitted detailed feedback on the measure and "recommend with conditions" for the Outpatient Quality Reporting program. In its feedback, the AMA acknowledged appreciation for developing a measure to address boarding and underscored that such a measure will hopefully facilitate hospital efforts to improve care within the ED setting, while recommending several important revisions before the measure would be implemented in any CMS programs. The AMA did not recommend the measure for the REH Quality Program because REHs cannot have inpatient beds except those furnished through a skilled nursing facility. Consensus was ultimately not reached by the Review Committee as to whether to recommend the measure for CMS' OQR or REH Quality Programs. CMS put forward the measure for endorsement review in the Fall 2024 cycle. In February 2025, the consensus-based entity endorsed the measure for the OQR Program with conditions including exploring unintended consequences to patients and providers, including burden and engaging with stakeholders to address challenges. In the 2026 OPPS Proposed Rule released in July 2025, CMS proposed adoption of the measure in the OQR Program beginning with voluntary reporting for the 2027 reporting period followed by mandatory reporting beginning with the 2028 reporting period/2030 payment period and to adopt the measure for the REH Program beginning with the 2027 reporting period/2029 payment period. The AMA is currently reviewing the rule and intends to submit comments on the proposed measure by the September comment deadline. All AMA advocacy letters can be accessed through our correspondence finder.

Curbing Increased ED Utilization for Individuals with a Mental Illness or Substance Use Disorder

ED utilization for individuals with a mental illness or substance use disorder (SUD) continues to increase for both adults and children, exacerbated by a lack of inpatient and outpatient beds due in part to closure of inpatient psychiatric facilities around the country due a decades-long trend towards deinstitutionalization.[4] People, particularly those who are uninsured or under-insured, are often unable to connect to a full continuum of care, including a lack of ambulatory care options, limited crisis intervention services, and a scarcity of community programs to help maintain stability and avert declines and relapses, and are thus driven to use the ED as a last resort. This rise in mental health and SUD-related admissions has become a major contributor to the ED boarding problem. Upstream contributors to this crisis include network insufficiency, payer barriers, and structural barriers such as Medicaid's Institution for Mental Diseases exclusion. With respect to network insufficiency and payer barriers, the AMA has strongly urged regulators to enforce mental health and substance use disorder parity laws. At the state level, the AMA supported multiple new laws in 2025 and joined The Kennedy Forum and Third Horizon to launch an interactive tool visualizing commercial insurer data to evaluate parity between mental health and SUD care compared to physical health. The Mental Health Parity Index is being piloted in Illinois with a planned expansion nationwide. It will help uncover parity violations for inpatient and outpatient care—violations that, if rectified, could help reduce patient boarding. The AMA also continues to urge the Administration to enforce parity under the Mental Health Parity and Addiction Equity Act. Recently, the AMA reiterated its ongoing support for increased access to and destigmatization of medications for treating opioid use disorder and how telehealth and mobile medical units can help increase access to treatment, which could mitigate the influx of SUD-related ED visits. The AMA also discusses the need for further study into effective drug overdose prevention strategies particularly for youths in hopes of curbing the steady rise in SUD-related admissions in recent years. The AMA also notes the importance of ensuring that lifesaving SUD medications are stocked by pharmacies and not unnecessarily restricted by dosage limits or PA policies for those who need it.

Increasing Social Supports

Social admissions are another common contributor to ED crowding and boarding because once patients are admitted, they may have no place else to go, taking up hospital beds for weeks, even months. Further, insurance will not likely

cover the entirety of such a hospital stay, contributing to financial and resource constraints for hospitals and patients. The AMA has been a vocal advocate of providing additional resources to help close these gaps, including advocating for funding for community-based resources. In comments in response to the 2025 proposed Medicare Physician Fee Schedule, the AMA emphasized that a 2.8 percent cut would impact services for connecting patients with health-related social needs to community-based resources including care coordination services to aid Medicare patients who are transitioning out of the acute care hospital or who have multiple chronic conditions.

Strengthening the Non-ED Care Infrastructure

Hospital EDs serve as a de facto safety net provider of health care services for communities that lack robust access to regular primary and specialty care physicians. As such, strengthening the primary and specialty care infrastructure of local communities to better manage care and avoid unnecessary ED visits is one critical tactic to avoid ED boarding, particularly in rural and underserved areas where boarding issues may be exacerbated. With decreases in Medicare reimbursement and looming cuts to Medicaid reimbursement, patients will be forced into EDs as primary care clinics and specialists close practices or stop accepting these patients. The AMA strongly advocates for strengthening Medicare physician payment through an inflation-based update and safeguarding Medicaid federal funding to ensure patients' access to care in non-ED settings. The AMA actively supports efforts to improve patient access to primary and specialty care and improve coordination, thereby alleviating pressure on the ED safety net through several relevant ongoing advocacy initiatives to expand the number of graduate medical education positions, ensure continued visas for foreign born physicians, strengthen the Conrad 30 Waiver Program, authorize loans for specialty physicians in rural areas, and promote the Patients for Accountable Specialty Care Model which would facilitate care coordination between specialists and primary care physicians participating in Accountable Care Organizations (ACOs). Lack of available beds in inpatient rehabilitation facilities and skilled nursing facilities (SNFs) to transfer hospital ED patients is another contributor to hospital boarding. Increasing their supply, particularly in rural and underserved areas, and removal of PA impediments to transferring inpatients to these facilities, could help to alleviate boarding. The AMA supports flexibilities that would help to promote the survival of these key institutions and improve ED throughput, including counting outpatient stays towards the SNF three-day requirements and SNF three-day waivers for ACOs. The AMA consistently advocates for strengthening the rural physician workforce; this, in turn, may decrease the need for rural patients to visit the ED.[5] If rural ED patients require transfer to tertiary care facility EDs that are unable to receive them due to boarding and crowding, this contributes to rural ED boarding and these patients can have worsened outcomes.[6]

Ensuring Medicare Flexibility for Telehealth and Remote Care/Supervision

Telehealth has the ability to help smooth demand for medical services and reduce ED boarding. The AMA strongly advocates for continued access to Medicare telehealth services through support of the CONNECT for Health Act, as well as its creation of a set of 16 telehealth codes through the Current Procedural Terminology (CPT®) process that were introduced in 2025. The AMA continues to advocate for Medicare reimbursement for at-home blood pressure (BP), glucose, pulse oximetry, heart-rhythm and other self-measuring tools, which help patients to better manage their conditions and seek medical attention if necessary before it becomes an emergent situation, avoiding unnecessary trips to the ED. The AMA also supports a permanent allowance of remote supervision for care delivered outside the ED. In recent comments, the AMA advocated for Stark Law flexibilities for rural providers as it relates to site of service requirements.

Reducing PA and Other Administration Burdens

PA requirements and other sources of administrative burden contribute to physician stress, lead to delays in care, which can allow conditions to worsen leading to more ED visits, take time away from treating patients, all of which can exacerbate ED boarding issues. Reducing administration burden remains one of the AMA's hallmark advocacy priorities. According to a recent AMA survey, 47 percent of physicians responded that PAs directly contributed to emergencies requiring immediate care/ED visits, and 33 percent reported that delays due to PAs resulted in related hospitalizations. The AMA is committed to mitigating the negative impacts of PA, including ED boarding. An AMA-convened workgroup of 17 state and specialty medical societies, national provider associations and patient representatives developed *Prior Authorization and Utilization Management Reform Principles*. Separately, in 2018 the AMA played a key role in developing a *Consensus Statement on Improving the Prior Authorization Process* along with five other prominent national health care and insurance organizations. The AMA works with patient coalitions and has presented to the National Conference of Insurance Legislators and the National Association of Insurance Commissioners - national policy-making organizations that significantly impact state activity and national conversations – to advance PA reform. The AMA has created model legislation for states to implement, and supported many states' advocacy over the years, including more than a dozen states in enacting laws in 2025 that reduce care delays and wasted time experienced by patients and physicians due to PA requirements. The AMA also developed a

webpage called FixPriorAuth.org to collect patient testimonials, allow patients and physicians to sign a petition to fix PA, and provide a social media toolkit to support PA reform efforts. The AMA was instrumental in the finalization of CMS regulations making important reforms to PA to cut patient care delays and electronically streamline the process for physicians. PA reform is a priority for Mehmet Oz, MD, the CMS Administrator. The AMA has offered its expertise and will continue to look for opportunities to work with the administration to advance the issue. The regulatory changes to PA mirrored many of the key provisions within the Improving Seniors' Timely Access to Care Act (H.R. 3514/S. 1816). This bipartisan, bicameral piece of legislation, which was a direct result of the PA Consensus Statement, has been introduced in multiple Congresses. As the long-term stability of the regulation remains unclear, passage of this Act remains a crucial advocacy goal for the AMA. To date, the legislation has secured more than 150 bipartisan House and 50 bipartisan Senate cosponsors. The AMA also recently expressed concerns to CMS regarding its proposed Wasteful and Inappropriate Service Reduction (WISeR) model, including that it risks patient harms and care disruptions, will exacerbate administrative burdens, and serves as a precedent for expanded mandatory PA requirements in traditional Medicare. In addition, the AMA testified before an advisory council tasked with recommending to the Department of Labor (DOL) possible regulatory changes to improve how employer-sponsored health plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) use PA requirements to manage their claims and appeals procedures. The AMA urged the advisory council to recommend changes to DOL's rules to reduce the burden and harm these programs have on physicians and patients. The advisory council's report aligned with many of the AMA's recommendations.

Increasing the Efficiency of Staff and Practice Workflows

The AMA continues to be a vocal proponent of the importance of a physician-led care team as an important component to ensure maximized efficiency of managing staff workflows in ED settings to mitigate boarding issues. As part of the AMA's ongoing efforts in this area, the AMA developed a playbook entitled, "Saving Time: Stop Unnecessary Work, Share Necessary Tasks With the Broader Team, and Gain Leadership Support," which covers a number of topics including more effectively leveraging technology such as clinical decision support tools and practice management software to improve practice efficiency, which in the ED setting can be used to speed and improve triage protocols, which can help to reduce wait times and ED boarding. The AMA is also hosting a Practice Innovation Boot Camp in September 2025 designed to equip attendees with time saving tools and strategies to reform their organizations and improve professional satisfaction amongst staff. Physician oversight of EDs can contribute to reduced wait times because physician involvement in the triage and care process can lead to more efficient patient flow and faster treatment. When physicians are involved early in the process, they can make informed decisions about which tests, treatments, and consults are needed, potentially shortening the overall time to diagnosis and treatment. A clear chain of command can also reduce the complexity of communication in the ED, involving multiple interactions between nurses, physicians, and other clinicians, a critical factor for efficient ED operations.

ADDRESSING ROOT CAUSES: ALIGNING PAYMENT AND INCENTIVE POLICIES TO MITIGATE ED BOARDING

Extending the Acute Care Hospital at Home Program

The Acute Care Hospital at Home (HaH) Program waiver was created during the COVID-19 Public Health Emergency to help alleviate hospital capacity issues by allowing hospitals to provide acute care services in patients' homes. More than 300 hospitals across 129 health systems in 37 states now operate under the waiver[7] representing approximately five percent of U.S. hospitals and 15 percent of academic medical centers. Numerous studies have found that patients and family caregivers prefer HaH, which delivers excellent clinical outcomes, decreased mortality rates, better patient and family experience, lower caregiver stress, high provider satisfaction, and lower costs of care.[8] The HaH Initiative has been extended by Congress several times, most recently until September 30, 2025. The AMA supports making the HaH program permanent and has continued to advocate for Congress to extend HaH. Of note, on July 10, bipartisan, bicameral legislation (H.R. 4313/S. 2237, the Hospital Inpatient Services Modernization Act) was introduced to extend the HaH waiver through 2030 and conduct a study regarding its effectiveness.

Protecting Access to Affordable Coverage Options and Ensuring Adequacy of Medicaid Funding

Uninsured and under-insured patients are more likely to lack access to scheduled care and have difficulty affording care, particularly emergency care, which can contribute to hospital and physician uncompensated care costs. Furthermore, Medicaid often reimburses hospitals and physicians at lower rates than private insurance or Medicare. Therefore, hospitals and physicians that treat a high number of Medicaid, uninsured, and/or underinsured patients can disproportionately experience financial pressures and resource shortages, which impact their ability to hire and retain staff and maintain or expand inpatient beds, leading to boarding issues. In the buildup to the passage of the "One Big

Beautiful Bill Act" (OBBBA), the AMA pushed back against Medicaid and ACA reforms that would hinder access to care, decrease coverage affordability, and lower federal Medicaid funding to states. The expiring premium tax credits along with changes made in the OBBBA could result in millions of additional uninsured patients, further exacerbating the boarding issue. The AMA also urged the Trump administration to reconsider a similar proposal to restrict certain types of Medicaid provider taxes, which states rely on to fund their Medicaid programs and separately asked HHS to reconsider several provisions expected to reduce the affordability and availability of ACA coverage.

Strengthening Medicare Reimbursement

The AMA routinely advocates for strengthening Medicare physician payment through an inflation-based update and has repeatedly opposed mandatory Medicare payment models that essentially equate to Medicare reimbursement cuts through mechanisms such as "target pricing." In our advocacy on the issue, we point out that models that transfer financial risk to physicians and prioritize short-term financial savings above all else are shortsighted and will not improve patient care or generate sustainable financial savings long-term and will disproportionately impact rural and safety net hospitals. The AMA recently reiterated its opposition to the Transforming Episode Accountability Model (TEAM) model, a mandatory model that would force participating hospitals to accept a discounted rate of 1.5 to 2 percent for certain clinical episodes citing concerns that TEAM would lead to hospital closures and called for more exceptions and protections for low-volume, rural, and safety net hospitals.

Addressing No Surprises Act Implementation and Prompt Pay Issues

The AMA continues to be vocal on the need to enforce No Surprises Act statutory timelines requiring that payment for disputed claims be made to the prevailing party within 30 days of the decision. This is critical for hospitals and physicians to avoid cash flow issues that can lead to under-resourcing and understaffing, both of which contribute to boarding issues. The AMA recently sent a letter in support of the No Surprises Enforcement Act which features increased penalties for parties that fail to comply with such statutory timelines.

ADDRESSING ROOT CAUSES: SUPPORTING PHYSICIANS FACING THE NEGATIVE OUTCOMES OF BOARDING

ED boarding puts increased pressure on physicians and other clinical staff, which can quickly degrade their mental health and contribute to feelings of burnout. Burnout contributes to workforce shortages with physicians retiring early from clinical practice. Reducing physician burnout is a critical component of the AMA's focus on *Fighting for Physicians*. The AMA is working to address the drivers of burnout, with advocacy to reform Medicare physician payment, protect Medicaid, reduce administrative burdens, promote physician-led care, and make technology work for physicians. Providing physicians access to mental health resources to deal with the resulting stress of boarding is critical. Through collaborative efforts with partners, the AMA helped to achieve a record number of licensure boards and hospitals updating their applications to support physician wellness. There are now 34 medical licensure boards and 521+ hospitals that have verified their licensing or credentialing applications are free from intrusive mental health questions and stigmatizing language. The AMA advocated for and supported new laws and policies in over a dozen states that protect physicians who seek care for wellness and burnout; and continues to work to advance the Dr. Lorna Breen Health Care Provider Protection Reauthorization Act, which supports the mental health and resiliency of health care workers. As part of its ongoing efforts to combat physician burnout, the AMA recently coauthored a study with the Mayo Clinic entitled, "*Changes in Burnout and Satisfaction with Work–Life Integration in Physicians and the General US Working Population.*" The AMA also developed the *AMA Organizational Biopsy*® a tool that helps organizations holistically measure and take action to improve the well-being of their physicians and other health professionals.

ED boarding increases stress on patients and physicians alike and has been shown to contribute to increased incidents of violence against physicians and other hospital staff.[9] Along with an increase in ED boarding, violence against physicians has risen in recent years. According to a January 2024 poll of ACEP members, 91 percent of emergency physicians said that they, or a colleague, were a victim of violence in the past year. In a 2022 ACEP survey, 85 percent of emergency physicians said they believe the rate of violence experienced in EDs has increased over the past five years. The AMA supports a multi-pronged "all hands on deck" strategy to mitigate violence against physicians, including continued research and making investments in enhanced security for hospital staff. The AMA also hosted an AMA Update podcast with Ramin Davidoff, MD, co-CEO, the Permanente Federation, in which he linked threats of violence against clinical staff to increased stress, which impacts their ability to provide high-quality care to their patients, and contributes to clinical staff leaving the profession, which can further exacerbate staffing shortages, a

contributor to ED boarding. To aid states in advocacy to address workplace violence, the AMA Advocacy Resource Center (ARC) has developed a "State Legislative Template: Protecting Physicians from Workplace Violence" with a companion "Chart: State Legislative Template: Protecting Physicians from Workplace Violence." This is in addition to an "ARC Issue Brief: Campaign to support medical student, resident and physician health and wellbeing." In accordance with D-405.975 *Due Process and Independent Contractors* the AMA has developed a "State Legislative Template: Protecting Physicians from Retaliation" in order to protect physicians who report safety concerns, among other potential instances of retaliation.

CONCLUSION

Mitigating ED boarding will require a combination of solutions at the federal, state, and local levels. The AMA will continue to support regulatory and legislative changes and promising innovative models/solutions at the federal and state levels that address the root causes and consequences of boarding. In addition, the AMA will continue to collaborate with ACEP and other stakeholders to further identify and advance solutions to ED boarding, including supporting ongoing efforts by AHRQ to convene stakeholders to identify an ED boarding standard and high-impact policy and practice levers that could be used to reduce ED boarding, decrease hospital crowding, and enhance system-wide throughput.

RECOMMENDATION

The Board of Trustees recommends that Policy D-130.957 be amended, in the sixth clause, by deletion of "Interim Meeting 2025" and addition of "Interim Meeting 2026 and the remainder of the report be filed:

Fiscal Note: Less than $500.

REFERENCES

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9 See Moore supra at 1.

5. ADDRESSING THE UNREGULATED BODY BROKERAGE INDUSTRY

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-460.890

At the 2024 Interim Meeting, Resolution 212, "Addressing the Unregulated Body Brokerage Industry," was introduced by Illinois and was referred. It asked the following:

> RESOLVED, that our American Medical Association amend existing policy H-460.890, Improving Body Donation Regulation,"[1] 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.

BACKGROUND

Body-brokers are individuals or businesses who procure bodies through soliciting donations (usually at funeral homes and hospices) and then sell or lease the donated bodies or parts of the body to other entities for a variety of purposes. Brokers will typically sell a body for $3,000 to $5,000; however, bodies have been sold for upwards of $10,000. Individual body parts are sold for a range of prices, e.g., "$350 for a foot, $300 for a spine."[2] The clients of body brokers include emergency services such as fire departments and paramedics, medical schools, medical researchers, and the military.[3]

In recent years, the body-brokerage industry has come under increased scrutiny due to claims that the autonomy and dignity of the person who donated their body was not respected or upheld. For example, in 2021, the body of a man who died of COVID-19, which was donated to a body-broker, was used in a "Cadaver Class" where people could pay money to see a live autopsy performed.[4] The family of the man was furious when they found out his body was used in this public way for monetary gain and asserted that the transaction was a breach of informed consent.[4] In another incident, a man who donated his mother's body for use in medical research sued a body-broker because her body was instead used to test "bomb impact" in experiments conducted by the U.S. Army.[5]

Notably, the industry is one whose "business model hinges on access to a large supply of free bodies, which often come from the poor." Brokers often offer "free cremation" in exchange for access to bodies as a way to appeal to "low-income families at their most vulnerable".[2] Those whose bodies go unclaimed often have their bodies sold to body-brokers without consent. For example, the unclaimed body of a veteran in Texas who "was entitled to a burial with military honors", was instead sold by the county medical examiner's office to a broker without the man's consent or his family's knowledge. Subsequently, the man's body was "cut into pieces and leased out across the country."[6] Critics, like Angela McArthur from the University of Minnesota Medical School, have likened the body-brokerage industry to a "free-for-all" and have stated that brokers are similar to "grave-robbers" of the 19th-century who are "profiting from the sale of humans."[2] It is against this backdrop that serious ethical concerns have been illuminated and have increased the demand for greater industry regulation.

DISCUSSION

Despite major ethical concerns, the legal landscape does not adequately address concerns of bodies being used in ways in which the donator did not consent. Importantly, there are no federal laws governing the sale of cadavers or body parts for use in research or education and few state laws provide adequate oversight.[2] The most common statutory guidance resides in the Uniform Anatomical Gift Act (UAGA), a model law adopted by the majority of states which "allows a descendant or surviving relatives to donate certain parts of the decedent's organs for certain purposes", i.e.,

organ donation or medical research.[11] The UAGA states that an anatomical gift can be made to a "university; organ procurement organization; or other appropriate person for research or education." However, the scope of who is deemed an "appropriate person for research or education" is left undefined. The result of this ambiguity is that any "commercial entity may obtain a donated body so long as they use it in some form of activity that is considered educational or research oriented." In many cases, the educational or research purpose is dubious or of minimal value.[12]

In response to the lack of legal oversight, the National Funeral Directors Association is supporting a bill they dub the "Body Broker Bill", officially known as the Consensual Donation & Research Integrity Act of 2025, which has been introduced in Congress but has not yet passed.[13,14] The bill claims to "protect the dignity of donors and give families peace of mind by creating standards for inspection; chain of custody; labeling and packaging; and proper disposition."[13] While the Body Broker Bill takes an important step toward regulating the industry, the bill is not as comprehensive as recent best practice guidance and standards on human body donation from the American Association for Anatomy (AAA).[15] The AAA guidelines call for body donation policies to include a mandatory standard for informed consent and outline core operational practices intended to ensure transparency and accountability during every aspect of the body donation process that are more ethically rigorous than those included in the Body Broker Bill. For example, the AAA advises against body part solicitation from terminal patients in hospitals or hospice care and that documentation be secured to ensure that all uses match the donation consent agreement.

Lastly, the for-profit acquisition and sale of donated human bodies and body parts for research and education also creates ethical concerns. While neither the UAGA nor Body Broker Bill prohibit the sale of body parts for profit, AAA best practices recommend that body donation should operate on a non-for-profit model. However, regardless of the financial model used, it is crucial to address the ethical concerns surrounding the body-brokerage industry by establishing stronger legal protections to ensure oversight and ethical accountability. While the resolution called for development of model state legislation, to most efficiently address these issues in upcoming state legislative sessions, the AAA policy guidelines should be utilized to guide advocacy.

CONCLUSION

Although the body broker industry has faced scrutiny, the industry does provide a necessary service which benefits both medical research and education. However, despite its necessity, the body brokerage industry must operate in an ethical and transparent manner.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 212-I-24 and the remainder of the report be filed.

1. That Policy H-460.890, Improving Body Donation Regulation," be amended by addition and deletion as follows:

    1. Our AMA recognizes the need for ethical, and transparent~~,~~ regulations for body and body part donation ~~regulations~~ consistent with body donation best practices including:

        a. *Outreach:* This covers all communications with body donors and their families, beginning with the initial engagement to request donations. Ethical outreach is premised on transparency and accountability, free from any form of coercion or enticement.
        b. *Registration:* A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the registration process includes any disposition and distribution of bodies or body parts, including the locations, possible uses of the body or body parts (i.e., military, education, forensic, etc.), and financial aspects of body donation. Additionally, the registration process should outline the body donor eligibility and suitability criteria.
        c. *Custody:* A transparent custody process is imperative for ensuring the ethical stewardship and management of the body entrusted to the end user (e.g., researchers, educators, clinicians).
        d. *Tracking:* A tracking system should be put in place to ensure the proper governance, oversight, and infrastructure (including registration and informed consent) during the use of donated bodies. Tracking systems should include a mechanism for monitoring body donation policies and procedures and a reporting mechanism for violations of these policies.

e. *Use:* Bodies should be used in a respectful, dignified, and ethical manner for education and research purposes.
f. *Disposition:* Final disposition of the body should be made in accordance with the wishes of the donor and their families.
g. *Memorialization:* A respectful memorial ceremony for the family in which the body donor is honored for their "altruism and commitment to education and research" should be held at the conclusion of the use of the body as well as governing oversight of the body donation policies.

2. Supports federal and state legislation consistent with body donation best practices that require all body donation programs adopt and implement policies which uphold informed consent, transparency, and accountability during the process of human body donation and use.
3. Encourages state medical societies to advocate for legislation consistent with body donation best practices.

Fiscal Note: Moderate – between $5,000 - $10,000

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6. INFORMATION BLOCKING RULE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policies D-315.972 and H-373.988

At the 2024 Interim Meeting of the American Medical Association (AMA), the House of Delegates (HOD) referred Resolution 226-I-24, "Information Blocking Rule." Resolution 226-I-24 included four Resolves, urging the AMA to take the following actions:

1. Support 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);
2. 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);
3. Support expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy);
4. Advocate 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).

There was mixed testimony on Resolution 226-I-24. 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 delays of normal results versus abnormal results with serious implications. Some testimony opposed the delay of results only when directed by a patient.

BACKGROUND

The Information Blocking Rule, part of the 21st Century Cures Act, mandates that patients receive immediate access to their electronic health information (EHI), including clinical notes, imaging, and lab results. While this improves transparency, it has led to some patients receiving distressing news without a physician providing context. Prior to the Cures Act, some data (e.g., radiology reports) had embargoes allowing physician review. These embargoes were lifted, drastically reducing the time patients wait for results—from 45 hours to just 5.5 hours post-finalization. Exceptions to the information blocking rule include the "Preventing Harm Exception," which allows delays if releasing EHI would cause physical harm. AMA policy (D-315.972) advocates for expanding this to include emotional and psychological harm.

DISCUSSION

The Information Blocking Rule, while designed to improve transparency and empower patients, has introduced new complexities in clinical practice. Specifically, the automatic and immediate release of sensitive test results before the treating physician has reviewed them can result in patient distress, confusion, and a potential erosion of the patient-physician relationship. Resolution 226-I-24 proposed several changes to address these concerns, including support for a short-term embargo of results, mandatory physician review prior to release, and expansion of the harm exception. These proposals must be carefully examined in light of federal regulations, patient rights, and existing AMA policy.

Short-Term Embargoes and Patient Preferences

AMA policy (D-315.972,"Redefining the Definition of Harm") supports allowing physicians to withhold sensitive information temporarily when its immediate release would likely cause significant emotional or psychological harm. However, such delays must be consistent with federal rules and typically require justification under the "Preventing Harm Exception." In an AMA survey of 1,000 patients, while nearly 43 percent said they want immediate access to their results, of this group more than 50 percent first want a physician to review and contact them in cases of debilitating, life-limiting, or terminal illness. AMA policy does not support embargoes imposed unilaterally by physicians without patient involvement. Additionally, current federal law does not permit patients to customize how

they receive their information—such as requesting physician review prior to release—though the Assistant Secretary for Technology Policy ASTP/ONC is considering modifications to support "requestor preference" exceptions in the future.

Mandatory Physician Review Requirements

Testimony indicated strong opposition to requiring physician or surrogate review of all test results prior to patient access. While well-intentioned, such a policy would create an undue administrative burden, particularly in the context of routine lab results. A large-scale study published in JAMA Network Open involving 8,139 respondents found that 96 percent of patients wanted their results delivered immediately, even before their physician reviewed them—including in cases involving abnormal findings. The latter study is cited in Office of the National Coordinator for Health Information Technology's blog. Accordingly, the Board does not recommend adoption of the second resolve clause of Resolution 226-I-24.

Staff Harassment and Safety Concerns

The third resolve of Resolution 226-I-24 calls for expanding the harm exception to include potential harassment or harm to medical staff. A proposal to expand the harm exception to the Information Blocking Rule to include harassment or potential harm to medical staff or others would be problematic, both legally and from a policy standpoint. The Information Blocking Rule explicitly limits the harm exception to instances where the release of EHI would pose a risk to the life or physical safety of the patient or another natural person. Extending this exception to include generalized concerns about staff harassment stretches the rule beyond its intended purpose and could lead to inconsistent, overly broad interpretations that undermine patient access rights.

In addition, the Information Blocking Rule prohibits imposing fees on patients for accessing their EHI. If a physician withholds results to require a virtual or in-person consultation, this may introduce costs—such as copays—that conflict with the Cures Act's principle of a patient's free access to their own health information.

CONCLUSION

In balancing the goal of minimizing patient distress with the patient's legal right to timely access to medical reports and results, the AMA must advocate for clear, narrowly tailored policies that respect both clinical judgment and patient autonomy. Resolution 226-I-24, in its original form, does not adequately achieve this balance. The Board, therefore, recommends alternative language that better aligns with AMA policy and legal constraints.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 226-I-24 and the remainder of the report be filed:

1. Our American Medical Association supports the use of patient-directed, short-term embargoes for results, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule.
2. Our AMA supports the ability of patients to request physician or surrogate review of reports and results prior to their release, when consistent with the harm exception to the Information Blocking Rule.
3. Our AMA reaffirms Policy D-315.972, supporting expansion of the harm exception to the Information Blocking Rule to include emotional and psychological harm and urge relevant government agencies to adopt enforcement discretion that would afford medical practices additional compliance flexibilities.

Fiscal Note: Less than $500.

RELEVANT AMA POLICY

Policy D-315.972, "Redefining the Definition of Harm"
Our AMA will: (1) advocate to the Office for Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient; (2) advocate that the Office for Civil Rights assemble a commission of

medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health; (3) continue to urge the Department of Health and Human Services (HHS)'s Office of the National Coordinator for Health Information Technology (ONC) and its Office of Inspector General (OIG) to leverage their enforcement discretion that would afford medical practices additional compliance flexibilities; and (4) urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.

7. CODIFICATION OF THE CHEVRON DEFERENCE DOCTRINE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED

Resolution 228-I-24, "Codification of the Chevron Deference Doctrine," was introduced by the Medical Student Section and was referred for further study. The resolution called for the following:

> 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.

Testimony on the resolution was mixed. Supporters emphasized the value of agency expertise in health care, public health, scientific, and technological regulation, warning that the overturning of *Chevron* could weaken protections in these fields. Others raised concerns that codification could limit the AMA's ability to challenge regulations that conflict with its policy priorities. Additional testimony questioned the risk of expanding executive authority and the potential implications for the AMA's broader advocacy strategy.

This report provides background on the *Chevron* doctrine and its reversal, examines implications of codifying a Chevron-like framework, including those raised in testimony, reviews relevant AMA policy, and offers recommendations.

DISCUSSION

Administrative Law: Agency Rulemaking and the APA

To better understand the *Chevron* doctrine and the impact of its overturning, it is important to review the function of the Administrative Procedure Act (APA) and administrative law more broadly.

Federal laws are enacted through the legislative process, in which Congress passes a bill and the President signs it into law. Congress often delegates rulemaking authority to federal agencies to implement and enforce those laws. Regulations issued pursuant to this authority are developed through a process governed by the APA and, once final, carry the force and effect of law. Even after a regulation becomes final, it generally remains subject to judicial review, under standards also established by the APA. A party may challenge a regulation on the grounds that the agency exceeded its statutory authority—that is, the regulation rests on an interpretation of the statute that is beyond the scope granted to the agency. In resolving such challenges, courts must interpret the relevant statute and determine whether the agency's regulation is consistent with its text and purpose. For decades, this type of judicial review was guided by the *Chevron* deference doctrine.

The Chevron Deference Doctrine

The Chevron deference doctrine emerged from the United States Supreme Court's 1984 decision in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc*., which established a two-step framework for reviewing an agency's interpretation of a statute it administers.[1] At the first step, courts were to determine whether Congress had "directly spoken to the precise question at issue."[2] If the statute clearly addressed the issue, the court's review ended there, and

Congress's directive would control.[3] But if the statute was silent or ambiguous, courts proceeded to the second step, which asked whether the agency's interpretation was "permissible," which is to say, reasonable.[4] If permissible, the court would defer to the agency's interpretation, even if it might have reached a different conclusion on its own.[5]

Chevron frequently guided judicial review in areas involving scientific or technical subject matter, including health care. For example, in *Gentiva Health Services, Inc. v. Becerra*, the U.S. Court of Appeals for the D.C. Circuit upheld the Centers for Medicare & Medicaid Services' (CMS) methodology for calculating Medicare reimbursements for hospice care during a budget sequestration imposed by the Budget Control Act of 2011.[6] The court found ambiguity in the Medicare statute's provision regarding the hospice aggregate cap, and, under *Chevron*, deferred to CMS' interpretation as a reasonable reading of the statute. The resulting rule, which was based on that interpretation and accounted for sequestration-related reductions when determining reimbursement, prevailed.

Ultimately, *Chevron* rested on the premise that agencies have subject-matter expertise regarding the statutes they administer, and on the presumption that when Congress left ambiguity in a statute intended for agency implementation, it expected the agency to exercise discretion in resolving that ambiguity.

The Overturning of Chevron

On June 28, 2024, the U.S. Supreme Court overturned the *Chevron* deference doctrine in *Loper Bright Enterprises v. Raimondo* and *Relentless, Inc. v. Dept. of Commerce*.[7] The Court held that the APA requires courts to exercise independent judgment in determining whether an agency exceeded its statutory authority.[8] The *Chevron* framework, the Court concluded, conflicted with that requirement by requiring judges to forego their independent judgment and defer to reasonable agency interpretations of ambiguous statutes.[9] The Court also rejected Chevron's core presumption that Congress intends for agencies to fill statutory gaps, reasoning that ambiguity may result for many reasons unrelated to delegation of interpretative authority.[10]

Despite overturning *Chevron*, the Supreme Court acknowledged that agency deference may still be appropriate in certain circumstances.[11] When Congress explicitly authorizes an agency to exercise discretion, courts must honor that delegation of authority.[12] The Court also noted that the best reading of a statute "may well be that the agency is authorized to exercise a degree of discretion."[13] In such cases, a reviewing court's role under the APA remains to interpret the statute independently and effectuate the will of Congress, subject to constitutional limits.[14] The Court further recognized that agency interpretations may still warrant respect or be considered persuasive. Courts may give weight to an agency's interpretation where its expertise is helpful, and particularly when the interpretation has remained consistent over time. Still, the Court emphasized that it is the judiciary that must have the final say on what the law means, thus significantly reducing the level of deference afforded to federal agencies.

Opportunities to Codify the Chevron Framework

The *Loper Bright* decision does not prevent Congress from explicitly delegating interpretive discretion to the agencies. As the Supreme Court acknowledged, courts must give effect to statutory text, and Congress may delegate interpretive authority to agencies through an amendment to the APA, through targeted provisions in individual statutes, or through standalone legislation. In other words, while Chevron's presumption of implicit delegation was rejected, Congress retains the power to make such delegation explicit, consistent with constitutional principles and the APA.
Although the Resolution asks the AMA to support codification of the *Chevron* doctrine at the state level, this is constitutionally impractical as doing so conflicts with the Supremacy Clause and separation of powers doctrine.

While bills aimed at codifying Chevron-like deference have been introduced in Congress, there has been no substantive effort from either party to advance such legislation. Between 2021 and 2023, Representative Pramila Jayapal (D-WA) introduced the "Stop Corporate Capture Act" in three consecutive sessions (H.R. 6107 – 117th Congress; H.R. 9390 – 117th Congress; and H.R. 1507 – 118th Congress), each proposing to provide statutory authority for (i.e., codify) *Chevron* deference. Although these bills predated *Loper Bright*, they were introduced amid growing judicial skepticism toward the doctrine. More recently, in 2024, Senator Elizabeth Warren (D-MA) introduced S. 4749 – 118th Congress, building on Representative Jayapal's efforts and citing the urgency of restoring the *Chevron* framework following the Court's decision. Like the earlier proposals, this bill was referred to committee but did not advance.

BENEFITS

Preserving the Role of Subject-Matter Expertise in Regulation

As noted, the *Chevron* doctrine rested on the premise that federal agencies are subject-matter experts regarding the statutes they administer and are therefore well positioned to resolve statutory gaps and ambiguities. Codifying a Chevron-like framework could preserve the role of agency expertise, which is often necessary for effective statutory implementation. Not only can agency expertise guide interpretation in technical contexts, but agencies are typically better equipped to respond to evolving evidence and public input as the rulemaking process allows for greater fluidity.

In contrast, courts are typically generalists whose decisions are guided by principles of legal interpretation, which may or may not give weight to an agency's view. While *Loper Bright* left room for courts to consider agency interpretations, it does not require them to do so unless specifically required by statute. Preserving a framework that allows agencies to reasonably interpret ambiguous statutes may support informed, evidence-based regulatory outcomes.

Democratic Accountability

Delegating interpretive authority to administrative agencies may help preserve democratic accountability in the policymaking process. Agency leaders are appointed by the President, confirmed by the Senate, and subject to ongoing congressional oversight. As a result, their decisions are shaped, at least in part, by electoral outcomes and evolving policy priorities. In contrast, federal judges hold life tenure and are insulated from political shifts by design. If Congress codified a Chevron-like framework that delegates broad interpretive authority to agencies rather than courts, it may support statutory implementation that reflects public needs and goals of the elected legislative and executive leadership.

CONSIDERATIONS

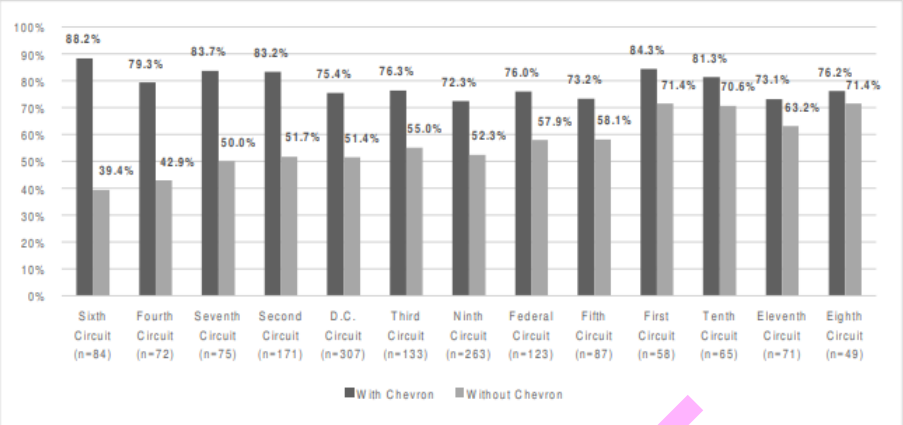
Risks of Executive Discretion

While executive agencies often bring subject-matter expertise to their interpretations and rulemaking, their actions are ultimately shaped by the priorities of the executive branch. In periods of political polarization or concentrated executive control, agency decision-making may diverge from established clinical or scientific standards. Codifying a Chevron-like framework that insulates agency interpretations from independent judicial review could reduce opportunities to challenge such decision-making. For the AMA, whose policies rely heavily on regulatory integrity across areas such as drug approvals, public health initiatives, and physician payment models, this concern is more than theoretical. Entrenching broad interpretive authority in the executive branch may limit the AMA's ability to contest policies that conflict with its mission and long-term advocacy goals.

Preserving Opportunities for Legal Advocacy

In some contexts, the narrowing of judicial deference may strengthen the AMA's ability to challenge regulations that adversely affect physicians or patient care. The AMA has previously turned to legal advocacy in response to agency rules it found harmful or overreaching and remains prepared to do so when necessary. Recently, following the *Loper Bright* decision, the AMA submitted amicus briefs in support of the Texas Medical Association's (TMA) lawsuit challenging a Department of Health and Human Services (HHS) rule implementing the No Surprises Act. The reviewing court invalidated the rule, finding that it exceeded the authority granted by Congress and impermissibly favored health plans over physicians, hospitals, and other providers.

FIGURE 9. CIRCUIT-BY-CIRCUIT COMPARISON OF WIN RATES WITH AND WITHOUT *CHEVRON* FRAMEWORK (n=1558)



An empirical study reviewed by the Congressional Research Service (CRS) determined that, in the Fifth Circuit, where TMA filed suit, agencies were 15.1 percent more likely to prevail when *Chevron* deference was applied. This difference may have significantly impacted TMA's ability to successfully challenge the statutory interpretation of the No Surprises Act. Thus, a post-Chevron framework, such as the one applied in that case, may strengthen the AMA's ability to pursue legal advocacy as a means of protecting patients and physicians when agencies exceed their statutory authority.

The CRS-reviewed study also suggests that the application of *Chevron* varied widely across circuits, areas, and subject areas. In some circuits, courts frequently reached similar outcomes regardless of whether the doctrine was applied. In other circuits, the application of *Chevron* so drastically increased an agency's ability to prevail that it would hinder, if not outright prevent, the AMA from being able to successfully challenge harmful statutory interpretations. Further, prior to its ruling in *Loper Bright* in mid-2024, the Supreme Court had not applied the *Chevron* doctrine since 2016.[15] Thus, while *Chevron* established a highly cited framework for judicial review, its actual impact on case outcomes may not have been as consistent as is widely assumed. Accordingly, codifying Chevron could introduce greater unpredictability into AMA's legal strategy.

Regulatory Changes Across Administrations

Agency interpretation is inherently fluid. Unlike courts, which operate with institutional continuity and are generally guided by precedent, agencies may repeal or modify statutory interpretation with each change in administration. Codifying a framework that presumes or requires judicial deference to permissible agency interpretations could increase the variability of regulatory policy, particularly in contentious areas of health care. This may hinder AMA's long-term advocacy, especially when seeking durable reform.

AMA POLICY

AMA policy reflects strong support for agencies' authority to promulgate rules as vehicles for evidence-based regulation, alongside a clear recognition that agency action is not infallible. The AMA has supported federal agencies when they ground policies in "objective scientific data,"[16] shield decision-making from "political considerations or conflicts of interest [that] overrule scientific evidence,"[17] and revise regulations only when "sufficient scientific evidence supports such changes."[18]

At the same time, AMA policy recognizes that agency rulemaking has not always aligned with congressional intent or served the best interest of patients and physicians. The AMA has raised concerns and opposed agency rules, including an Environmental Protection Agency proposal that would have permitted the sale of diesel engines not compliant with emissions standards;[19] HHS regulations prescribing impractical conditions of participation for small, rural hospitals;[20] and a CMS effort to lower surgical fees through third-party redefinition of global surgical periods.[21] Consistently, AMA policy reflects a commitment to regulatory integrity, accountability, and responsiveness to the needs of physicians and the patients they serve.

CONCLUSION

AMA policy does not support judicial deference to agency decisions as a categorical principle. Rather, it favors frameworks that preserve the role of agency expertise while maintaining safeguards to ensure federal rules are consistent with congressional intent and grounded in sound clinical judgment. The APA already provides such a framework by requiring courts to exercise independent judgment in statutory interpretation, while still leaving room for consideration of agency expertise where appropriate. Given these considerations, the Board recommends that our AMA continue its advocacy with Congress toward statutory clarity rather than advocating for deference to agencies. Additionally, our AMA has strong policy directing us to support the development of clear rules by regulatory bodies with evidence-based input from advisory groups. Therefore, your board recommends that resolution 228-I-24 not be adopted and the remainder of the report be filed.

RECOMMENDATION

The Board of Trustees recommends that resolution 228-I-24 not be adopted and that the remainder of the report be filed.

Fiscal Note: Less than $500.

REFERENCES

1 *Chevron U.S.A., Inc. v. NRDC,* 467 U.S. 837 (1984).
2 *Id.*
3 *Id.*
4 *Id.*
5 *Id.*
6 *Gentiva Health Servs., Inc. v. Becerra*, 31 F.4th 766 (D.C. Cir. 2022).
7 *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024).
8 *Id.*
9 *Id.*
10 *Id.* at 399.
11 *Id.* at 371.
12 *Id.* at 394.
13 *Id.*
14 *Id.* at 404.
15 *Loper Bright*, 603 U.S. at 406.
16 Policy H-480.959, "Reprocessing of Single-Use Medical Devices."
17 Policy H-100.992, "FDA."
18 Policy D-50.998, "Blood Donor Recruitment."
19 Policy D-135.996, "Reducing Sources of Diesel Exhaust."
20 Policy H-465.999, "Certification of Rural Hospitals for Medicare."
21 Policy H-70.948, "Exclusion of Preoperative Services from Surgical Global Fee."

8. ON THE ETHICS OF HUMAN LIFESPAN PROLONGATION

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED

At the 2024 Interim Meeting, the House of Delegates (HOD) adopted policy D-140.947, "On the Ethics of Human Lifespan Prolongation," which directs our AMA to:

> undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges.

This report provides background and ethical analysis in fulfillment of the directive.

BACKGROUND

Investment in longevity research has surged in recent years, increasing from half of a billion dollars in 2013 to $6.2 billion in 2021.[1] This longevity market includes not only longevity biotech firms and startups, but also regenerative medicine providers, AI-driven drug discovery platforms, biomarker discovery and diagnostic platforms, and novel therapeutic technologies, such as stem cell-, gene-, and immunotherapy. These technologies are often aimed at ultimately improving the human lifespan and healthspan. While life expectancy is a statistical measure of the average years of life someone can expect to live, the human lifespan refers to the maximum length of life a person can potentially achieve, while healthspan refers to the portion of life a person spends in a healthy state free of chronic diseases and disability. The interdisciplinary field of research dedicated to studying the biological mechanisms of aging and how they contribute to age-related diseases is known as geroscience.[2]

With the advent of modern medicine, life expectancy has nearly doubled in the U.S. since 1900, reaching an average of approximately 78.4 years in 2023.[2,3] Unlike life expectancy, the human lifespan appears to be biologically fixed, with a ceiling around 125 years.[4] However, some people believe that this biological limit can be overcome. Often referred to as radical life extension, some adherents believe that the human lifespan might someday be extended to 150 years, 300 years, or even thousands of years.[4] Importantly, a central goal of radical life extension is to increase not only the human lifespan but also the human healthspan. In the U.S., the lifespan-healthspan gap has been increasing over the past two decades, meaning that while life expectancy has increased, there has also been growth in the number of years people live impacted by chronic disease or disability.[5] Successful radical life extension would thus enable humans to live beyond their current biological limits and do so while experiencing optimal health.

Proponents of radical life extension often view disease, aging, and even death as obstacles to overcome, and argue that such technologies will ease human suffering and drive innovations in disease prevention and treatment.[2] Opponents typically cite concerns regarding demographics and sustainability, questions of equitable access and social justice, and fears of negative social impacts as views on aging and death change.[4,6,7] Because the technology for radical life extension is still hypothetical, any ethical analysis and debate is inherently speculative; however, as the possibility of such technology increasingly moves from the realm of science fiction to scientific reality, it is important that ethical guidance related to its development, clinical use, and regulation be established.

ETHICS ANALYSIS & DISCUSSION

Achieving radical life extension technologies would represent a profound scientific development with wide-ranging societal impacts. The potential to eradicate chronic diseases and disability while also extending lifespans would represent an enormous reduction in human harm and illness. However, the development of such technologies also has the potential to drastically increase existing inequalities and destabilize existing social norms. Much of the ethical debate regarding whether radical life extension technologies should be developed utilizes a utilitarian approach, arguing that only if the benefits to society are greater than the harms should such innovations be pursued.[8,9]

Aging as a Disease & the Scope of Biomedical Research

Proponents of radical life extension advocate a certain pathologization of aging, representing it as a disease that should be treated. In contrast, critics typically represent aging as a natural part of human life and argue that biomedical interventions should focus on shrinking the human healthspan-lifespan gap rather than on increasing longevity.[6,9] Currently, the Food and Drug Association (FDA) considers aging a natural process and does not recognize aging as a disease, which makes it difficult to get FDA approval for drugs that specifically target aging.[10] However, researchers have found ways to still pursue studies of geroscience. For example, Metformin, an FDA-approved first-line treatment for type 2 diabetes, is also being investigated for its potential not to delay aging specifically but to delay the onset of age-related diseases.[11] If current trials are successful, it could lead to a paradigm shift in how aging is recognized by the FDA and pave the way for the approval of drugs that directly target aging and not just individual diseases. The World Health Organization (WHO) has already begun to move in this direction with regard to the deterioration associated with aging, implying that againg is a disease by including "aging associated decline in intrinsic capacity" as a disease code in their 11th edition of the International Classification of Diseases (ICD).[10] As scientific pressure grows in the US, the FDA is likely to revisit the issue and reevaluate their stance towards aging. If the FDA does change its position, however, the question will remain whether (and how much) funding for clinical research should be diverted from other pursuits towards studies on how to slow or prevent aging.

Equality of Access and Social Justice

A primary ethical concern regarding radical life extension is the possibility that it would exacerbate inequality.[9,12,13] Critics argue that radical life extension technologies would be unethical if they were only available to wealthy individuals. In this view, because such technologies would likely be quite expensive, at least initially, only some members of society would be able to benefit from them.[12] Additionally, there is concern that a focus on longevity technologies would tie up limited resources for improving health in other domains and, as a result, other issues that impact health would be ignored (such as education, pollution, and climate change).[14] Opponents also claim that health research should focus on closing current healthspan-lifespan gaps, rather than on increasing human longevity.[15] On the other hand, proponents argue that combating aging may in fact be far more cost-effective because aging is the most significant risk factor for disability and most prevalent chronic diseases. They also suggest that while radical life extension technologies are likely to be expensive and not widely available to everyone at first, there is no reason to believe that this situation would persist for long.[9] Some even advocate that, eventually, everyone globally should have access to any interventions that promote healthy aging regardless of socio-economic status.[9]

When weighing the benefits and burdens of radical life extension, the question becomes one of equity, and more specifically, how much social inequality society is willing to accept. There is general agreement that developing longevity technologies would be unethical if doing so greatly increased inequalities over a long period of time, creating two castes of people (those who can access such technologies and those who cannot). However, there is less agreement regarding whether increasing inequalities in the immediate would be unethical if the long-term results were that everyone benefited and lived longer, healthier lives.

Demographic and Resource Concerns

Another important ethical concern has to do with the demographic implications of people living longer. If people die less frequently, populations are likely to grow larger, resulting in a society that consists of an older populous.[15] Increased longevity could also result in longer reproductive years and lead to people having more children. This jump in population could in turn place an unsustainable strain on available resources.[4] Alternatively, some critics have voiced concerns that radially extending life might result in a decreased sense of purpose and thus lead to reductions in social commitments and engagement, eventually leading to decreases in childbearing and reproduction.[7]

Changing Social Values and Norms

Concerns regarding the demographic impact of radical life extension highlight the fact that such innovations would initiate radical social changes. The potential impacts on social values and norms are perhaps the most common yet most amorphous ethical concerns. If radical life extension were to be achieved, it would mean a collision of far more generations than exists in parallel today, which could lead to generational divides and contentions over status and social roles.[6] A rising share of older voters could lead to growing political tensions, as policies favoring the young

shift to policies that favor the old.[16] Alternatively, extending the years of youth could lead to a devaluation of the elderly as fundamentally inadequate or defective.[12,14] These tensions could be exacerbated if a generation feels that there is no need to make room for younger generations. Other concerns include fears that radical life extension would diminish the sacredness of life;[4] that altering the human lifespan beyond its biological limits would represent a reconstruction of what it means to be human;[17] and that the slowing of successive generational cycles could lead to the slowing of cycles of innovation and adaptation.[7]

CONCLUSION

Because research on radical life extension is currently situated within a capitalist enterprise, longevity projects and issues of inequality are inherently interconnected.[12] Moreover, the possibility of radical life extension has attracted heavy involvement by the ultra-wealthy, including Larry Page (cofounder of Google) and Jeff Bezos (Amazon's founder), both of whom have significantly invested in longevity research (conducted by Calico Labs and Altos Labs, respectively).[14] Such investments have raised concerns that should these technologies prove successful, they will only be accessible to a select few and will fuel an ever increasing social divide. If radical life extension were achieved, it would also require significant changes within society to ensure that the future elderly are as healthy and as supported as possible. There would also be a need to ensure that social institutions such as education, jobs, health insurance, and social security are able to support the longer lives of the young.[16]

If radical life extension becomes a reality, society is likely to be divided into the Haves (those who extend their lives), the Have-nots (those who would like to but can't afford to extend their lives), and the Will-nots (those who refuse to extend their lives). Proponents recognize the potential benefits of radical life extension but emphasize that these advancements should be pursued with careful attention to minimizing harm, the significant benefits to the Haves justify pursuit of radical life extension.[8] The argument in favor hinges on the belief that it is always ethical to seek to alleviate suffering and improve the human condition, and this is exactly what radical life extension would achieve.[7] However, issues of equity and ethics should be considered. Over the long term, it should be a goal for these innovative treatments to be distributed equitably within the United States and across the globe.[4] What this would look like in practice, however, and how much inequity is socially acceptable in pursuit of radical life extension, is still up for debate.

Due to the currently hypothetical nature of radical life extension technology, developing specific guidelines or regulations at this time presents a challenge, as the technology itself and any impacts it may have remain purely theoretical. However, as is the case with any emerging medical technology, all research on radical life extension should adhere to the appropriate ethical standards set forth by the AMA *Code of Medical Ethics* and the research ethics outlined in the World Medical Association's Declaration of Helsinki. Furthermore, regardless of the form such technology may take or the duration of extended life it may grant, radical life extension, if it were to become a reality, should be made accessible in an ethical, equitable, and just manner.

RECOMMENDATIONS

The Board of Trustees recommends that Policy D-140.947 be rescinded as having been accomplished by this report and the remainder of the report be filed.

Fiscal Note: Minimal – less than $500

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9. 2025 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This report is submitted for the information of the House of Delegates (HOD). Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year to date. This report also includes an update on Policy D-65.972, "Updating the AMA Definition of Infertility." (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

DISCUSSION OF 2025 ADVOCACY EFFORTS

In 2025, a new Administration and Congress took power in Washington, DC. The AMA's advocacy agenda initially focused on several issues that have been recent priorities for the AMA, including Medicare payment, prior authorization, physician-led team-based care, physician wellness, and practice/technology developments. Several other issues emerged as Congress started to dig in on its legislative agenda, including Medicaid, the Affordable Care Act (ACA), and student loans. This led the AMA to attempt to mitigate some of the provisions in the sweeping legislative package. Initially, the AMA communicated its concerns in direct conversations outside the public eye but pivoted to a more public position once the legislative text was revealed. The AMA did reduce the harm caused by some of the more problematic provisions in the "*One Big Beautiful Bill Act*" (OBBBA), but the bill became law and ended up including several policy changes that will lead to fewer Americans having health insurance and fewer students being able to access needed medical school loans. The AMA is deeply disappointed with this result. Efforts will now turn to focus on providing physician practices information on how to limit the effects of the law on patients and recommendations for state implementation of new requirements in a way that minimizes coverage loss.

So far in 2025, the AMA has sent close to 100 comment letters to federal and state policymakers, as well as organized another 17 sign-on letters, on a host of issues. These efforts include some of the topics discussed above, but they also range from climate change to the overdose epidemic to immigration to maternal health and many others. AMA advocacy letters are available in the AMA's Federal and State Correspondence Finder. The AMA also offers the now weekly Advocacy Update newsletter as a way to stay abreast of AMA federal and state lobbying efforts. The AMA also urges physicians to attend the State Advocacy Summit and the National Advocacy Conference (NAC) as ways to learn about key issues, and with the NAC, lobby federal lawmakers directly in our nation's capital. And of course, please consider contributing to AMPAC.

Medicare Payment

The AMA is urging Congress to fix a broken Medicare payment system that is placing enormous financial pressure on physicians and threatening access to the care they provide. The fiscal stability of physician practices and long-term viability of the U.S. health care system is at stake because Medicare physician payment rates have plummeted 33 percent since 2001 (adjusted for inflation in practice costs). Congress failed to prevent or reverse a 2.83 percent payment cut that took effect on January 1, 2025, adding salt to the wound of prior cuts. Medicare payment reform is needed to remove a major financial stressor that physicians face, ensure access to care for patients, and put the overall health care system on a more sustainable path.

The AMA has rallied the Federation to support legislative efforts based on four key components:

- Automatic annual inflation-based updates;
- Budget neutrality;
- Revising the Medicare Merit-based Incentive Payment System (MIPS); and
- Supporting the development of Alternative Payment Models (APM).

The AMA sought to reverse the 2025 payment cut at the end of 2024, and this effort continued into 2025. At AMA's urging, over 170 House members signed on to support H.R. 879 that would reverse the cut and include a two percent payment increase. The AMA also prompted and is strongly supportive of the companion bill in the Senate (S. 1640). Congress needs to act before the situation deteriorates further.

In the House version of the OBBBA, there was a provision that included payment updates tied to the Medicare Economic Index (MEI) which the AMA supported. The Senate considered this option but chose to include a one-time 2.5 percent payment update in 2026 instead. The Senate version became the final version when OBBBA was enacted.

So far in 2025, the AMA Fix Medicare Now campaign has delivered strong grassroots results, generating over 85 million earned media and ad impressions, more than 2.2 million media and ad engagements, 670,000+ pageviews, 633,000+ site users, and 68,000+ contacts to Congress urging action on Medicare physician payment reform. The campaign has also secured over 150 third-party targeted media placements in influential publications and key congressional districts nationwide, reaching a total audience of more than 500 million.

There are signs of progress on other fronts, including MedPAC recommending to Congress that the 2026 Medicare payment update and the default payment update for all future years be linked to increases in the cost of providing care. Also, in its 2025 report, the Medicare Trustees said that, under current law, they "expect access to Medicare-participating physicians to become a significant issue in the long term."

An AMA-conducted claims analysis for Medicare add-on code G2211 found that the 2024 budget neutrality adjustment was overstated by nearly $1 billion. While this issue was not corrected in the proposed 2026 Medicare physician fee schedule (MPFS), the AMA will continue to call for the Centers for Medicare & Medicaid Services (CMS) to address this in the final MPFS rule. Under the Administration proposal, most physicians would see a conversion factor increase of 3.3 percent in 2026, while qualifying physicians in advanced APM would see an increase of 3.8 percent in 2026. These increases are primarily due to action by Congress to provide the temporary, one-year 2.5 percent pay boost for physicians in the OBBBA. However, these updates would be offset by a proposed negative 2.5 percent "efficiency adjustment" that would be applied to all non-time-based services, including 8,961 physician services, and cuts to payments for physician services provided in the hospital or ambulatory surgery center due to the CMS belief that those physicians no longer maintain a separate office with separate overhead and non-clinical staff expenses. The AMA will continue to review the proposed MPFS and submit thorough comments on numerous issues.

The AMA also submitted the results of the Physician Practice Information Survey to CMS in early 2025. The resulting data impacting the MEI distributions and practice expense data were presented to national medical specialty societies and MedPAC.

Further, the AMA is lobbying the Administration on MIPS reform as part of its regulatory burden reduction efforts. Responding to AMA advocacy, CMS is allowing hardship exemptions for the 2025 MIPS cost category due to issues impacting practice operations, such as a cyberattack, and a new hardship exemption for 2024 MIPS due to the nationwide shortage of IV fluids.

For a more detailed discussion of the AMA's 2025 efforts on Medicare payment reform, please see Board Report 14-I-25 which focuses solely on this topic.

Access to Care

When it became clear that the Administration and Congress would propose making significant changes to health care safety net programs in 2025, the AMA engaged in conversations with individual members of Congress to share its policy and urge lawmakers to protect vulnerable patients. The AMA made the point repeatedly during the health care reform debate in 2009 that the uninsured live sicker and die younger, and that statement was still very relevant in the 2025 debate. While there were incremental improvements during the legislative discussions that will keep some potentially affected patients enrolled in health plans (e.g., per capita caps were not imposed, Federal Medical Assistance Percentage rates were not decreased, and the Medicaid expansion eligibility pathway was not eliminated), the end result is that nearly 10 million patients will lose their current coverage.

For months, the AMA engaged with specific "grasstops" physicians and states to express concerns about significant disruptions to Medicaid. When the House bill was released in early May, AMA issued a formal letter opposing the proposed Medicaid provisions. When the House was considering its reconciliation bill, the AMA wrote to Speaker Mike Johnson (R-LA) and Democratic Leader Hakeem Jeffries (D-NY) urging them to preserve Medicaid and the Children's Health Insurance Program, ACA coverage, and medical education loan availability. The AMA then launched a broader grassroots campaign calling for its physician and patient grassroots advocates to contact Congress on these issues too. When the House bill passed, the AMA turned its focus to the Senate and made the same requests to Majority Leader John Thune (R-SD) and Minority Leader Charles Schumer (D-NY). In the end, the OBBBA was enacted and included some difficult provisions on access to care including:

- The OBBBA creates new administrative requirements and conditions on eligibility (including work requirements) for patients seeking to enroll in or maintain Medicaid coverage and restricts states' ability to use provider taxes to finance their Medicaid programs.
- The OBBBA imposes verification requirements for patients in ACA marketplace plans receiving premium tax credits, including pre-enrollment verification requirements that will effectively end automatic re-enrollment for these patients. (The OBBBA does not address the scheduled expiration of enhanced tax credits at the end of 2025.)
- The OBBBA, in part, removes the ability for medical students to receive Federal Direct Stafford Loans and Federal Direct PLUS Loans, caps the amount that can be borrowed for school, and limits federal student loan borrowers to only two repayment options.

Moving forward on access to care, the AMA will seek to help physicians work with their patients to maintain eligibility. Further, the AMA is a member of a wide-ranging coalition, Keep Americans Covered, that is focused on extending the ACA subsidies which are set to expire at the end of 2025. The AMA will also seek ways to influence issues tied to OBBBA implementation to limit some of its harsher provisions. For example, the AMA recently submitted comments to CMS expressing strong concerns with a proposed rule that would establish new criteria to limit certain forms of Medicaid provider taxes impacting seven states, as well as prevent future states from adopting similar taxes. The AMA reiterated its support for provider taxes under certain circumstances and pointed out that allowing such reforms to be implemented will create significant gaps in state budgets, forcing states to raise taxes or reduce benefits, coverage, or provider payments, or a combination thereof. The next shoe to drop would then likely be practice and hospital closures and jeopardized access in vulnerable communities.

Prior Authorization

Physicians and patients remain frustrated by the excessive use of prior authorization by insurers to delay or deny much-needed care. The AMA is fighting to remove obstacles to patient care by reforming the prior authorization process in a way that lessens the burdens on physicians, reduces burnout, and leads to improved outcomes for patients.

According to the most recent AMA research:

- Patient harm – More than one in four physicians (29 percent) reported that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.
- Bad outcomes – More than nine in 10 physicians (94 percent) reported that prior authorization has a negative impact on patient clinical outcomes.
- Delayed care – More than nine in 10 physicians (93 percent) reported that prior authorization delays access to necessary care.
- Disrupted care – More than three-fourths of physicians (82 percent) reported that patients abandon treatment due to authorization struggles with health insurers.
- Shifted costs – Four in five physicians (80 percent) reported that prior authorization delays or denials "at least sometimes" make patients pay out of pocket for medications.
- Lost workforce productivity – More than half of physicians (58 percent) who cared for patients in the workforce reported that prior authorizations had impeded a patient's job performance.

AMA secured an important victory for physicians in 2024 in the CMS final rule that requires government-regulated health plans to reduce the timeframes for prior authorization decisions and to publicly report program metrics, which will reduce care delays and improve transparency. AMA continues to monitor implementation to ensure that the goals of the rule come to fruition.

In June 2025, AHIP and Blue Cross Blue Shield Association (BCBSA) announced that over 50 of their member/licensed plans were pledging to voluntarily improve prior authorization. The AMA response to the announcement highlighted the role of AMA advocacy in this development and noted the similarity between this most recent commitment and agreements plans made in the 2018 Consensus Statement on Improving the Prior Authorization Process. The AMA is pleased with the announcement but will remain vigilant in monitoring insurer compliance. The AMA was also encouraged that CMS Administrator Mehmet Oz, MD, and Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr, held a press event coinciding with the June 2025 AHIP/BCBSA announcement that supported the industry reforms.

Despite these developments, on June 27 CMS announced a new CMMI model called the Wasteful and Inappropriate Service Reduction (WISeR) Model. The WISeR Model will create new prior authorization requirements in Medicare Fee for Service (FFS) for 17 services in six states over six performance years, beginning in January 2026. Prior authorization reviews will be conducted by vendors using augmented intelligence and machine learning. The AMA sent a letter to CMS expressing significant concerns about this development and urging a pause in implementation.

The AMA continues to work to provide medical societies with legislative language, talking points, testimony, data, and other resources to push for important prior authorization reforms in state legislatures. More than 20 prior authorization bills have been enacted in the last year (AZ, AR, CO, GA, HI, IN, IA, MD, MT, NE, NM, ND, NV, OK, OR, RI, TN, TX, UT, VA, VT, WA). Broadly, state bills are aiming to decrease the growing volume of PA requirements, reduce delays in patient care associated with prior authorization, improve the transparency of prior authorization rules, and increase reporting of prior authorization data. AMA resources have been critical to state success. The AMA continues to advocate to national policymaking organizations (e.g., the National Association of Insurance Commissioners and the National Council of Insurance Legislators) on the importance of reform and enforcement. The AMA works closely with coalitions of other impacted organizations, including patient advocacy groups, to make the case for important patient protections from payers' utilization management requirements. In addition, the AMA testified before an advisory council tasked with recommending to the Department of Labor (DOL) possible regulatory changes to improve how employer-sponsored health plans regulated under the Employee Retirement Income Security Act of 1974 use PA requirements to manage their claims and appeals procedures. The AMA urged the advisory council to recommend changes to DOL's rules to reduce the burden and harm these programs have on physicians and patients. The advisory council's report aligned with many of the AMA's recommendations.

At the AMA's urging, the House and Senate reintroduced the "Improving Seniors' Timely Access to Care Act of 2025" (H.R. 3514; S. 1816). This bicameral, bipartisan legislation seeks to reform prior authorization in Medicare Advantage plans by improving transparency through public reporting of program metrics and streamlining the process using standard electronic transactions. As of July, the legislation has already garnered tremendous bipartisan congressional support, specifically securing 51 Senate and 135 House cosponsors. Additionally, the House reintroduced the "Reducing Medically Unnecessary Delays in Care Act of 2025" (H.R. 2433), bipartisan legislation that seeks to reform prior authorization requirements in Medicare, Medicare Advantage, and Part D prescription drug plans by ensuring that only specialty board-certified physicians review treatment decisions.

Physician-led Team-based Care

Patients want, expect, and deserve medical care led by a physician, whose expertise and training are unmatched in medicine. The AMA is fighting inappropriate scope expansion attempts at both the state and federal levels. The AMA Scope of Practice Partnership (SOPP), a coalition of 113 national, state and specialty medical and osteopathic associations, has been instrumental in pushing back on expansion efforts that could harm patients and has awarded more than $4.8 million in grants to states to fund advocacy tools and campaigns since 2007. The SOPP Steering Committee has awarded 14 grants to SOPP members in 2025: AZ, GA, ID, IN, KY, ME, MD/AAO-HNS, NE, NH, NM, OH, PA, SC and TX.

So far in 2025, over 40 states have seen scope expansion efforts, and the AMA, in conjunction with the Federation, has achieved success on over 100 bills, with key wins in MO, MS, NM, TX, and WA. The common bill topics are attempts to: remove physician supervision of or collaboration with nurse practitioners or advanced practice registered nurses (APRN); allow optometrists to perform surgery; remove/weaken physician supervision or collaboration of physician assistants; pass pharmacist test and treat legislation; allow nurse anesthetists to provide anesthesia care without any physician involvement; create a license for naturopaths and/or allows naturopaths to prescribe medications, perform minor surgeries, or order and interpret diagnostic tests; and permit psychologists to prescribe.

At the federal level, the AMA continues to lead a coalition to oppose the Department of Veterans Affairs (VA) Supremacy Project, which aims to set national standards of practice for all health professionals that provide care in the VA system. The AMA also submitted a Federation sign-on letter in opposition to H.R. 3164, the "Ensuring Community Access to Pharmacist Services (ECAPS) Act." Despite efforts to modify the text of this legislation from the 118th Congress, this bill still has numerous shortcomings, including inappropriately allowing pharmacists to perform services that would normally only be authorized and covered if they were furnished by a physician, testing and treating patients for certain illnesses, and expanding Medicare payment for pharmacists in limited but significant ways.

Finally, the AMA continues to update and create new resources to educate lawmakers on the importance of physician-led care and why inappropriate scope expansions threaten patient safety, including our data series modules, GEOMAPS, Health Workforce Mapper, Issue Briefs, and one-pager series.

Physician Wellness

The AMA remains steadfast in its advocacy to advance physician wellness. At the federal level, the AMA is calling for the reauthorization of the "Dr. Lorna Breen Health Care Provider Protection Act." Further, after more than a year working with Senator Tim Kaine's (D-VA) office, the annual National Defense Authorization Act (NDAA) legislation will require the Department of Defense (DoD) to review its policies for credentialing health care workers to remove barriers to accessing mental health care. The combined efforts of the AMA and the Dr. Lorna Breen Heroes' Foundation identified areas in DoD policy inconsistent with AMA policy to avoid using stigmatizing, inappropriate language concerning mental and behavioral health. Working together, the AMA provided technical analysis and language for the NDAA, and will continue to work with Sen. Kaine and the U.S. Senate to ensure that the language will stay in the final must-pass bill. AMA will also continue to work with Sen. Kaine and DoD to provide ongoing technical support.

At the state and health system levels, the AMA continues to advocate for removing requirements for physicians to disclose whether they have received treatment for a mental health, behavioral health, or other health condition when there is no current impairment. AMA direct advocacy and resources supported the enactment of four new state laws (CO, AZ, MT, VA), changes by six state medical boards (AK, CA-DO, NV, PA-MD, PA-DO, WA-DO), and updates

by 181 new hospitals across 20 health systems this year. AMA advocacy helped reverse a decision by New Hampshire regulators to discontinue the state physician health program.

Ensuring Technology Works for Physicians

Technology has an increasingly important role to play in care delivery, streamlining the physicians' workday and improving patient outcomes. It is critical that digital health tools work as they are supposed to and are not just one more burden placed on physicians. Many health technology tools that come to market are poorly designed and fail to deliver on their exciting promise in the clinical environment. The AMA is working to ensure that new health technology, including augmented intelligence (AI) and telehealth, reaches its full clinical potential by providing support for technology adoption, developing the appropriate guardrails for implementation, and by giving physicians a seat at the table in the early stages of technology design.

This is a broad category of topics, but highlights of the AMA's efforts include: working closely with the Federation to shore up gaps in Health Insurance Portability and Accountability Act regulations; providing substantive feedback on federal and state AI requests for information, regulations, and legislation—which is reflected in several proposed policies; participating in a National Conference of State Legislatures work group on AI; and establishing an AI Medical Specialty Collaborative of over 35 organizations, including front-line physicians.

Recent successes include the Food and Drug Administration releasing significant draft guidance for AI developers that incorporates AMA recommendations; three states (AZ, MD, NE) have enacted laws this year to place guardrails on payers'/health plans' use of AI, consistent with AMA policy/AI principles; and electronic health record developers being prohibited from using technical, contractional, or financial roadblocks to prevent physician-provider and physician-patient information exchange.

Finally, the AMA wrote an opinion piece in The Hill on the new Administration AI proposal. In the piece, the AMA called for a "broad, well-coordinated federal regulatory approach to AI design and integration," and also stated "strong physician representation must be present at every stage" if AI in health care will meet its full potential.

Student Loans

The OBBBA created more barriers to prospective students pursuing careers in medicine despite AMA objections. In letters to House and Senate leaders, the AMA expressed its deep concern about the negative ramifications of this bill and asked that, at a minimum, carveouts be provided for medical school education to ensure that the nation can continue to educate the next generation of physicians. Medical education remains the most expensive post-secondary education in the U.S. with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt. Unfortunately, the final provisions in the OBBBA disqualify graduate and professional students from receiving Federal Direct PLUS Loans after July 1, 2026; place a ceiling on the amount of Federal Direct Unsubsidized Stafford Loans that will not fully cover medical school costs for some students; places new requirements on loan repayment; and will limit the ability of borrowers to defer loans based on unemployment or economic hardship, among other new requirements. The AMA will monitor the effect of these provisions closely and will seek ways to blunt their impact.

Advisory Committee on Immunization Practices (ACIP)

The AMA was extremely concerned with the proposed changes to the Advisory Committee on Immunization Practices (ACIP) membership. The AMA issued a statement opposing the removal of the sitting members of ACIP, as well as a subsequent statement expressing concern over the selection of new members without transparency and proper vetting. The AMA also sent a letter to Senator Bill Cassidy, MD, (R-LA) urging, "An inquiry as to the circumstances surrounding the decision to remove and replace all sitting members of ACIP." In addition, the AMA and nearly 100 state medical associations and national medical specialty societies sent a sign-on letter to HHS Secretary Robert F. Kennedy, Jr., expressing deep concern over the termination of the 17 ACIP members. The AMA continues to monitor this situation and seek ways to ensure that ACIP recommendations maintain their scientific integrity.

The AMA also joined several Federation members and other health care groups to write an open letter to the American public regarding vaccines and respiratory viruses. The groups reaffirmed support for vaccinations as the best way to protect against the flu, COVID-19, and RSV. The letter authors also called on insurers, hospitals, and public health agencies to ensure vaccines remain available to patients without cost sharing.

The AMA weighed in again when it was announced that volunteer members from the AMA and other physician and health care organizations would be removed from ACIP work groups. The removal of these medical experts is very alarming. On a similar front, the AMA expressed its concern regarding mRNA research funding cuts announced on August 5, 2025. The AMA stated "COVID-19 vaccines using mRNA technology helped saved countless lives during the pandemic. We urge the Administration to continue vital research to improve mRNA vaccines, not throw the baby out with the bathwater by effectively preventing research from moving forward."

United States Preventive Services Task Force (USPSTF)

When media reports started to circulate in late July that the members of the United States Preventive Services Task Force (USPSTF) could be removed, the AMA wrote to Secretary Kennedy and urged him not to do so. The AMA reiterated that the USPSTF plays a critical, non-partisan role in guiding physicians' efforts to prevent disease and improve the health of patients by helping to ensure access to evidence-based clinical preventive services. Besides asking the Secretary to retain the previously appointed members of the USPSTF, the AMA also called for his commitment to the long-standing process of regular meetings to ensure the important work of the USPSTF can continue without interruption. The USPSTF has long played an essential role in making evidence-based recommendations for clinical prevention of disease. USPSTF members have been selected through an open, public nomination process and are nationally recognized experts in primary care, prevention and evidence-based medicine. They serve on a volunteer basis, dedicating their time to help reduce disease and improve the health of all Americans. Importantly, the USPSTF puts forth recommendations that dictate coverage policy for health insurers nationwide. By law, insurers must cover USPSTF-recommended services without cost sharing.

Research Funding

The AMA has voiced its concern over the impact of proposed and implemented research funding cuts. On July 16, the AMA sent a letter to the House and Senate Appropriations Committees advocating against proposed cuts to the National Institutes of Health (NIH). In the letter, the AMA stressed the concern surrounding the proposed cuts to the NIH. While the AMA shares the Administration's goals of reducing chronic disease and is strongly committed to prioritizing actions to ensure a healthier America, these proposed cuts would have serious negative consequences for the development of new treatments and cures, and the overall health of the American people. The AMA will continue to work with the Chair and Ranking Members of both the House and Senate Appropriation Committees to ensure that the NIH does not see a 40 percent reduction in funding.

Reproductive Health

The AMA strongly opposes the interference of government in the practice of medicine and strongly opposes laws that prohibit physicians from providing evidence-based medical care that is in the best interest of their patients. The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion and contraception, as a right. The AMA continues to work closely with state medical associations to make sense of confusing legal obligations in restrictive states, identifying strategies to mitigate harm, and advocating against new restrictive laws.

The AMA Task Force to Preserve the Patient-Physician Relationship convened in-person meetings in February and July. The Task Force includes 29 physician leaders from AMA Councils, state medical associations, and national medical specialty societies. The February agenda addressed payment and reimbursement for gender-affirming care and the July meeting agenda addressed challenges in workforce, training, and education stemming from abortion and gender-affirming care restrictions. The Task Force identified multiple potential deliverables to expand access to care, as well as training opportunities and support for the physician workforce. These deliverables are in addition to ongoing projects of the task force including support for legal defense resources and legal guidance for physicians, development of a website to serve as a resource hub for physicians, collaboration on guidance for institutions, opinion research to inform advocacy messaging, and others. The resource hub website will be released prior to the Interim Meeting.

In accordance with Policy D-65.972, the AMA expressed concern to the health insurance industry that some health plans discriminate in coverage of fertility services on the basis of marital status, sexual orientation, or gender identity. Further, the AMA Advocacy Resource Center communicated with state medical associations and national medical specialty societies about the AMA's willingness to work with interested organizations on policies to address such discrimination in coverage of fertility services. Use of marital status, sexual orientation, or gender identity in the definition of infertility is restrictive and outdated. These exclusions are not medically justified and serve only to entrench inequities in access to reproductive care. The AMA calls for health plans to adopt infertility coverage policies

that reflect the American Society for Reproductive Medicine definition of infertility to protect patients from discrimination on the basis of who they are or how they form their families.

Maternal Health

The AMA continues to address disparities in maternal health outcomes. In line with the Administration's efforts to reduce regulatory burden, the AMA has advocated that CMS revoke expensive, burdensome conditions of participation that require all hospitals and critical access hospitals (CAHs) to meet numerous requirements to provide obstetrical services, which could exacerbate the growth in maternal health deserts. At a minimum, CMS should exempt rural hospitals and CAHs. On April 14, the AMA sent a letter to the House and Senate in support of the Rural Obstetrics Readiness Act (H.R. 1254/S. 380), which would provide grant funding toward evidence-based training programs on emergency obstetrics services for rural health care facilities without dedicated obstetrics units. On March 28, the AMA sent a letter in support of the Connected MOM Act (S. 141), which would require CMS to report on, and provide resources for states related to, coverage of remote physiologic devices and related services (e.g., blood glucose monitors) under Medicaid.

Overdose Epidemic

The nation's drug-overdose epidemic killed more than 80,000 Americans in 2024—a welcome decrease from recent years—but still a historic and tragic level. The AMA continues its advocacy to policymakers and other stakeholders—including health insurers, pharmacy benefit management companies, and national pharmacy chains—to remove barriers to evidence-based care for opioid use disorder and for pain and increase access to naloxone and other proven harm reduction initiatives. The AMA supports H.R. 2483, the "SUPPORT for Patients and Communities Reauthorization Act of 2025" to reauthorize billions of dollars in federal funding to help combat the opioid crisis. This legislation passed overwhelmingly in the House and is pending in the Senate. The AMA urges states to use opioid litigation settlement funds on public health and treatment initiatives, and the AMA is working with several national patient advocacy groups to help ensure states are transparent and accurately reporting where settlement funds are being spent. The AMA helped at least three states (CO, VA, WA) strengthen their mental health and substance use disorder parity laws in 2025.

Climate Change

The AMA has been very active in the area of climate change and health. In the summer of 2025, the AMA hosted a successful three-part webinar series on climate change and health covering: The Hidden Health Impacts of Climate Change, Climate Resiliency in Health Care, and Decarbonizing the Health Care Sector. The AMA provided public comment on the risk of repealing the Endangerment Finding related to vehicle emission standards. The AMA also provided public comment in response to the EPA proposed rule, "Repeal of Greenhouse Gas Emissions Standards for Fossil Fuel-Fired Electric Generating Units." The AMA maintains a strong presence with the Medical Societies Consortium on Climate and Health (MSCCH), a group that comprises over 100 medical societies and allied health groups in the US. The AMA serves on the executive committee of the consortium. Additionally, through the MSCCH the AMA represents the US to the Global Climate and Health Alliance. The *AMA Journal of Ethics* in August 2025 considered physicians' duties amid nuclear and climate threats. The AMA also hosted a webinar on improving environmental sustainability in medical practice. Also, earlier in 2025, the MSCCH gathered 86 groups to thank the Occupational Safety and Health Administration (OSHA) for proposing a new heat injury and prevention standard to better protect workers from heat-related health risks. There has been long-term interest in this issue, and with summers getting hotter and heat waves more frequent and severe, this is an urgent issue. The Consortium called on OSHA to finalize and implement this proposed standard quickly to save lives and protect the communities the signing organizations serve.

Pharmacy Benefit Managers (PBMs)

The AMA is supporting H.R. 4317, the "Pharmacy Benefit Manager (PBM) Reform Act of 2025," a bipartisan effort to bring long-overdue transparency, accountability, and fairness to the PBM industry. The PBM Reform Act of 2025 encompasses a comprehensive set of provisions designed to increase transparency, accountability, and fairness in the prescription drug supply chain. The bill would ban spread pricing in Medicaid and establish a transparent reimbursement model to ensure pharmacies are fairly compensated for serving beneficiaries. It would also decouple PBM compensation from drug costs, enhance transparency for employers and patients, and authorize the HHS to define and enforce reasonable contract terms.

The AMA furthered its PBM research base this year with the release of the *Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2025 Update*. Key findings include that the four largest PBMs collectively had a 67 percent share of the national PBM market in 2023. OptumRx was the largest PBM in the U.S. in 2023 with a 22.2 percent market share—up slightly from 20.8 percent in 2022. It is followed by CVS Health with an 18.9 percent share—down from 21.3 percent in 2022. Express Scripts was third largest with a 15.5 percent share, followed by Prime Therapeutics with a 10.6 percent share. Nationally in 2023, 77 percent of prescription drug plan (PDP) lives were covered by an insurer that is vertically integrated with a PBM.

Physician Shortages

The U.S. is facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians. There is a projected shortage of up to 86,000 physicians by 2036. The AMA is supporting H.R. 3890, the "Resident Physician Shortage Reduction Act of 2025," to address the projected shortfalls. This bipartisan legislation would gradually raise the number of Medicare-supported graduate medical education positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted at hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas, especially those hospitals affiliated with historically Black medical schools, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

International Medical Graduates

The AMA recognizes the critical role that non-U.S. citizen International Medical Graduates (IMG) play in alleviating the physician shortage by providing health care to many Americans, especially in communities in need. The AMA is supporting several bills that would alleviate some of the more onerous issues that IMG physicians face. In April, the AMA sent a letter expressing support for H.R. 1201, the "Doctors in our Borders Act," which would expand the number of Conrad 30 waivers a state or regional commission can receive from 30 to 100. Earlier in March, the AMA sent a letter to both the House and Senate expressing support for H.R. 1585/S. 709, the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize and make targeted improvements to the J-1 visa waiver program in a manner that helps alleviate the shortage of physicians, especially in rural and underserved areas, and promotes a more diversified workforce. Also in March, the AMA signed onto a letter to both the House and Senate co-signed with 45 organizations in strong support of the introduction of the "Conrad State 30 and Physician Access Reauthorization Act" (H.R. 1585/S. 709).

Finally, the AMA sent a letter to Secretary of State Marco Rubio regarding J-1 appointments for foreign national physicians which were paused by the U.S. Department of State (DOS). The AMA HOD adopted Resolution 237-A-25 in response to concerns over this pause. Shortly after the AMA's letter was submitted, the DOS announced that interviews for visas will no longer be paused and that interview availability for physicians will be prioritized. The Educational Commission for Foreign Medical Graduates (ECFMG), the universal sponsor for J-1 physicians, worked aggressively to provide an exception and prioritization for physicians throughout this interview pause that began in May of 2025. The AMA was in constant contact with and supported ECFMG in this effort.

Medical Liability Reform

The AMA has been working with state medical associations to enact medical liability reforms that would stop, or at least limit, efforts to scale back existing tort reforms. The AMA is working with the Montana Medical Association to protect existing tort reforms anticipating challenges in next year's session. More recently, at the request of the Florida Medical Association, the AMA wrote a letter to the Governor of Florida to veto a bill that would have greatly expanded physician malpractice liability in wrongful death cases, and the Governor did in fact veto that bill. The AMA also supported the Rhode Island Medical Society in an effort to defeat a bill that would have repealed Rhode Island's collateral source rule. A recently published AMA Policy Research Perspective finds a clear upward trend in the prevalence of medical liability premium increases over the past six years (2019-2024), a pattern not observed since the early 2000s and which merits further monitoring. The AMA also published an updated version of MLR Now! which is a good resource on this topic.

Physician-owned Hospitals

The AMA is supporting the "Patient Access to Higher Quality Health Care Act of 2025," which would repeal the ACA's restrictions on the whole hospital exception to the Stark physician self-referral law, thereby eliminating

statutory and regulatory barriers that prevent the formation or expansion of physician-owned hospitals (POHs). POHs provide high quality care to patients and introduce much-needed competition in the health care industry. Unfortunately, the ACA imposed severe restrictions on POHs, banning new physician-led hospitals and sharply limiting the ability of existing POHs to grow. These constraints have been compounded by regulatory changes made in 2022 which reversed a prior effort to ease restrictions on POHs serving Medicaid populations and further narrowed the circumstances under which expansion is allowed. The AMA has urged HHS and CMS to rescind the latter regulatory barriers.

No Surprises Act

On July 24, the AMA wrote to both the House (H.R. 4710) and the Senate (S. 2420) to support the "No Surprises Act Enforcement Act." The AMA continues to stand behind the intended goal of the No Surprises Act (NSA)—to protect patients from surprise medical bills while ensuring physicians and health care providers receive fair payment for services provided. A careful balance was reached with passage of the NSA, and successful implementation of the law requires all parties to abide by the requirements of the statute. Unfortunately, many health plans are failing to do so. It is the AMA's understanding that many physicians are not receiving payment from health plans within the statutory 30-day time period following an Independent Dispute Resolution (IDR) decision in their favor, and in fact, many physicians continue to report receiving no payment at all. These bills would help enforce IDR decisions and reestablish the balance achieved in the statute.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- As mentioned earlier in the report, please sign up for AMA Advocacy Update a weekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, X, and Instagram.

The AMA also encourages HOD members to attend the State Advocacy Summit and National Advocacy Conference. The 2026 State Advocacy Summit will take place on Jan. 8-10 at the Terranea Resort in Rancho Palos Verdes, California. The 2026 National Advocacy Conference will occur on Feb. 23-25 at the Grand Hyatt in Washington, D.C.

Finally, please consider contributing to AMPAC as another way to engage in AMA advocacy efforts.

CONCLUSION

The AMA and the Federation of Medicine are fighting for physicians and patients on the top health care issues in 2025. There has been progress on some priorities, but there have also been some setbacks. The AMA will continue to fight to make inroads at both the federal and state levels. Please stay informed of the AMA's efforts through the resources listed in this report, and it is vital that physicians make their voices heard when the AMA issues grassroots calls to action.

10. IMPROVING USABILITY OF ELECTRONIC HEALTH RECORDS (EHRS) FOR TRANSGENDER AND GENDER DIVERSE PATIENTS

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policies D-65.968, H-65.929 and H-315.967

At the 2024 Interim meeting of the American Medical Association (AMA) the House of Delegates (HOD), Resolution 004, "Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients," was referred for report back at the Interim 2025 meeting. This resolution was introduced by the LGBTQ Section and called for the following:

RESOLVED, that our American Medical Association amend Policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967

Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4~~5~~) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care.

RESOLVED, that our AMA supports the use of the term "chosen name" over "preferred name," recognizing the value of the term "chosen name" to transgender and gender diverse patients.

While testimony on this resolution was mostly supportive, there were concerns about terminology and minors' privacy.

This report seeks to advance proposals aligned with best practices for inclusive health documentation, including adoption of the term, "chosen name", and the development of an organ inventory within EHRs—documenting both a patient's medical transition history and current present organs—to ensure anatomically appropriate preventive care, screenings, and treatment. Building on these priorities, the report emphasizes the importance of ensuring that transgender and gender-diverse patients' chosen names are visible across health records, while also acknowledging the challenges to adopting the resolution given the current health care information technology (IT) and political

landscape. It further highlights the need for inclusive and standardized data collection practices, equitable treatment in health care technology systems, and expanded use of personal health records to reduce the administrative burden on physicians.

BACKGROUND

Sexual orientation and gender identity (SOGI) data is information collected by health care organizations about a person's sexual orientation and gender identity to help providers and researchers better understand gender-diverse patients, enable culturally-responsive, patient-centered care, and monitor and improve access to quality care.[1] The AMA supports the voluntary, culturally sensitive inclusion of patient data on sex, gender identity, and sexual orientation in medical records[2,3], and is committed to equitable, inclusive care for transgender and gender-diverse patients. In medical contexts, the terminology used to refer to transgender patients' names carries significant weight. Specifically, the term "chosen name" is preferred over "preferred name" due to its affirmation of identity and the mental health benefits associated with its use.[4] Policy H-315.967 underscores the idea of informed consent, including transparent discussions on who can access a patient's data and how it will be used, extending beyond clinical interventions to data privacy and sharing policies. Focus groups revealed that transgender patients appreciated two-step gender identity questions in EHRs, but expressed concern about privacy and desired greater control, including opt-out options, especially in contexts where data might be shared.[5] Guidance on collecting sexual orientation and gender identity emphasizes offering an opt-out ("Choose not to disclose") option.[6] Patients must be informed about why data is collected, how it will be used, and that refusal will not affect their treatment. A recent study showed that patients of sexual and gender minority expect informed consent before capturing SOGI data, prefer to choose when and how to share it, and are more comfortable when staff understand its relevance and patients have the option to decline.[7]

The term "clinical sex" goes beyond a medically convenient label; it's a contextual, biologically informed data element designed to ensure precise, safe, and inclusive health care. It is important to recognize that ongoing efforts have aimed to make EHRs more inclusive and clinically relevant by bridging the gap between patient identity, clinical accuracy, and respectful care. Sex for Clinical Use (SFCU) and Sex Parameter for Clinical Use (SPCU) are standardized health data elements that captures the sex classification most relevant to a specific clinical context (e.g., lab reference ranges, imaging studies, and medication dosing), as defined by the Health Level 7 (HL7) Gender Harmony Project.[8] SFCU/SPCU reflects the biological characteristics relevant to clinical care—such as anatomy, hormones, organs, chromosomes—as opposed to legal sex, sex assigned at birth, or gender identity. The HL7 Fast Healthcare Interoperability Resources standard includes an extension usable in patient portal or laboratory resources.[9] It supports the four-value schema: male, female, specified, and unknown. Health care providers are encouraged to adopt practices that respect and affirm patients' identities. The addition of SOGI fields over the last ten years have already established a basis of improving health care for the gender-expansive patient population.[10] This includes updating EHRs to distinguish between legal and chosen names, ensuring that staff are trained to use patients' chosen names and pronouns, and creating an inclusive environment that acknowledges and supports transgender patients.

EHR systems have been required to be capable of collecting SOGI data since a ruling by the Center of Medicare and Medicaid Services (CMS) in 2015[11], but reliability of these infrastructures have remained questionable by gender-diverse communities. Studies have shown that over 60 percent of adult EHRs are missing SOGI information[12], impeding the ability to identify and address health disparities within LGBTQ+ populations. Most EHRs now support distinct fields for legal sex, sex assigned at birth, gender identity, organ inventories (e.g., presence/absence of uterus, prostate, etc.), and context-specific sex fields that inform lab reference ranges, clinical decision support, and alerts.[13] This ensures correct testing and screening, and supports health equity and interoperability. Organ inventories are proven tools to ensure equitable, anatomy-based care. They are increasingly supported by leading EHR vendors and adopted by institutions like Epic[14], Geisinger[15], Allscripts[16], Department of Veterans Affairs[17], and Fenway Health.[17] Recommendations from the LGBTQ Primary Care Toolkit endorse voluntary SOGI and organ inventory disclosure through patient portals or clinic tablets[18], with clear messaging that patients may update or decline to provide this information—supporting autonomy and mental comfort. Successful integration depends on standardizing data, aligning workflows, providing training, and addressing anatomical complexity. Continued expansion is essential to close care gaps for transgender, gender-diverse, and all individuals with diverse anatomical realities.[19] While further

EHR modifications[20] and staff training[21] to promote collection of more inclusive data have been a continued suggestion amongst those in the medical community, the quantifiable impact of these changes has yet to be determined.

DISCUSSION

Referring to a transgender individual's "chosen name" acknowledges their self-identified name as their actual name, not merely a preference. The term "preferred name" can imply that the name is optional or less legitimate, which may undermine the individual's identity. Queering Medicine, a grassroots advocacy organization for improving health outcomes, notes that the term "preferred name" is considered offensive by many in the transgender and nonbinary communities, as it suggests that others have the discretion to use or ignore it.[22] Additionally, using a transgender person's chosen name has been linked to significant reductions in mental health risks. A study published in the *Journal of Adolescent Health* found that transgender youth who could use their chosen name in multiple contexts experienced 71 percent fewer symptoms of severe depression, 34 percent less instances of reported suicidal ideation, and 65 percent reduction in suicide attempts.[23] Ensuring the correct terminology is being used in the clinician's office is the first step increasing the patient's comfort, ensuring mutual trust, and improving health outcomes.

Data Interoperability

A lack of documenting gender (and related data like SFCU or organ inventory) can lead to clinical errors, poor patient experiences, and long-term harm. Systems and clinicians who thoughtfully record and use this information provide better, safer, and more affirming care.[24–26] A qualitative study of transgender individuals in Chicago found that structured gender identity fields (e.g., two-step questions) improved perceived provider competence, but also highlighted serious risks around privacy violations, misinterpretation, and compromised safety when disclosures were mishandled.[5] As part of another qualitative study, transgender patients who were asked to discuss their experiences reviewing their EHRs reported experiencing harm via various aspects of EHR documentation, including frequent use of incorrect names, pronouns, or gender; stigmatizing or blaming language in clinical notes; and limited system capabilities that hinder quality, equitable care.[27] According to a US Transgender Survey conducted by the National Center for Transgender Equality, 33 percent of transgender respondents reported a negative experience with a health care provider in the past year.[28] Using the 2015 U.S. Transgender Survey, a study that explored avoidance of health care due to anticipated discrimination among transgender adults found that almost one-quarter of participants (22.8 percent) avoided health care due to anticipated discrimination, deepening gaps in trust and care. Although legislative and regulatory efforts surrounding transgender care are rapidly evolving, several of these entities have, in the past, recommended structured collection of gender identity, sex assigned at birth, and related EHR data fields to protect privacy and support clinical decision-making. For example, a 2011 Institute of Medicine (now the National Academy of Medicine) report titled, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding", recommended that SOGI data be collected in EHRs with consideration for privacy concerns.[29] In 2023, the Department of Health and Human Services (HHS) published its SOGI Data Action Plan to improve data collection for the LGBTQ+ community and in turn, support more equitable representation and care.[30] Further, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) mandated in 2015 that certified EHR systems support the recording and display of gender identity, sex, "name to use", and pronouns, requiring full support for these fields by January 2026.[31]

EHRs not adequately accommodating both legal and chosen names not only creates significant challenges for transgender and gender diverse patients, but for the physicians and practices caring for them as well. Current systems often fail to record patients' names and pronouns appropriately, conflate sex and gender, and treat sex and gender as binary concepts. Many EHRs lack distinct fields for capturing both legal and chosen names, leading to chosen names being reverted to legal names previously stored in the system, repeated misnaming, and confusion during care—even when patients have clearly communicated their chosen name.[32] For example, many EHRs have historically used a single field that mixes administrative sex, clinical sex, gender identity, and pronouns under one category like "sex" or "gender".[33] Even when systems do provide multiple fields for this information, issues arise due to the need for different names in different settings such as in the case of radiology information systems being linked to other medical records like Medicare. [32] A 2020 study at Rush University found that 76 percent of inpatient records lacked gender identity data, and a 2023 study at an academic medical center in New York found six discrepancies in transgender patients' documented gender identities[34]. Even when features (e.g., multi-part fields and dropdowns for pronouns) exist, they're

not uniformly activated or used across vendor installations, meaning many users never see or use them. Additionally, sensitivity for identifying transgender individuals using EHR gender fields was remarkably low for data quality standards. These inconsistencies can result in administrative complications, as insurance billing and certain services (e.g., lab, x-ray, or procedures) all are governed by safety practices, the Health Insurance Portability and Accountability Act (HIPAA), and the Red Flag Rule, thus requiring verification of legal identity.[35] Furthermore, inconsistent documentation across systems can inadvertently expose a patient's transgender identity to providers, family, or friends, particularly in emergent situations, increasing the risk of discrimination and undermining trust in the health care system.[36]

To capture more accurate details, many EHRs enable free-text responses in the EHR SOGI field for patients to indicate their gender identity and pronouns in cases where an applicable option wasn't available. In a study that assessed how well SOGI fields, International Statistical Classification of Diseases and Related Health Problems, 10th Revision codes, and medication records identified gender-expansive patients, researchers reviewed free text responses from participants who selected "Other" in the SOGI field and responses included, "agender", "gender fluid", "gender nonconforming", "gender queer", indications of pronouns other than "he/him" or "she/hers", and "transfeminine" or "transmasculine".[10] However, free-text fields in EHRs have been reported to contribute to data overflow.[37] Information in these fields can become unmanageable for providers and potentially be overlooked. Managing this information also adds to physicians' time in the EHR, contributing to increased burnout. To address this burden, along with noisy SOGI data and incomplete and inconsistent gender identity documentation, researchers developed and validated a deep-learning natural language processing pipeline to accurately predict patient gender identity. Using a list of 109 expert-curated and literature-reported gender-related keywords, their model screened both structured data and free-text notes from over 3,000 patients in a large Boston health system to identify transgender and gender-diverse individuals. Compared with rule-based methods, the deep-learning model achieved substantially higher-accuracy, sensitivity, and precision.[38] However, a key limitation of such models is their reliance on existing EHR data, which may reflect provider biases and system constraints in capturing gender identity. As a result, these models risk reinforcing biases caused by inconsistent or inaccurate documentation, misgendering, and limited data fields. The Boston study experienced this challenge: in some cases, the model misclassified patients as transgender/gender-diverse based solely on procedures like a hysterectomy or vaginectomy, due to insufficient training data. Similarly, errors occurred when patients used they/them pronouns, reflecting an overgeneralization caused by limited training exposure to gender-diverse language.[38]

Without structured and manageable fields for sex assigned at birth, gender identity, SFCU, and organ inventory, clinical decision supports—a health IT tool that provides clinicians with knowledge and person-specific information to enhance care (e.g., computerized alerts, clinical guidelines, reminders, documentation templates, and condition-specific order sets)[39]—may miss important health risks such as cancer screenings, titrated lab interpretation, or medication needs. Adopting and properly leveraging HL7 Gender Harmony and vendor toolkits is crucial, but must be paired with staff training, governance, and careful configuration to prevent implementation gaps.

Addressing Privacy Concerns

The collection of SOGI data in the United States is crucial for addressing health inequities and ensuring high quality care for LGBTQ+ populations. The terminology used in EHRs to refer to a patient's name—specifically, the distinction between "chosen name" and "preferred name"—has significant implications for privacy, security, and the well-being of gender-diverse individuals.

While HIPAA provides a framework for protecting patient information, it has limitations concerning SOGI data. For instance, certain legal interpretations have allowed for the disclosure of SOGI information without explicit patient consent, especially when such data are collected as part of demographic information rather than clinical record.[40] This was the case in Vanderbilt University Medical Center's (VUMC's) 2023 disclosure of the full medical records of transgender and gender-diverse patients to the Tennessee Attorney General amid an anti-LGBTQ+ political climate. The probe was prompted by claims that VUMC had improperly billed Medicaid for gender-affirming care. This disclosure was made without patient consent and sparked significant backlash, with critics arguing that it jeopardized the safety, privacy, and trust of transgender patients.[40,41]

The case also exposed broader vulnerabilities in federal privacy protections for this patient population. Under the HIPAA Privacy Rule, covered entities may disclose protected health information (PHI) without patient authorization if required by another law (provided such disclosure complies with the requirements of that law). In such cases, health care providers are not liable for these disclosures and often cannot prevent them. This loophole was a key factor in the VUMC case, raising concerns about the adequacy of federal safeguards for this kind of sensitive health data.[41] Compounding the issue, in early 2025, HHS rescinded its 2022 guidance that had previously offered protections for gender-affirming care and patient privacy[42], leaving transgender and gender-diverse patients and their providers with less clarity and even fewer protections to rely on.

Under HIPAA, a patient's name is considered PHI. This designation requires health care providers to implement safeguards to protect the confidentiality and integrity of patient names. However, HIPAA does not specifically address the nuances of chosen names for transgender individuals, potentially leaving gaps in protection when legal and chosen names differ.

The absence of comprehensive federal privacy legislation results in a patchwork of state laws, leading to inconsistent protections for SOGI data. In some states, there are no explicit safeguards against discrimination based on sexual orientation or gender identity, increasing the risk of data misuse. For example, in states without protective laws, individuals may face discrimination in housing, employment, or education if their SOGI information is disclosed.[43] Smaller practices are at higher risk of being unable to protect this data against federal threats, such as digital surveillance and geofencing of reproductive or gender-affirming care sites. Collecting gender and sexual orientation and gender identity data requires strong appropriate technical safeguards and privacy protocols to prevent trauma for LGBTQ+ patients, especially those with past misgendering or being outed in care settings.[44] Fenway Health and the VA implement EHR fields for gender identity, anatomical inventories, and affirmation history, coupled with staff training, clearly explained data use, and privacy protections. These measures help prevent “re-traumatization” and enhance mental well-being.[15] Respect and transparency around data handling reduce the risk of re-traumatization and support positive patient outcomes. Oregon’s Equity & Inclusion Division highlights that collecting SOGI data demonstrates care and safety for LGBTQ+ individuals.[45] Paired with staff training and community-led input, it helps build trust, especially important in mental health screenings and identity disclosure contexts.

Even when minors can consent to sensitive care (e.g. sexual/mental health), EHR portals often default to giving guardians full access, risking unwanted disclosure of SOGI data.[46] A 2023 JAMA Pediatrics survey showed that approximately 50 percent of young adults avoid portal use and omit sensitive information for fear parents might see it, citing threats to their physical well-being if revealed to be transgender.[47] While collecting minors' SOGI data supports personalized care, privacy protections are often insufficient, leading to coerced disclosures, harmful breaches, and emotional risk. The Privacy Rule allows parents to access their minor children’s medical records as their personal representative when access isn’t inconsistent with state or other law. Exceptions to this are when parental consent is required by law; when the minor is directed by the court to obtain care; and when—and to the extent that—the parent agrees that the minor and provider may have a confidential relationship.[48] Additionally, even when state law permits confidential care, legislation like the 21st Century Cures Act still pose challenges. For example, the Cures Act’s open notes policy can unintentionally expose minors’ sensitive information to parents.[49] While the Cures Act builds on HIPAA to improve access to electronic health information, it doesn’t override HIPAA’s core privacy protections which allows disclosure of PHI for billing without consent.[50] Though data is limited, AMA physicians report such disclosures are common due to the lack of alternative workflows. Protecting minor privacy must extend to payers’ billing systems, not just providers and EHR vendors.[51] More robust technical, legal, and workflow standards must be researched to aid data collection and improve current systems.

Historical and ongoing discrimination against LGBTQ+ individuals fosters a climate of mistrust, making individuals hesitant to share SOGI information. Concerns about confidentiality breaches and potential repercussions can lead to underreporting or refusal to disclose such data, hindering efforts to gather accurate information for public health and policy-making purposes. Using "preferred name" instead of "chosen name" can inadvertently suggest that the name is optional or less legitimate, potentially leading to misidentification and privacy breaches. For transgender patients, being addressed by their legal name rather than their chosen name can result in unintended disclosure of their gender identity, especially in environments where they may not have disclosed this information. This misidentification can lead to emotional distress and a reluctance to seek necessary medical care–broadening the health disparity gap.

Unstable Political Landscape

The current political landscape in the United States has introduced a series of legislative and executive actions that have significant adverse effects on the rights and well-being of gender-diverse individuals and the physicians that care for them.

As of early 2025, 27 states have enacted bans on gender-affirming care for minors, with 26 of these 27 states prohibiting hormone therapy and surgeries for minors, and one state (Arizona) prohibiting only surgical care.[52] Such bans are typically enforced by criminal, civil, and professional penalties for providers who furnish gender-affirming care services, as well as sometimes penalties for parents of children who support their children's access to this care.[53] Notably, these restrictions do not apply to services provided for purposes other than gender affirmation, such as treatments for disorders of sexual development and precocious puberty. As of July 2025, 40.1 percent (120,400) of trans youth aged 13-17 are living in the 27 states that have passed bans on gender-affirming care.[54] Despite the protections afforded in states with "shield laws" designed to protect access to abortion and gender-affirming care, these laws are currently being challenged.[55–57] Given the strong correlation between transgender individuals and mental health, state-level anti-transgender policies exacerbate these issues. Public health experts warn that such policies not only harm individual well-being but also strain health care systems and exacerbate inequities.[58] The denial of gender-affirming care and the erosion of legal protections necessitate urgent attention and intervention.

On January 20, 2025, Executive Order 14168 was signed, mandating federal agencies to recognize only a binary definition of sex based on biological attributes assigned at birth. This order rescinded federal recognition of transgender identities, ceased funding for gender-affirming care, and prohibited the use of gender self-identification on federal documents.[59] Additionally, it called for a reevaluation of Title VII protections concerning gender identity. Subsequent directives led to the removal of federal data sets and resources related to sexual orientation and gender identity from government websites, hindering research and public health initiatives aimed at addressing the needs of LGBTQ+ populations. These events reflect a broader trend of institutional censorship affecting educational resources related to gender diversity.

The politicization of transgender rights has broad societal implications, including intensified stigma and marginalization, and the undermining of the rights, health care access, and well-being of these communities. These challenges underscore the urgent need for informed advocacy and policy reform, especially efforts that address how inadequate privacy protections leave LGBTQ+ individuals vulnerable. Navigating the shifting political landscape requires careful attention to evolving attitudes—as well as emerging knowledge and best practices—from LGBTQ+ communities and their providers.

CONCLUSION

Aligning medical documentation with the needs of transgender and gender-diverse patients is a critical step toward addressing long-standing health inequities. This report highlights the importance of supporting the voluntary, culturally sensitive inclusion of gender identity, "chosen names", and organ inventories to promote safer, more accurate, and affirming care. Many EHR vendors have already made strides in supporting this type of data collection, but more research is likely needed on specific efforts and impact of use across the health care system.

Affirming practices—such as using "chosen names" and linking screenings to anatomy rather than gender identity—are supported by strong clinical and mental health evidence, but ongoing challenges highlight the need for robust privacy protections. While some federal protections have been rolled back or face legal threats, laws like HIPAA and state confidentiality statutes still mandate safeguards, though they may be limited in their protection of transgender patients. Smaller practices may also lack the resources to implement optimal data protections. Informed consent and the option to opt out without compromising care are essential to maintaining patient trust.
In addition, there is a lack of consensus and consistent use of key terms such as clinical sex, raising concerns about the longevity of this resolution if adopted. Improving the usability of EHRs for transgender and gender diverse patients requires ongoing collaboration among the LGBTQ+ community, physicians, health systems and practices, and EHR vendors. Medical documentation that appropriately supports this patient population while upholding the highest

privacy standards to protect these patients and the physicians that care for them, would be a vital step toward a more equitable and responsive health care delivery system.

AMA POLICY

The AMA has adopted several policies to support gender-diverse individuals in health care, foster care, and legal protections.

The AMA (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians (Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation")

The AMA will also advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data (Policy H-440.817, "Protecting the Integrity of Public Health Data Collection").

Additionally—given the medical spectrum of gender identity and sex—the AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth (Policy D-295.312, "Medical Spectrum of Gender").

The AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors (Policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity").

Further, the AMA continues to (1) support the dignity of the individual, human rights and the sanctity of human life; (2) reaffirm its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; and recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Policy H-65.965, "Support of Human Rights and Freedom (H-65.965)

The AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement (Policy H-65.976, "Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations").

Additionally, AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity (Policy H-65.983, "Nondiscrimination Policy")
Regarding LGBTQ+ older adults, AMA will disseminate educational content to increase awareness and understanding of LGBTQ++ health aging issues among the general public, health care professionals, and policy makers; promote cultural competency training for clinicians in caring for LGBTQ++ older adults; promote policies and practices for implementation within all health care settings that are inclusive and affirming for LGBTQ++ older adults; and advocate for increased funding and resources for research into health issues of LGBTQ++ older adults (Policy D-65.979, "LGBTQ+ Older Adults")

Moreover, our AMA:

1. Believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people (Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations").

Further, AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth (Policy H-60.927, "Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations").

AMA will also develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting

Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership (Policy D-315.974, "Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms").

Regarding research and the LGBTQ+ communities, AMA will work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations (Policy D-460.966, "Endorsing LGBTQ+ Research IRB Training").

In addition, AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience (Policy H-65.957, "Preventing Anti-Transgender Violence").

Further, AMA:

1. Recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources.
3. Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide.
4. Encourages (a) efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk; as well as (b) continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system.
5. Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults; and research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
6. Will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic.
7. Will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health.
8. Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for children, youth, and young adults
9. Will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy (Policy H-60.937, "Youth and Young Adult Suicide Prevention").

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 004-I-24 and the remainder of the report be filed:

1. Our AMA reaffirm Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation."
2. Our AMA support the use of the term "chosen name" over "preferred name," recognizing its importance to transgender and gender-diverse patients.
3. Our AMA acknowledge the evolving nature of language and engage appropriate collaborators to ensure the continued relevance and accuracy of terminology used across AMA resources and advocacy.
4. Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant collaborators (e.g., the ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR usability for transgender and gender-diverse patients, with attention to strong privacy protections, and report back on this progress by I-26.

Fiscal Note: Moderate

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11. SUPPORTING DIVERSITY IN RESEARCH

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy H-460.875

At the 2024 Interim Meeting, the House of Delegates (HOD) referred Resolution 007-I-24, "Supporting Diversity in Research," introduced by the Minority Affairs Section, which offered four resolves aimed at improving diversity in research:

> RESOLVED, that our American Medical Association support the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes (New HOD Policy); and be it further
>
> RESOLVED, that our AMA encourage all Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of medical and clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people (New HOD Policy); and be it further
>
> RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent of Subjects Who Do Not Speak English (1995)" (Directive to Take Action); and be it further
>
> RESOLVED, that our AMA support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations. (New HOD Policy)

In response to Resolution 007, this report provides background, discussion, and recommendations.

BACKGROUND

Ideally, the makeup of research participants (or human subjects) would closely resemble the demographic diversity of the general population or the prevalence of a specific disease.[1] Despite federal regulations aimed at promoting participant diversity in research, it is widely acknowledged that there is a need for greater diversity and inclusion in clinical trials and health research.[2,3] Improving diversity in clinical research would help strengthen the generalizability, external validity, and quality of research results.[4,5] Improving representation in clinical research would also reduce health disparities, potentially saving the U.S. billions of dollars, improve trust in science and medicine, and help promote public health and health equity.[4,6] Because improving research participant diversity promotes trust, fairness, justice, and health equity, achieving greater representation in clinical research is not only a scientific imperative but an ethical one as well.[4,7]

DISCUSSION

Enrolling diverse research participant populations is crucial to ensure accurate and equitable outcomes, as disease prevalence and responses to treatments can vary significantly across different groups.[8] Underrepresentation of certain groups in research can lead to biased findings and ineffective interventions for those populations. Despite evidence of recent increases in participation by women and elderly individuals in clinical trials, research participants remain mostly white and male.[6] Groups that are frequently underrepresented in clinical research include, but are not limited to, non-white women, pregnant and lactating individuals, gender minorities, sexual minorities, racial and ethnic minorities, individuals with disabilities, individuals with mental illness, older adults, children, and individuals with limited English proficiency (LEP).[3,6,9] Because some subgroups of patients might respond differently to interventions due to genetic, social, and cultural factors, ensuring diversity within research study cohorts is crucial to ensure that research is generalizable, that the risks and benefits of research are fairly distributed, and that research does not perpetuate existing health inequities.[8] By including underrepresented and excluded groups, research may lead to more effective therapies that can help reduce health disparities.[4] Inclusive enrolment practices can also lead to increases in participation and greater public trust in science and medicine.[7]

Federal Regulations and Research Participant Diversity

In the U.S., federal regulations require diversity in research participation, particularly in federally funded studies, to ensure that research findings are generalizable and equitable. The National Institutes of Health (NIH) Revitalization Act of 1993 mandates that NIH-funded clinical research include women and minorities as participants.[10] In 2019, the NIH instituted the Inclusion Across the Lifespan policy, mandating that NIH-funded research include individuals of all ages, including children and older adults, unless there exists scientifically or ethically justifiable reasons for exclusion.[11] The Common Rule (45 CFR 46), which outlines federal protections for human research participants, emphasizes equitable selection of participants; it also states that in obtaining informed consent, all information given to the research participant (or their legally authorized representative) must be in language understandable to them.[12] The U.S. Department of Health and Human Services' Office for Human Research Protections, in their guidance "Informed Consent of Subjects Who Do Not Speak English" published in 1995 and last reviewed in 2016, similarly states that when obtaining informed consent, information should be presented in language understandable to the participant.[13] However, despite these regulations, underrepresentation and exclusion of certain groups in research persists.

One challenge to improving representation in clinical research has been that data on population demographics across clinical trials has not been consistently reported. Demographic data of participants enrolled in clinical trials in the U.S. is most readily collected by ClinicalTrials.gov (a registry maintained by the National Library of Medicine at the NIH), but limitations on how often and how comprehensively data are collected and made available have made longitudinal institute-level data difficult to examine, and not all trials report their demographic characteristics.[6] It is therefore crucial that policies be developed to ensure that more complete incidence data across demographic groups and subgroups are captured and disseminated for more conditions in order to improve clinical research diversity.[14]

In addition, it has been argued that federal regulations and guidance are insufficient and overly vague on issues related to language diversity for informed consent and exclusion criteria for clinical trials, and that there exists considerable variation in IRB policies.[3,15] Recent executive orders, which have revoked previous orders directing federal agencies to address disparities, including in research funding and participation, have further complicated attempts at addressing underrepresentation and exclusion of certain groups in clinical research.[16,17]

Improving Enrollment Diversity

Strategies to improve the representation of participants in clinical research requires the engagement of multiple stakeholders and must be embedded at every stage of the research process, from ideation, to study design, implementation, and approval and dissemination.[6,9] However, Collister et al. acknowledge, "Diversity in recruitment requires additional resources, time, and skills from trial teams, and this requirement for diversity needs to be balanced with the feasibility and generalizability of the trial."[5] They add that new systems-level approaches to increase participant diversity need to be developed for both industry and investigators.[5]

To facilitate the successful inclusion of underrepresented and excluded groups in research, several strategies have been developed. For example, in the National Academies report "Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups," the authors note, "From goal setting to community partnering strategies, intentionality and planning are critical themes for overcoming the systemic barriers previously outlined […]. While planning and engagement with diverse communities is resource, time, and labor intensive, it is critical to advancing inclusion."[6] This highlights the fact that equitable representation in clinical research must be a goal from the onset. They add, "Setting a priori recruitment goals for the inclusion of underrepresented groups is essential to planning and can help research teams measure progress and develop more effective engagement strategies".[6]

Other strategies outlined include building and maintaining trust with research participants and their communities at large; anticipating and removing barriers to participation; identifying and reaching out to relevant community stakeholders to help develop more equitable study designs and drive recruitment and retention of diverse research participants; and educating researchers on strategies to increase the enrollment of diverse participants, including the use of broad eligibility criteria and avoiding sex-specific exclusion criteria.[6]

The FDA, in collaboration with the Clinical Trials Transformation Initiative, held a two-day virtual public workshop in 2024 focused on ways to increase the enrollment of historically underrepresented populations in clinical studies and promote greater representation in research. Panelists discussed barriers to clinical study diversity and "how strategies to improve diversity should consider the languages and varying levels of health and digital literacy, broadband access for digital tools, and accessibility among potential participants to enable inclusive and equitable participation."[9] Other strategies discussed included "targeted patient engagement plans, enhanced site selection and inclusive patient educational materials using decentralized trial tools, digital technologies, choosing sites that are located in diverse areas, protocol optimization with inclusive study design elements, and using patient concierges to help with scheduling and reimbursement for travel and transportation."[9]

With respect to individuals with limited English proficiency, Muthukmar et al write, "A meaningful percentage of U. S. interventional clinical trials for adults exclude individuals who cannot read, speak, and/or understand English, or are not native English speakers. To advance more inclusive and generalizable research, funders, sponsors, institutions, investigators, institutional review boards, and others should prioritize translating study materials and eliminate language requirements unless justified either scientifically or ethically."[18] In their analysis, they found that 18.98 percent of clinical trials required the ability to read, speak, and/or understand English, while only 2.71 percent specifically required accommodations for translation. They add that funders and sponsors should include translation costs as a matter of course, that institutions with access to translation or interpreter services for clinical purposes could extend these services to researchers, and that IRBs should develop standardized guidelines for the implementation of translators, which currently do not exist.[18]

A common refrain when it comes to increasing participant diversity in research is the importance of building trust with local communities.[2,4,6,9] *JAMA* Editor-in-Chief Kirsten Bibbins-Domingo explains, "Building trust with local communities requires a sustained commitment and presence, with financial investment in research infrastructure and systems and technologies to reduce barriers to participation."[2] This requires adopting the collaborative mindset and long-term commitments central to community-based participatory research, which aims to bring equity into the center of research projects by collaborating with community members and other stakeholders throughout the research process to address community needs. Bibbins-Domingo notes, "This begins with community-centered engagement and prioritization across the research life cycle, from the substance and design of questions being asked, to culturally cognizant recruitment and retention of study participants, to analysis and reporting of results, and to monitoring and reporting across the research ecosystem to ensure that the goals of inclusion are met."[2] Of course, there is wide acknowledgement that strategies to increase participant diversity will require additional resources but that committing to doing so will help advance more inclusive and generalizable research.

In addition to strategies aimed at fostering trust and improving enrollment diversity, clinical researchers should also reconsider eligibility criteria for participation in research. A study by Plosky et al. found that 85 percent of protocols allowed broad investigator discretion in determining eligibility and often utilized phrasing so non-specific or expansive as to render entire groups ineligible.[3] They suggest that eligibility criteria be as inclusive as possible, that written justification be provided so that oversight bodies such as IRBs could review whether exclusion is justified, and that accommodations be considered, such as virtual visits, additional time for the informed consent process, communications assistance, American Sign Language interpreters, or transportation to study appointments.[3]

For LEP individuals, the provision of interpreters or translators could greatly reduce the underrepresentation of this group in clinical research. An interpreter is generally a person trained in the language of health care who conducts live interpretations between two people, while a translator is generally someone who translates text-based documents between the source language and the target language.[19] In thinking through the language support needed for a clinical trial, Willis et al. state, "it is important to distinguish trial contexts where language is required solely as part of the informed consent process (an ethical imperative for all research participants) and trial contexts where language is part of the intervention."[8] Generative AI models have recently been proposed as one means to meet the needs of LEP individuals and foster greater inclusion in clinical research. However, these technologies must be considered alongside issues of accuracy, safety, privacy, and other risks involved. For instance, due to differences in languages available for AI model training, translation performance in the US is significantly better for Spanish than for other languages with less diffusion, creating a higher risk for clinically significant errors for these linguistic populations.[20,21]

While digital health technologies, such as generative AI translators, may help support the inclusion of underrepresented and excluded populations, they should not be considered solutions on their own. Barriers such as a lack of broadband, digital literacy, and the potential for embedded biases should be carefully considered. It is also crucial not to dismiss the importance of building human connection with participants and communities, which is vital to building and sustaining trust.[9] To support enrollment diversity, all study protocols should include considerations for diverse linguistic groups, including LEP, deaf, and hard of hearing individuals and should provide clear protections for these groups during the informed consent process. As Alhalel et al. state, "Fulfilling the ethical demands for inclusive clinical trials also requires research funders to prioritize language access by including expenses for language assistance resources in all clinical trial budgets."[22]

RELEVANT AMA POLICY

AMA policies that support participant diversity in research include H-525.988, "Sex and Gender Differences in Medical Research," which affirms support for including "people of all sexes and gender identities and expressions in studies that involve the health of society at large".[23] H-460.881, "Increasing Diversity in Stem Cell Biobanks and Disease Models," encourages "participation by underrepresented populations" and the collection of "racially and ethnically diverse sample" to "better represent the population."[24]

Though not specific to research, H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," states that "patients should have access to documentation and communications in their preferred language" and that "physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires".[25] And H-180.944, "Plan for Continued Progress Toward Health Equity," defines health equity as a goal of our AMA.[26]

The AMA *Code of Medical Ethics* also contains several relevant opinions. Opinion 7.1.1, "Physician Involvement in Research," states that research participants "must be able to make informed decisions about whether to participate or continue in a given protocol."[27] Opinion 7.1.2, "Informed Consent in Research," states that physicians must ensure that research participants have "given voluntary, informed consent before enrolling".[28] Opinion 8.5, "Disparities in Health Care," states that physicians should "Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system" and support "the development of quality measures and resources to help reduce disparities."[29] And Opinion 11.2.7, "Responsibilities to Promote Equitable Care," states that physicians should "Identify institutional policies and practices that perpetuate or create barriers to equitable care" and "Participate in designing and supporting well-considered strategies for change to ensure equitable care for all."[30]

Viewed collectively, these policies reveal a commitment to supporting health equity, patient-centered care, and quality research, and provide a foundation for further policy development aimed at reducing the underrepresentation and exclusion of certain groups from clinical research.

CONCLUSION

While Resolution 007-I-24, "Supporting Diversity in Research," focused specifically on the need to increase representation of LEP individuals and deaf and hard of hearing people in clinical research, this report has examined the importance of supporting diversity in research for all underrepresented and excluded populations. Lack of participant diversity in research is an urgent problem that needs to be addressed. It is critical, for example, that the clinical researchers examine how various populations are defined and how these definitions impact who is included or excluded.[6] It is important to note, however, that barriers and solutions will vary by topic or field of study, the population, intervention, and the trial setting, such that local approaches will likely be more successful than one-size-fits-all practices.[5] For example, eligibility criteria should only be as strict as is medically and ethically necessary, and categorical exclusions should be avoided in favor of criteria that can be objectively assessed on an individual basis.[3] While strategies for promoting inclusion should not be overburdensome to the point of limiting the feasibility of carrying out research, improving diversity in clinical research is an ethical and scientific imperative that will lead to improved generalizability and health equity.[4,8]

Achieving greater representation in research will require a multifaced approach. Community engagement, decentralization of research sites, and use of digital tools can all enhance the accessibility of clinical research, and improving representation among investigators and clinical research staff may translate to improved recruitment and retention of underrepresented groups.[4] Gross et al. state, "It is imperative that industry sponsors and academic investigators embrace diversity in research and development to address the variability of individual patients treated"—highlighting the importance of centering representation at every stage of the research program.[14] True reform will require greater outreach to communities, targeted recruitment strategies, improved IRB and regulatory oversight, and stronger federal regulations and guidelines. As Hwang and Brawley acknowledge, "new diversity provisions [by the House of Representatives] do not fully resolve the underlying causes of a lack of representativeness in clinical trials, which include restrictive eligibility criteria, costs associated with participation, limited enrollment outreach in marginalized racial and ethnic communities and in safety-net facilities, implicit English-language requirements, and systemic inequities in access to care."[31] Addressing these systemic barriers will require a concerted effort and commitment by all stakeholders involved in clinical research.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 007-I-24 and the remainder of this report be filed:

1. That our American Medical Association support the use of language interpreters and translators at no cost to individual physicians or practices in clinical trials and health research participation to promote equitable data collection and outcomes.
2. That our AMA encourage Institutional and Research Review Boards (IRBs) to develop and publish standardized guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people.
3. That our AMA encourage Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for improving the diversity of research participants, including (1) that eligibility criteria be as inclusive as possible, (2) that written justification for exclusion be provided for review, and (3) that additional accommodations for potential enrollees be considered.
4. That our AMA support greater inclusion in clinical trials and health research of all peoples and groups that are underrepresented or excluded from such research to promote greater study generalization, health equity, and justice.
5. That our AMA support community-centered engagement before, during, and after clinical trials and health research to foster and sustain public trust in medicine and science.
6. That our AMA encourage that all study protocols involving human research participants include appropriate funding to support the inclusion of underrepresented and excluded populations.

Fiscal Note: Minimal – less than $500

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12. SUPPORT FOR DOULA CARE PROGRAMS

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policies H-35.958 and H-373.994

At the 2024 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 908 entitled, "Support for Doula Care Programs," was introduced by the Medical Student Section and called on the AMA to:

> Support access to continuous one-to-one emotional support provided by nonmedical support personnel, such as doulas, including for patients who are incarcerated or detained.

Resolution 908-I-24 was referred to the Board of Trustees because testimony noted concerns surrounding doulas' scope of practice and highlighted a need for additional information concerning doulas' level of training and credentialing. There were also several calls for referral for study of this item to better detail the role of the doula within physician-led, team-based maternity care.

BACKGROUND

Doulas

Doulas are trained individuals that provide "non-clinical physical, emotional, and informational support during the perinatal period. Doula work has also expanded to include the full spectrum of pregnancy outcomes (e.g., birth, abortion, adoption, miscarriage, stillbirth, and perinatal loss), as well as services to women, men, transgender, and gender non-conforming people."[1]

Doulas are meant to perform tasks such as providing emotional support for the birthing individual and their family, helping individuals and families navigate the health care system, assisting with referrals to community-based social services, aiding in creating an individual's birth plan, and performing additional non-clinical tasks throughout the

pregnancy, birth, and up to one year postpartum.[2] Most states that cover doula services in some capacity ensure that in the state's definition of a certified doula they emphasize that these individuals provide only non-clinical support.

Studies have shown that, when doulas provide appropriate non-clinical care, there can be improved outcomes for both the mother and the infant. For example, individuals that utilized a doula were four times less likely to deliver a baby with a low birth weight, two times less likely to experience a birth complication, more likely to breastfeed, and more likely to report a positive birth experience.[3] Additionally, a study found that women enrolled in Medicaid had a 47 percent lower risk of having a Cesarean section, were 46 percent more likely to attend a postpartum checkup, and had a 29 percent lower risk of preterm birth when utilizing non-clinical doula support.[4]

Medicaid

Medicaid is jointly funded through the states and the federal government with the federal government providing 69 percent of the approximately $880 billion that were spent on Medicaid in FY 2023.[5] States have a significant amount of control over how Medicaid is administered in their state including which benefits will be covered, which services are provided (such as dental care, prescription drugs, vision and more), and how much providers are paid.[6] These terms are defined either through statute or through state plans which set the scope of the Medicaid plans for each state and specify the terms for receiving matching funds from the federal government.[7] Changes and expansions to how and what states cover in their Medicaid programs can be made through State Plan Amendments (SPAs).

In 2021, Medicaid paid for about 41 percent of all births nationally and plays a critical role in providing maternity-related services.[8] In alignment with this, a growing number of states have submitted SPAs to allow for the coverage of doula care through Medicaid in some capacity.[9]

Medicaid can cover doula services under "multiple benefit categories, including preventive services, [or] services of licensed practitioners, clinic services, and freestanding birth center services."[10] Additionally, states can cover doula services through different state plan benefits. For example, "while there is no distinct Medicaid state plan benefit called home visiting, states may cover many of the individual component services of home visiting programs through existing Medicaid coverage authorities" thus allowing Medicaid payment for at home doula services.[11]

If doula services are categorized as preventive services, doulas would need to be recommended by a physician or other licensed practitioner in order to bill Medicaid. However, if care provided by a doula is considered to be part of the services of a licensed practitioner the doula would need to be licensed, or supervised by, and bill under a licensed practitioner.[12] The states that do cover doula services through Medicaid vary in what services they will cover, the number of visits that will be allowed, and the length of time that a doula can remain with a birthing individual.[13]

Many doulas are "solo practitioners and lack the capacity and infrastructure to manage health plan contracting and billing requirements, so many doulas require women to pay for their services out-of-pocket without using insurance."[14] However, when doulas do participate in Medicaid, payment rates for their services vary significantly by state and are often billed based on a combination of HCPCS, ICD-10, and CPT codes.[15,16] Moreover, some states have begun to try and increase the usage of doula services by utilizing "value-based payment arrangements to incentivize the use of innovative maternal health care delivery models and improve health outcomes."[17] However, Medicaid funding for each state has an overall limit and therefore payment for some providers, such as doulas, could limit payment for other providers, such as obstetricians and gynecologists (OB-GYN).

Training and Certification

Currently no mandatory licensure, certification, or credentialing requirements exist for doulas in the United States, but to be paid by Medicaid doulas are required to meet the qualifications put in place by the state in which they are providing services.[18] States vary significantly in what they require for doulas to be covered by Medicaid. (Please see Appendix A). However, in order to be able to receive payment from Medicaid almost all states require some form of certification.

Most states that cover doula services under Medicaid have multiple training pathways that doulas can undertake to gain certification. These pathways are usually divided into training pathways and experience pathways. Experience pathways are based on either preexisting credentials or hands-on experience that has been gained by the doula throughout the course of their career. Training pathways are based on undertaking classes and programs that cover

needed competencies as determined by the state. The training pathway for each state differs in terms of the courses required, competencies that are needed, and the length of the program. States that have this pathway often have a list of preapproved state and national organizations that offer a certificate upon completion of the training.

For example, there are numerous national organizations that offer some form of doula training and certification which most states that cover doula service via Medicaid will accept. Within this there are two larger organizations that are commonly used within the United States. These organizations are DONA International and the Childbirth and Postpartum Professional Association (CAPPA).

To be certified by DONA International as a birth doula, individuals must participate in a DONA International approved birth doula workshop that has at least 16 hours of instruction time and receive education in childbirth and lactation support. Education in this space includes eight hours of observation at classes taught to expectant parents, a three-hour lactation support class, provision of in person labor support for 15 hours, attendance at three births, and reading two position papers and four books from an approved reading list.[19]

To become a certified labor doula by CAPPA an individual must attend a CAPPA Labor Doula training class, read selected books from an approved reading list, pass the scope of practice pretest, watch certain training materials, attend three births, and pass an examination.[20]

Additionally, the National Doula Certification Board is gaining in influence. To be certified as a professional doula an individual must participate in an approved training course and complete at least 200 hours of training and 75 hours of hands-on clinical experience including attending five births, being current in CPR training, having OSHA/Bloodborne Pathogens and Universal Precautions training, and having professional liability insurance.[21]

The core competencies in each training program and state differ. However, all the training that doulas acquire is non-clinical. For example, most states require doulas to attend a certain number of births and birthing classes in a non-clinical support role, and undertake training on topics such as ethics, cultural competency, grief, lactation support, labor support techniques, anatomy throughout pregnancy, and engagement with hospital systems and community support systems. Please see the chart in Appendix A which covers the state-required core competencies where they exist.

Moreover, most states require that doulas complete some training on Health Insurance Portability and Accountability Act (HIPAA) compliance, possess up to date CPR certifications for both adults and infants, pass a background check, provide necessary documentation of any required training or certifications, fill out an application, and pay associated fees.

It should be noted that many states do not preclude doulas who are not certified from practicing but rather prevent these individuals from calling themselves "certified doulas" and do not allow these individuals to bill Medicaid for their services.

Nevertheless, throughout all states, doulas must remain within the scope of their practice when providing support and must "always remain non-clinical and non-medical...Birth doulas do not perform vital sign checks, fetal heart tone checks, nor any cervical examinations. When practicing as a birth doula, it is outside scope of practice to provide any medical advice, diagnose, or treat anything. This includes but is not limited to specific dietary recommendations, suggestions for over-the-counter medication, or 'natural' products such as supplements…All clients should be redirected back to their health care provider or qualified professional for medical advice, [and] treatment…."[22] In alignment with this a number of states have created some form of oversight for certified doulas, usually in the form of a Doula Registry or Certification Board which can suspend or revoke licensure if doulas are not following the requirements surrounding their training and certification.

Private Insurance

As of April 2025, only Rhode Island and Louisiana require coverage of doula services from private insurance plans. Rhode Island has fully implemented and requires both private plans and Medicaid to cover doula services.

In addition to these two states, four states are currently working to implement mandated doula coverage for private insurance plans. These states are Colorado, Illinois, Virginia, and Delaware. Colorado is trying to begin implementation of its doula services requirement this year but has experienced challenges in implementation including

difficulties with creating a provider registration system. Virginia is also slated to begin implementation this year, but the State Corporation Commission has not yet included doula care in its mandated benefits list. Illinois and Delaware will begin enforcing this benefit in 2026.

Furthermore, Utah has made doula services available to state employees via the Public Employees' Benefit and Insurance Program, and California covers doula services through CalPERS for public employees. However, neither state mandates that state-regulated private insurance plans must cover doula care. [23]

DISCUSSION

Doulas can play a beneficial role for pregnant, birthing, and postpartum individuals and their families. However, it is imperative that doulas remain strictly within their defined scope of practice by providing only support services that do not involve clinical care. To help ensure this, a number of states have begun to require doulas who want to become Medicaid providers to gain a certificate and register with the state. Though education, certification, disciplinary, and insurance requirements differ significantly among the states that offer doula services through their Medicaid plans, most states do have some form of oversight for these providers. These additional competencies and checks can help to ensure that doulas are properly educated and perform duties only within their non-clinical support role. Nevertheless, there are still states that do not yet cover doula services and do not yet have training, licensure, and other requirements for doulas in place.

Additionally, doulas are not yet widely utilized due to several issues including access, payment, and a lack of knowledge surrounding doula services.[24] With certified doula services either not covered or only recently covered by insurance, many providers and birthing individuals do not yet understand the services offered by and the scope of practice of a doula. Additionally, many Doula Registry or Certification Boards are new, and their oversight capability is uncertain. Colloquially, it has been noted that doulas have at times exceeded the scope of their support role and provided medical advice such as recommending that birthing individuals continue to push rather than receive a Cesarean section, recommending individuals not receive an epidural, and providing other advice that could be categorized as clinical. Furthermore, though some states require liability insurance for certified doulas, others do not. (See Appendix A). This means that if doulas exceed the scope of their nonclinical support role, have ethical violations, engage in professional negligence or misconduct, patients may not be able to recover adequate compensation for any damage that occurs. Moreover, doulas themselves do not have the added layer of protection that insurance offers in some states.

The Board further notes that there are multiple types of doulas and doula certifications, including birthing doulas, lactation doulas, postpartum doulas, and even doulas who do not engage in birthing care but instead provide care to other populations such as individuals who are dying. As such, the Board believes that carte blanche support for doulas cannot be given at this time.

However, when doulas are working as part of a physician-led care team, there can be positive outcomes for the birthing individual and the infant. To help facilitate this, some hospital systems are beginning to issue guidebooks to help physicians and other care providers understand the role of a doula and to outline ways in which doulas can be utilized.[25] For example, New York has highlighted that doulas can be utilized to do things like help the birthing individual ambulate while in labor, access and understand hospital labor and delivery policies, facilitate discussions surrounding a birth plan, acquire their placenta, and more.[26] Additionally, some states require that doulas either work under or are referred by a physician in order to receive payment from Medicaid. Therefore, increased education about how to effectively utilize a doula as part of a birth team can have positive impacts and aid physicians providing maternal care. So long as doulas remain within their scope of practice they can help facilitate increased communication, compliance, and comfort for patients within the health care system.

Moreover, since Medicaid funds a large percentage of births across the United States it is important that the addition or maintenance of doula services in state plans does not disrupt or minimize payment for physicians who participate in Medicaid, especially OB-GYNs and other physicians who provide maternal and infant care. States have limited budgets that they must allocate within their Medicaid programs and Medicaid providers are already typically paid less than they are by private insurance. (See Appendix B). According to the Medicaid-To-Medicare Fee Index, developed by researchers at the Urban Institute, Medicaid physician fees were approximately 87 percent for obstetric care in 2024.[27] Using data from FAIR Health's private health insurance claims database from March 2019 to February 2020, researchers at the Urban Institute estimated that commercial rates averaged 110 percent of Medicare for obstetrics and gynecology, without providing specific information about maternity care.[28] However, we do know that Medicare

physician payment rates are inadequate, having declined 33 percent from 2001 to 2025 when adjusted for inflation in practice costs.[29] The national Medicare physician fee schedule payment amounts for maternity care services in 2025 include:

- $2,355.47 for CPT code 59400, which describes a global maternity care package, including vaginal delivery with antepartum and postpartum care.
- $2,616.51for CPT code 59510, which describes a global maternity care package, including Cesarean delivery, antepartum and postpartum care.
- $2,467.39 for CPT code 59610, which describes a global maternity care package, including vaginal delivery after previous cesarean delivery, antepartum and postpartum care.[1]

Additionally, with the passage of H.R.1, the "One Big Beautiful Bill Act," states will likely begin to face tighter budgets and experience budget deficits in Medicaid and as a result may have to cut services and payment rates for Medicaid providers.[30] Therefore, it is important that core services, such as access to reproductive and obstetrical services, are not compromised in favor of doula services.

Though the original Resolution 908-I-24 mostly considered care provided by doulas, there was a slightly broader context to the proposed resolution regarding non-medical support personnel. Existing AMA policy H-373.994, "Patient Navigation Programs," applies to patient navigators, community health workers, and other non-clinical public health workers and already acknowledges the beneficial role these individuals can play in patient care while providing guidelines for patient navigators to follow. Since the existing AMA policy already covers these non-medical support personnel, the existing policy should be reaffirmed.

CONCLUSION

Doulas can play an important role in maternal care, as part of a physician-led care team, if they strictly adhere to their non-clinical support role. As part of this, especially if funding for doula services will be incorporated into Medicaid funding, it is imperative to ensure that doulas are required to undertake adequate training so that they can provide the necessary support to birthing individuals and their families within the scope of their support role. Therefore, there should be oversight of doula services that help ensure that doulas provide only non-clinical support, ensure that licensure is a required component of providing services, confirm that doulas are overseen by an appropriate disciplinary board, and that doulas obtain liability insurance. Moreover, access to and payment for doula services should never compromise patient access to and payment for physician services.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 908-I-24, and the remainder of the report be filed.

1. Our American Medical Association (AMA) recognizes that access to doula services for pregnant and birthing individuals can have a positive impact on birth outcomes.

2. To help ensure that doula services enhance patient care, our AMA supports doula services when doulas provide non-clinical peripartum and birthing support and:
    a. possess registration/licenses/certifications that include training specifically limited to nonclinical support and adhere to state certification requirements;
    b. retain registration/licenses/certifications that are continuously monitored and overseen by a disciplinary board within the state that the doula is certified and delivering services;
    c. obtain liability insurance that has an adequate level of coverage;
    d. fully disclose relevant training, experience, and credentials, to help patients understand the scope of non-clinical support the doula is qualified to provide;
    e. work in partnership with a physician-led care team; and
    f. do not compromise access to physician care.

[1] Maternity care services are on the agenda for the CPT Editorial Panel's September 2025 meeting and following any coding changes, new or revised codes may be reviewed by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).

3. That existing AMA Policy H-373.994, "Patient Navigation Programs," be reaffirmed.

Fiscal Note: Less than $500.

APPENDIX A: DOULA STATE LICENSURE AND TRAINING REQUIREMENTS

State	Licensure Requirements	Training/Pathways
Alabama	There are not any licensure requirements or any statutory coverage requirements for Doula services in Alabama.	
Alaska	There are not any licensure requirements or any statutory coverage requirements for Doula services in Alaska.	
Arizona [31, 32, 33]	Doula certification is voluntary but is needed to bill for services. Must be 18 years of age or older. Must have at least a high school diploma or high school equivalency diploma. A social security number and documentation of citizenship or alien status. Complete first aid and adult basic CPR through a course recognized by the American Heart Association. Complete neonatal resuscitation through a course recognized by the American Academy of Pediatrics or American Heart Association. Agree to a code of ethics as prescribed by the Department. The Department may deny, suspend, or revoke a certification. Does to have a complaint, allegation, or investigation pending from another regulatory entity in another state or country related to unprofessional conduct and has not voluntarily surrendered a certification or license in any other state or country while under investigation for unprofessional conduct. Complete a background check. Submit an application. Pay the fees. Must renew their license every three years by putting in an application and paying the necessary fees and completing 15 hours of continuing education.	For all pathways an individual must have written documentation of: • Observing at least one birth after completing the specified training or education, signed and dated by the medical provider or licensed midwife who assisted the laboring mother • Attending a minimum of three births while serving as the primary doula, including evaluations from the laboring mother and from the medical provider or licensed midwife who assisted the laboring mother ○ Proof of current certification from a nationally recognized doula organization may substitute for some of the education requirements Pathway One: • Completion of at least 30 hours of in-person instruction or a combination of in person and online instruction in core competency • Must have a doula competency attestation form Pathway Two • Community training in non-western doula practices, as determined by the Department, documentation confirming that core competencies have been met through culturally specific training or education subject to Department review • Must have a doula competency attestation form Pathway Three • Other related individualized or experiential training or education that is subject to review by the Director • Must have a doula competency attestation form

State	Licensure Requirements	Training/Pathways
	Must be recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law. Services must be documented in the member's medical record and may include care coordination, social support, coaching, and emotional support.	Pathway Four • Proof of current certification from an approved training organization Pathway Five – Practice Pathway: • Individuals practicing as a doula in Arizona for at least five years before September 29, 2021, may be eligible to be a certified doula if the individual has: o Proof of current certification from a nationally recognized doula organization o Three letters of recommendation from medical providers or licensed midwives who have worked with the individual within the preceding two years and can attest to the individual's competency in providing doula services Pathway 6 – Reciprocity Pathway: • Must complete application • Must have been credentialed in another states for at least one year Meet the requirements of core competencies and certified doula scope of practice. Core competencies include: • Entrepreneurship • Standards of practice and ethics • The childbirth processes • Parental engagement • Postpartum care • Grief • Trauma-informed care • Cultural doula practices • Anatomy and physiology • HIPAA
Arkansas [34]	Must be 18 years of age or older. Must maintain a certification from a doula certification organization designated by the department in conjunction with the Doula Alliance of Arkansas, or hold a certificate as a doula from the Doula Alliance of Arkansas. Must create and maintain a publicly accessible registry for certified doulas. Pay application fee. Must recertify every two years and complete 10 hours of professional development over that time and pay applicable fees.	

State	Licensure Requirements	Training/Pathways
	Department of Health may suspend, revoke, or refuse to issue or renew the certification of a certified community-based doula.	

California [35, 36]	Must be at least 18 years old.
	
	Enroll as a Medicaid provider.
	
	Obtain a National Provider Identifier (NPL).
	
	Have a social security number.
	
	Possess an adult/infant CPR certification.
	
	Complete basic HIPAA training.
	
	Must be certified but the certificate does not need to be from a specific organization as long as it covers the requirements listed in the Medi-Cal Provider Manual: Doula Services.
	
	The requirement for different types of insurance is dependent on the local requirements (county/city) where the doula provides services.
	
	Must complete three hours of continuing education every three years.
		Training Pathway:
		• Complete a minimum of 16 hours of training in the following areas:
		  ○ Lactation support
		  ○ Childbirth education
		  ○ Foundations on anatomy of pregnancy and childbirth
		  ○ Nonmedical comfort measures, prenatal support and labor support techniques
		  ○ Developing a community resource list
		• Attest that they have provide support as a doula at a minimum of three births
		
		Experience Pathway:
		• At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
		• Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization.
		  ○ Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization, or an enrolled doula

Colorado [37, 38]	Must be at least 18 years of age. Enroll as a Medicaid provider, register as a doula, and obtain an NPI. Complete the Doula Provider Attestation Form. Submit a copy of current CPR certification. Sign the Doula Code of Conduct. Must pass a background check. Must recertify every five years.	The Certification Pathway: • Completion of a training program that is approved by the Department • Attendance at a minimum of three births within the last five years The Experience Pathway: • Attendance at 10 births in the role of a Doula with five births within the past two years • Submission of four letters of recommendation that include two letters from clinical members of a birth team (e.g., Nurse, Nurse Practitioner, Midwife, Obstetrician) for a previously attended birth, and two letters from previous clients • Attesting to having knowledge and competency in specific prenatal,

State	Licensure Requirements	Training/Pathways
		labor/delivery, postpartum lactation, and newborn areas of care
Connecticut [39]	Allows for doulas to perform services but they may only be called certified doulas if they meet the delineated criteria. Must be eighteen years of age or older. Apply to and be certified by the Department of Public Health and pay an application fee. Must have two reference letters from families or professionals with direct knowledge of the applicant's experience as a doula verifying the applicant's training or experience. If the rules are not followed disciplinary action may be taken. Must renew certification every three years and complete continuing education requirements.	Training Pathway: • Demonstration of the applicant's completion of a doula training program or a combination of approved programs Experience Pathway: • An attestation by the applicant that such applicant has provided doula services to at least three families and training in not less than four core competencies identified by the Doula Training Program Review Committee during the five years preceding the date of the application Certification by Endorsement: • Present evidence satisfactory to the commissioner that the applicant is certified as a doula in another state or jurisdiction whose requirements for certification are substantially similar to those of this state for not less than two years before the date such doula submits an application for certification. • No certification shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.
Delaware [40, 41]	Must have an insurance policy that meets the requirements. Documentation of fingerprint background check. Must live or work in Delaware. Must sign a Code of Ethics. There will be a demographic collection. Must attest to being a doula, obtaining the credentials for Medicaid reimbursement purposes, and to understanding the credential is not a certification or verification of education. Must be recertified every three years with 20 hours of continuing education and documentation of one birth.	Training Pathway: • Documentation of a total of three births, of which one the applicant is the primary doula providing labor support to the client within the last three years. • Documentation of a minimum of 16 total hours of birth and labor doula education which includes: lactation support, childbirth education, nonmedical comfort measures, prenatal support, labor support techniques, and postpartum support. • Documentation of current CPR certification; certificate(s) must include competencies for adults and infants. • Documentation of HIPAA training: one hour Legacy Doula: • Documentation of a minimum of 15 clients within the last three years. • Documentation of nine births attended within the last three years.

State	Licensure Requirements	Training/Pathways
		• Documentation of current CPR certification; certificate(s) must include competencies for adults and infants. • Documentation of HIPAA training: one hour • Documentation of two professional evaluations • Submission of an essay on lived experience that is at least 250 words
Florida [42]	Services are up to the individual state managed care plans, and so the Agency for Health Care Administration does not have broader authority or control over implementation of the doula benefit. Each Medicaid managed care plan in the state is able to determine the scope and administration of the benefit, as well as credentialing requirements and reimbursement.	
Georgia	There are not any licensure requirements or any statutory coverage requirements for Doula services in Georgia.	
Hawaii	There are not any licensure requirements or any statutory coverage requirements for Doula services in Hawaii.	
Idaho	There are not any licensure requirements or any statutory coverage requirements for Doula services in Idaho.	

Illinois [43]	Must be 18 years old or older.
	
	Submit all application paperwork to Southern Illinois University (SIU) School of Medicine (SOM). Office of Certification System.
	
	Must be certified by the Illinois Medicaid-Certified Doula Program, a partnership between HFS and the SIU SOM.
	
	Must enroll in the Department of Healthcare and Family Services IMPACT system.
	
	Must recertify every three years.
		Training Program Pathway:
		• Active doula (three perinatal doula experiences within past 12 months)
		• Completion of labor and postpartum doula certification from an approved training organization
		• Completion of courses below if they are not a part of approved provider training:
		  ○ Cultural Competency/Bias Training
		  ○ HIPAA (Health Insurance Portability and Accountability Act)
		  ○ Trauma-informed Care
		  ○ CPR/Basic Life Support
		  ○ Anatomy and Physiology (Pregnancy and Birth)
		
		Legacy Doula Pathway:
		• Active doula (five perinatal doula experiences in the past three years)
		• Completion of courses below:
		  ○ Cultural Competency/Bias Training
		  ○ HIPAA (Health Insurance Portability and Accountability Act)
		  ○ Trauma-informed Care
		  ○ CPR/Basic Life Support
		  ○ Anatomy and Physiology (Pregnancy and Birth)

State	Licensure Requirements	Training/Pathways
Indiana [44]	Must be trained and certified by a nationally recognized institution in providing emotional and physical support, but not medical or midwife care, to pregnant women before, during, and after childbirth. Medicaid coverage is allowed but no budget has been allocated for this coverage.	
Iowa [45]	There is currently a pilot program underway called the Maternal Health Doula Project, but there do not appear to be any licensure requirements associated with this program at this time.	
Kansas [46]	Complete the Doula Attestation Form. Must have a W9. Provide support at a minimum of three births. Must recertify every three years and complete 10 hours of continuing education.	Current Doula Pathway: • Must have a Doula certification from an approved training program New Enrollment Training Pathway: • Certificate of Completion for 30 hours of training in any combination of the following areas: ○ Birth Doula Training ○ Antepartum Doula Training ○ Postpartum Doula Training ○ Lactation Support ○ Childbirth Education ○ Foundations on Anatomy of Pregnancy and Childbirth ○ Nonmedical Comfort Measures, Prenatal Support, and Labor Support Techniques ○ Postpartum Health ○ Reproductive Health Counseling ○ Pregnancy Loss and Support ○ Cultural Competency ○ HIPAA Training ○ Adult and Children/Infant CPR Certification ○ Developing a Community Resource List
Kentucky [47]	There do not appear to be any licensure requirements or any statutory coverage requirements for Doula services in Kentucky. However, companies such as Humana do cover doula services in Kentucky.	
Louisiana [48, 49, 50]	Must be at least 18 years of age. Possess either a high school diploma or high school equivalency documentation. Be a citizen of or lawfully authorized to be employed in the United States. Apply to and be registered by the Louisiana Doula Registry Board.	Experience Pathway: • Submission of three letters of recommendation from clients to whom the individual has provided doula services within the previous five years. Such letters must provide specific details concerning the names, dates, and services provided or • Submission of proof that the individual contracted with and provided doula

State	Licensure Requirements	Training/Pathways
	Acceptance as a Medicaid provider and have an NPI. The board can revoke the registration of a doula who violates professional standards. Must recertify every five years and must complete 20 contact hours of continuing education during that time. If an applicant does not recertify in time, they may still have their credentials reinstated if they apply within one year of their credentials elapsing.	services to at least three clients within the previous five years Training Pathway: • Demonstrate receipt of a certificate of completion of training as a doula by a board approved doula training organization • The curriculum for training doulas must include at least eight hours of instruction having significant intellectual, practical, or clinical content, dealing with matters related to maternal healthcare, including during pregnancy, intrapartum, and postpartum
Maine [51]	Maine is in the process of developing standards.	
Maryland [52, 53, 54, 55]	Enroll as a Medicaid provider and meet all conditions for participation. Have an NPI. Be at least 18 years of age. Maintain up to date certification through a doula certification program approved by Maryland Medicaid and present proof of all specified certifications. Maintain up to date certification through an accepted doula certification program. Have adequate liability insurance. Pass a background check. An obstetrician-gynecologist, family medicine practitioner, or certified nurse midwife must be present while doula services are provided during labor and delivery.	
Massachusetts [56]	Must be at least 18 years old. Enroll as a MassHealth doula provider and get an NPI. Complete trainings provided by the Executive Office of Health and Human Services (EOHHS) on topics including, but not limited to: • Overview of the MassHealth Doula Services Program, including best practices for meeting the needs of diverse MassHealth members and their families	Formal Training Pathway: • Provide a certificate of completion or other proof of doula training(s) attended, and/or proof of doula certification by a doula-certifying organization and a completed attestation form, using the template provided by EOHHS, stating that the completed formal training(s) covered the required competencies listed above. Experience Pathway: • Provide the following recommendations using templates provided by EOHHS: o Recommendations from at least three different former clients for

State	Licensure Requirements	Training/Pathways
	• Federal and state laws and regulations established for the protection of the privacy and security of the member information doulas create, use, collect, store, and/or transmit • Navigating MassHealth-covered services and community resources for MassHealth members	whom the prospective MassHealth doula provided doula services (either paid or volunteer) within the last five years ○ Recommendations from at least two different licensed health care providers such as physicians, midwives, social workers, or nurses who observed the applicant providing doula services within the last five years Out-of-state Providers: • Obtain a MassHealth provider number and meet the following criteria: ○ Be legally authorized to perform the services of a doula in their own state ○ Participate in their state's Medicaid program (or the equivalent) ○ Meet the conditions for Out-of-state Services. Formal Training Pathway and Experience Pathway must have the core competencies which include: • Basic understanding of the following topics at a minimum, as those topics relate to the ability to provide emotional, informational, and physical support to individuals and families during the perinatal period, regardless of the outcome of the pregnancy: ○ Maternal anatomy and physiology during the perinatal period, including basic fetal growth and development in each trimester of pregnancy ○ Common medical interventions during pregnancy, childbirth, and the postpartum period ○ Common potential complications associated with pregnancy, childbirth, and the postpartum period, including but not limited to: ▪ Pregnancy and infant loss ▪ Mental health conditions including Perinatal Mood and Anxiety Disorders (PMADs) ▪ Substance use disorder (SUD) ▪ High blood pressure ○ Labor and delivery comfort measures ○ Best practices for supporting members in advocating for their needs and making informed

State	Licensure Requirements	Training/Pathways
		decisions using a trauma-informed approach ○ Basic newborn care, including the fundamentals of breastfeeding/chest feeding
Michigan [57, 58]	Must be at least 18 years of age. Possess a high school diploma or equivalent. Must be on the Michigan Department of Health and Human Services (MDHHS) Doula Registry. Enroll as a Medicaid provider, obtain an NPI, and complete an online application. Possess a certification for completing training provided by an MDHHS approved doula training program or organization. Have liability insurance	At a minimum, a doula training program must include skill development in the following areas: • Communication, including active listening, cross-cultural communication, and interprofessional communication • Perinatal self-care measures • Coordination of and linkage to community services and resources • Labor and coping strategies • Newborn care and supportive measures MDHHS is currently researching pathways for legacy certification, or certification for doulas by providing proof of experience in lieu of training, within the confines of state and federal regulations.
Minnesota [59, 60]	Submit an application by going to the Minnesota Department of Health Licensing System. Provide evidence of maintaining a certification from one of the designated/approved Doula Certification Organizations and pay the requisite fee. Pass a criminal background check. Must renew certification and provide updated information to the doula registry every three years.	
Mississippi	There are not any licensure requirements or any statutory coverage requirements for Doula services in Mississippi.	
Missouri [61]	Must be at least 18 years of age. Must be enrolled as a MO HealthNet provider and have an NPI. Must have liability insurance as an individual or through a supervising organization. Complete a professional background check. Completion of at least six continuing education unit hours per year or equivalent continuing education as specified by the training organization.	Must possess a current certificate issued by a national or Missouri-based doula training organization whose curriculum meets the following definition and standards: • Curriculum that covers a doula's role, which includes breastfeeding support, perinatal mood and anxiety disorders, anticipatory care strategies, cultural competency, how to deliver perinatal education and support, how to increase client autonomy during birth, and how to support clients who may need additional care. • Understanding the importance of health-related social needs, including navigation of social services, trauma-

State	Licensure Requirements	Training/Pathways
		informed care, and strategies specific to the community served. • The student must successfully complete the training program and be deemed competent to provide doula services. Certification is attained after evaluation by a birth professional or trainer. For doulas whose training came from another source, or from multiple sources, MO HealthNet will determine eligibility for reimbursement as follows: • If there exists any statewide organization composed of doula trainers from three or more independent, well-established doula training organizations located in Missouri whose purpose includes validation of core competencies of trainings, then MO HealthNet may verify that an individual's training and experience satisfies the above-stated criteria through a public roster maintained by such an organization • If no such organization exists, future doula training organizations must prove that their training satisfies the above definition in order to be added to the written policy guide, which will include a list of all approved certification programs.
Montana [62]	Pay the fee. Submit a completed application. Satisfactorily complete competencies that meet the established requirements. Not engage in unprofessional conduct. Not currently subject to any disciplinary proceedings. May be disciplined in accordance with law.	Experience Pathway: • Serves as an unlicensed doula for a period prior to January 1, 2026, may be licensed if: ○ Provides sufficient evidence to the department of labor and industry that their experience providing doula services is equivalent to the requirements for licensure defined-2025 69th Legislature 2025 SB 319 by department rule. ○ To be eligible for licensure under this section, an individual shall demonstrate the evidence to the department on or before December 31, 2027.
Nebraska	There are not any licensure requirements or any statutory coverage requirements for Doula services in Nebraska though a pilot program is underway.	
Nevada [63, 64]	Current adult and infant CPR certification. Must agree to adhere to the Nevada Certification Board's birth doula specific code of ethics.	All training for initial certification must have been completed within the past five years from an NCB approved foundational birth doula training that includes the core competencies of:

State	Licensure Requirements	Training/Pathways
	Must live or work in Nevada at least 50 percent of the time. Must maintain certification from the Nevada Certification Board. Enroll as an individual Nevada Medicaid Provider and get an NPI. Must pay the associated fees. Must recertify every two years by paying the renewal fee, having proof of current adult and infant CPR certification, and completing 20 hours of continuing education in the Nevada Birth Doula Competencies.	• Perinatal counseling and support services • Labor support • Infant care • Four hours of NCB approved training in Trauma-Informed Care • Six hours of NCB approved training in Cultural Competence/Cultural Humility • One hour of NCB approved training in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Attendance at a minimum of one birth within the past five years, with a recommendation submitted to NCB by the birthing individual.
New Hampshire [65]	Doula certification and lactation service certification is voluntary. The doula and lactation consultants certified by the office of professional licensure must be credentialed by an organization accredited by: • The American National Standards Institute • The National Commission for Certifying Agencies • Another nationally or internationally recognized accreditation organization identified by the office of professional licensure.	
New Jersey [66, 67, 68]	Must be at least 18 years old. Must have HIPAA training. Must have adult/infant CPR certification. A certified doula has received and maintains a certification to perform doula services from an approved training program or organization. The Department of Health has a Doula Registry for doulas that: • Submit to the department an application for inclusion on the registry, and whose application is approved by the department • Pays any applicable fees established by the department • Passes a criminal history record background check • Annually submits evidence that the applicant is a certified doula Enroll as a Medicaid provider.	Doula training programs must be approved by the New Jersey Department of Human Services (NJ-DHS)—in consultation with the NJ Department of Health (NJDOH). There is a list of recognized training programs. Approved community doula training programs must include: • Core competency training that includes evidence-based perinatal education, birth plan development, continuous support during labor, comfort measures, and infant feeding • Practical (hands-on) experience, including prenatal, labor, birth and postpartum observation/support • Community-based/cultural competency training that includes delivering person-centered and trauma-informed care, and facilitating access to NJ-specific community-based resources • Relevant readings associated with classroom hours, cultural competency,

State	Licensure Requirements	Training/Pathways
	Must pass a background check. Must have liability insurance.	HIPAA and CPR training, and practical experience
New Mexico [69, 70, 71]	Be at least 18 years old at the time the application is submitted. Maintain a current adult and infant CPR certification from the American Red Cross or American Heart Association. Have a Driver's License or state-issued identification card. Live in, or within 100 miles, of New Mexico. Provide attestation of having completed HIPAA Training within one year prior to the date of the Doula Certification application. Complete one of three Pathways towards Doula Certification with the NM Department of Health. Must pass a background check. Enroll as a Medicaid provider. Must recertify every two years with 24 hours of continuing education completed during that time.	Pathway 1 Training Pathway: • Certified in an identified doula training program. Pathway 2 Core Competencies Pathway: • Complete a doula training that meets the requirements for core competencies. • Provide attestation of the completion of services to three doula clients. Pathway 3 Experience Pathway: • Provide three letters of recommendation attesting to the competency of the applicant's skills and experience as a doula. • Provide attestation of the completion of services to three doula clients in either a paid or voluntary capacity. • Have at least two years of experience providing doula services without formal training.
New York [72, 73]	Must be 18 years or older. Have current adult and infant CPR certification. Have current liability insurance. Review and comply with HIPAA and complete HIPAA training. NYS Medicaid Fee-for-Service Doula Directory. Enroll as a New York State Medicaid provider and obtain an NPI. Must recertify as a New York State Medicaid provider every five years and demonstrate completion of continuing education.	Training Pathway: • 24-hour minimum training in all required competencies • Doula support provided at a minimum of three births Work Experience Pathway: • 30 births or 1000 hours of doula experience within the last 10 years • Testimonials of doula skills in prenatal, labor and postpartum care
North Carolina	There are not any licensure requirements or any statutory coverage requirements for Doula services in North Carolina.	
North Dakota	There are not any licensure requirements or any statutory coverage requirements for Doula services in North Dakota.	

State	Licensure Requirements	Training/Pathways
Ohio [74]	Be at least 18 years of age at the time of submitting the doula application. Submit an application. Pay the required fee. Be certified by a doula certification organization that is recognized on an international, national, state, or local level, for training and certifying doulas, or, if not certified, have education and experience considered by the board to be appropriate. Must complete a background check. Must recertify every other year.	Certification Pathway: • If applying based on certification by a doula certification organization recognized on an international, national, state, or local level, for training and certifying doulas, the certification must be current and must either be: o Provided directly to the board by the doula certifying organization; or o If provided by the applicant, the applicant must provide contact information sufficient for the board to verify the certification. o Must attest that they have completed four hours of training directly related to racial bias, health disparities, and cultural competency either through their doula certification organization or otherwise. Education and Experience Pathway: • Complete ten hours of education that meets the requirements of the Administrative Code for doula continuing education. o At least four of those hours must be training directly related to racial bias, health disparities, and cultural competency. o The remaining six hours should relate to the doula's practice. • Education may be demonstrated by attestation to having completed education meeting these requirements. At the discretion of the board, the applicant may be required to show proof of completion of the education. • Must have been actively engaged in practice as a doula for three years immediately prior to the date the application is submitted to the board. Alternatively, may attest to having provided doula services to five clients over the three years immediately prior to the date of the application. At the board's discretion, an applicant may be required to provide date spans and a general description of the doula services provided for each of the five clients.
Oklahoma [75]	Must be 18 years of age. Obtain and maintain a National Provider Identifier (NPI). Enroll as a SoonerCare Contracted provider.	

State	Licensure Requirements	Training/Pathways
	Use the taxonomy number required by the State. Possess one of the following certifications from an organization recognized by the Oklahoma Health Care Authority: • Birth doula • Postpartum doula • Full-spectrum doula • Community-based doula	

Oregon [76, 77]	Enroll as a Medicaid provider.
	
	Have current CPR certification for children/infants and adults.
	
	Complete Oral Health training.
	
	Be state-certified as a Traditional Health Worker (THW).
	
	Adhere to THW Standards of Professional Conduct.
	
	Be certified and registered with the OHA, Office of Equity and Inclusion with approved curricula used to train birth doulas.
	
	Must complete a background check.
	
	Recertification Requirements:
	
	• At least 20 hours of continuing education during every three-year renewal period. A minimum of three hours within the 20 hours must be suicide risk assessment, treatment and management appropriate to their scope of work.
	• A current CPR certification for children/infants and adults
		New Applicants:
		• A minimum of 40 contact hours from an Authority approved training program that includes a minimum of 28 contact hours of in-person education offered by an Authority approved training program, that includes any combination of childbirth education and birth doula training in addition to completing the 12 hours of training topics through an Authority approved training program or through another training program provided by a birth doula certification organization.
		• Six contact hours in cultural competency training.
		• Six contact hours in one or more of the following topics as they relate to birth doula care:
		  ○ One hour of interprofessional collaboration.
		  ○ One hour of Health Insurance Portability and Accountability Act (HIPAA) compliance.
		  ○ Four hours of trauma-informed care.
		• Complete a 1.5 hour OHA-approved oral health training.
		• Create a community resource list for the geographical areas served.
		• Document attendance at a minimum of three births.
		• Document attendance at a minimum of three postpartum visits.
		
		The Legacy Clause:
		• A clear copy of government issued identification
		• An OHA-approved oral health training
		• Proof of attending 10 births and providing 500 hours of community work supporting birthing persons and families in the capacity of a birth doula within the five years.

State	Licensure Requirements	Training/Pathways
		• Community resource list specific to the region you are providing doula services to. • One letter of recommendation from any previous employer/client for whom THW services were provided within the last five years. Letter must be on professional letterhead, must contain author's signature and contact information. Job duties must be listed as they relate to the worker-type you are applying for. Competency Test: • If you have had your certification expired for more than six months you can take the Competency Skills Test to renew your certification by: o Passing the Competency Skills Test o Having proof of 20 CEUs required for worker type with three of the 20 hours coming from suicide prevention training (must be completed in the last 3 years) o Oral health training (must be completed in the last 3 years) o Current CPR certification for children/infants and adults Note: All core curriculum for training birth doulas must cover the following topics: • Anatomy and physiology of labor, birth, maternal postpartum, neonatal transition, and breastfeeding; • Labor coping strategies, comfort measures, and non-pharmacological techniques for pain management; • The reasons for, procedures of, and risks and benefits of common medical interventions, medications, and Cesarean birth; • Emotional and psychosocial support of birthing persons and their support team • Birth doula scope of practice, standards of practice, and basic ethical principles • The role of the birth doula with members of the birth team • Communication skills, including active listening, cross-cultural communication, and inter-professional communication • Self-advocacy and empowerment techniques • Breastfeeding support measures • Postpartum support measures for the birthing person and baby relationship

State	Licensure Requirements	Training/Pathways
		• Perinatal mental health • Family adjustment and dynamics • Evidence-informed educational and informational strategies • Community resource referrals • Professional conduct, including relationship boundaries and maintaining confidentiality • Self-care

Pennsylvania [78, 79]	Must be at least 18 years old.
	
	Must be certified by the Pennsylvania Certification Board.
	
	Documentation of current CPR certification for adults and infants.
	
	Pay the required fee.
	
	Three client evaluations from families served.
	
	Must be recertified every three years.
		Training Pathway:
		• Must be educated through an approved doula certifying or training body that meets core competencies
		  ○ There is no time limit on when the education/training was received and no limit to the amount of online education that may be submitted
		  ○ Training must be non-repetitive meaning the same training cannot be claimed more than one time even if the training is taken on different dates from different providers
		• Must have 24 total hours of relevant education/training to the Certified Perinatal Doula knowledge areas.
		• Must have one hour of training in HIPAA/client confidentiality.
		
		Experience Pathway:
		• One year of experience is required for applicants who have not obtained their education through an approved doula certifying body or an approved doula training organization.
		• Must be currently practicing, and experience must be acquired within two years prior to the submission of the application.
		• Three client evaluations from families served within the last year. If the applicant does not currently live in Pennsylvania, all client evaluations must be from clients living in Pennsylvania.

Rhode Island [80]	Certification is not required to practice as a doula in Rhode Island. Certification is for doulas who plan to accept insurance reimbursement and those contracting with Medicaid. Enroll as a Medicaid provider. Documentation of current CPR certification for adults and infants.	20 total hours of relevant education/training to the Certified Perinatal Doula domains: • 12 hours must be in birth doula training, antepartum doula training, postpartum doula training and/or childbirth education • At least one training must be a doula training • Two hours must be in breastfeeding or document a valid lactation certification

State	Licensure Requirements	Training/Pathways
	Documentation of current SafeServ certification for meal preparation. Certified by Rhode Island Certification Board. Pay the required fees. Live or work in Rhode Island at the time of applying for certification. Must be recertified every two years.	• Two hours must be attendance at a childbirth class or document a valid childbirth education certification • Three hours must be in cultural competency • One hour must be in HIPAA/client confidentiality • There is no time limit on when the education/training was received and no limit to the amount of online education that may be submitted • Training must be non-repetitive meaning the same training cannot be claimed more than one time even if the training is taken on different dates from different providers
South Carolina	There are not any licensure requirements or any statutory coverage requirements for Doula services in South Carolina.	
South Dakota [81, 82]	Must be at least 18 years old. Must maintain up-to-date certification through a doula certification program approved by South Dakota Medicaid.	
Tennessee [83]	Tennessee created a Doula Services Advisory Committee which is currently exploring ways to integrate Doulas into care in Tennessee. This Committee has made recommendations but there do not appear to be any licensure requirements or any statutory coverage requirements for Doula services in Tennessee at this time.	

Texas [84, 85]	Must be 18 years of age or older.
	
	Complete standardized HHSC training modules online with certificate of proof.
	
	Complete HIPAA training.
	
	Develop a Community Resource Document.
	
	Be certified by a recognized national certification program, as determined by HHSC.
		Doula Training Pathway:
		• HHSC standardized case management training for CPW through the Online Provider Education Portal
		  ○ Additional hours of core competency, doula-specific, training for applicants who do not meet the five year experience requirements:
		  ○ Childbirth education
		  ○ Lactation support. Or show proof of being a certified lactation counselor (CLC or IBCLC)
		  ○ Nonmedical comfort measures, prenatal support, and labor support techniques
		  ○ Chronic and acute health conditions during the perinatal period
		  ○ Cultural competency training
		• Attendance in at least three births with three written professional letters of recommendation
		
		Doula Experience Pathway:

State	Licensure Requirements	Training/Pathways
		• HHSC standardized case management training for CPW through the Online Provider Education Portal • Five years of experience in the capacity as a doula • Attendance in at least three births in the capacity of a birth doula with three written professional letters of recommendation
Utah [86]	Passed legislation asking that the state develop a state plan amendment to cover doula services, but it does not appear that there are licensure requirements yet.	
Vermont [87]	Does not require doulas to be certified to practice. Must be at least 18 years of age. Pay necessary fees. The Office of Professional Regulation may discipline a certified community-based perinatal doula for unprofessional conduct. Complete and submit an application. Pass any criminal history background or registry checks required by the Director. May discipline providers for unprofessional conduct. Must renew certification every two years.	Must have sufficient and appropriate competencies in community-based perinatal doula services, whether acquired through experience, mentorship, training, formal education, or a combination of these, as determined by the Director.
Virginia [88, 89, 90]	Virginia does not require a doula to be certified by a certifying body approved by the State Board of Health to practice as a doula. For certified doulas they must be enrolled as a Medicaid provider. Must be at least 18 years old. Any person seeking to be a Virginia state-certified doula must be a community-based doula and: • Meet the established qualifications and education requirements for the Certification of Doulas • Hold a certification as a certified doula from a certifying body approved by the Virginia Board of Health--Virginia Certification Board (VCB).	Within the last three years must have had 60 total hours specific to the knowledge areas from an approved certifying body approved by the State Board of Health. • Two hours must be in Maternal and Infant Health Concepts and Approaches • 10 hours must be in Lactation anticipatory guidance and support • 20 hours must be in Service Coordination and System Navigation • Eight hours must be in Health Promotion and Prevention • Five hours must be in Advocacy, Outreach and Engagement • Two hours must be in Communication • Eight hours must be in Cultural Humility and Responsiveness • Five hours must be in Ethical Responsibilities and Professionalism The training and education requirements do not apply to doulas who have already

State	Licensure Requirements	Training/Pathways
	Must recertify every two years and complete a minimum of 15 hours of continuing education from an approved training entity.	obtained an initial level of certification within the three years prior to January 6, 2022, and are applying to be a state-certified doula through the certifying body approved by the State Board of Health, provided that the applicant provides proof of completion of any unmet training and education requirements within one year of application.
Washington [91, 92]	Doula certification is voluntary. For individuals that want to bill Medicaid they must submit a completed application as required by the department and possess current certification as a birth doula with the Washington State Department of Health. Must be at least 18 years old. Satisfactorily complete competencies that meet the established requirements. Not engage in unprofessional conduct. Not currently subject to any disciplinary proceedings. Complete background check. Pay needed fees. Successfully complete culturally congruent ancestral practices, training, and education as required or complete the requirements under the ancestral pathway competencies. Culturally congruent ancestral practices, training, and education: • Demonstrate knowledge of culturally congruent ancestral practices, training, and education that upholds culturally congruent care. • Culturally congruent ancestral training or experience may include, but is not limited to: ○ History of obstetrics ○ Trauma-informed care ○ Social determinants of health ○ Adverse childhood experiences ○ Other training and education that enhances the applicant's knowledge of culturally congruent care or culturally congruent ancestral practices, training, and education.	Training Pathway: • Successfully complete training and education programs approved by the secretary that collectively introduce students to the key principles of the following topics: ○ Role of a birth doula ○ Prenatal and birth care ○ Postpartum care ○ Communication and interpersonal skills ○ Doula safety and self-care ○ Birth justice and advocacy Culturally Congruent Ancestral Practices (Experience) Pathway: • Submission of proof of successful completion of culturally congruent ancestral practices, training, and education which the secretary will review to determine whether the training and education meet the competency-based requirements. • Complete birth doula ancestral training that is substantially equivalent to the required training. Documentation of completion must include: ○ An attestation on forms provided by the department that they have completed training that is substantially equivalent to the required training or ○ Three written client testimonial letters or letters of recommendation from profession-related leaders or peers using testimonial templates provided by the department. Letters must be written within the last five years. One letter must be from either a licensed provider, a community-based organization, or a practicing doula or midwife. Endorsement Pathway: • An initial applicant currently certified to practice as a birth doula in another state, the District of Columbia, or a territory of

State	Licensure Requirements	Training/Pathways
	• An attestation that they have successfully completed training or have experience in one of the categories; or • A certificate of completion from relevant training that lists the applicant's name. Complete 10 hours of continuing education every renewal cycle. Eight hours of continuing education and leadership development activities must be obtained through designated activities. A minimum of five hours must directly relate to the practice of a birth doula. Any remaining hours may be in leadership development activities that enhance the practice of the birth doula. A birth doula shall also complete two hours of health equity continuing education every four years.	the United States may be certified by endorsement. An applicant shall comply with the requirements for licensure and submit proof of: ○ Current certification from another United States jurisdiction, if the applicant is certified in a United States jurisdiction that has substantially equivalent standards to Washington. ○ For applicants who have been certified for at least two years in another United States jurisdiction that does not have substantially equivalent standards, the applicant must submit: ▪ Current certification from another United States jurisdiction; and ▪ Proof of 10 hours of continuing education within the two-year period immediately preceding certification. ○ For applicants who have been certified for less than two years in a United States jurisdiction that does not have substantially equivalent standards, the applicant may apply for certification through the application process.
Washington DC [93]	Must be at least 18 years of age. Possess a high school diploma or the equivalent. Possess a current certification by a doula training program or organization, approved by the District of Columbia Department of Health Care Finance (DHCF). Enroll as a DHCF provider and receive an NPI and taxonomy number. During enrollment doulas must also provide information on: • Certificate of Occupancy (or Lease) or Business License • Disclosure of Ownership • NPI # and Taxonomy • Professional Certification (Interim until DC Health creates a Certification) • Proof of Liability Insurance of at least $1M per occurrence/$3M per aggregate • W-9 • Proof of doula certification from the District (once available)	
West Virginia	There are not any licensure requirements or any statutory coverage requirements for Doula services in West Virigina.	

State	Licensure Requirements	Training/Pathways
Wisconsin	There are not any licensure requirements or any statutory coverage requirements for Doula services in Wisconsin.	
Wyoming	There are not any licensure requirements or any statutory coverage requirements for Doula services in Wyoming.	

APPENDIX B: ACOG MEDICAID REIMBURSEMENT CHART

State	Date Searched	Service Description	CPT Code	Medicaid Rate	Medicare Rate	Comparison
Alabama	3/4/2025	Vaginal Delivery	59400	$1,690	$2,108.02	80.17%
		Cesarean delivery	59510	$1,690	$2,330.72	72.51%
		VBAC Delivery	59610	$1,690	$2,196.55	76.94%
Alaska	3/25/2025	Vaginal Delivery	59400	$3,951.12	$2,888.61	136.78%
		Cesarean delivery	59510	$4,366.82	$3,190.25	136.88%
		VBAC Delivery	59610	$4,114.64	$3,006.20	136.87%
Arizona	3/4/2025	Vaginal Delivery	59400	$3,811.89	$2,287.13	166.67%
		Cesarean delivery	59510	$4,204.21	$2,536.15	165.77%
		VBAC Delivery	59610	$3,981.05	$2,391.06	166.50%
Arkansas	3/4/2025	Vaginal Delivery	59400	$1,210	$2,081.97	58.12%
		Cesarean delivery	59510	$1,230.26	$2,300.02	53.49%
		VBAC Delivery	59610	$1,525.41	$2,167.38	70.38%
California	3/5/2025	Vaginal Delivery	59400	$2,091.21	$2,306.54	90.66%
		Cesarean delivery	59510	$2,297.54	$2,542.89	90.35%
		VBAC Delivery	59610	$2,173.65	$2,395.53	90.74%
Colorado	3/5/2025	Vaginal Delivery	59400	$2,428.11	$2,352.91	103.20%
		Cesarean delivery	59510	$2,676.71	$2,605.51	102.73%
		VBAC Delivery	59610	$2,530.12	$2,455.99	103.02%
Connecticut	3/21/2025	Vaginal Delivery	59400	$2,612.33	$2,524.99	103.46%
		Cesarean delivery	59510	$2,950.61	$2,809.14	105.04%
		VBAC Delivery	59610	$2,732.42	$2,649.58	103.13%

State	Date Searched	Service Description	CPT Code	Medicaid Rate	Medicare Rate	Comparison
DC	3/5/2025	Vaginal Delivery	59400	$2,142.16	$2,638.34	81.19%
		Cesarean delivery	59510	$2,381.50	$2,930.07	81.28%
		VBAC Delivery	59610	$2,245.26	$2,762.98	81.26%
Georgia	3/5/2025	Vaginal Delivery	59400	$2,470.87	$2,298.66	107.49%
		Cesarean delivery	59510	$2,752.40	$2,562.01	107.43%
		VBAC Delivery	59610	$2,595.61	$2,417.10	107.39%
Hawaii	4/4/2025	Vaginal Delivery	59400	$2,408.90	$2,336.77	103.09%
		Cesarean delivery	59510	$2,656.47	$2,574.58	103.18%
		VBAC Delivery	59610	$2,502.15	$2,425.17	103.17%
Idaho	3/5/2025	Vaginal Delivery	59400	$1,919.32	$2,103.42	91.25%
		Cesarean delivery	59510	$2,118.75	$2,320.11	91.32%
		VBAC Delivery	59610	$1,996.03	$2,185.84	91.32%
Illinois	3/6/2025	Vaginal Delivery	59400	$1,840.25	$2,406.13	76.48%
		Cesarean delivery	59510	$2,046.31	$2,689.70	76.08%
		VBAC Delivery	59610	$1,938.17	$2,538.55	76.35%
Iowa	3/6/2025	Vaginal Delivery	59400	$1,364.46	$2,106.28	64.78%
		Cesarean delivery	59510	$1,550.85	$2,322.97	66.76%
		VBAC Delivery	59610	$1,485.07	$2,188.50	67.86%
Kansas	3/6/2025	Vaginal Delivery	59400	$1,751.03	$2,127.46	82.31%
		Cesarean delivery	59510	$1,924.96	$2,349.75	81.92%
		VBAC Delivery	59610	$1,821.50	$2,214.17	82.27%
Maine	3/11/2025	Vaginal Delivery	59400	$1,570.42	$2,169.09	72.40%
		Cesarean delivery	59510	$1,737.43	$2,399.76	72.40%
		VBAC Delivery	59610	$1,637.54	$2,261.79	72.40%
Massachusetts	3/18/2025	Vaginal Delivery	59400	$2,173.45	$2,360.26	92.09%
		Cesarean delivery	59510	$2,405.36	$2,612.26	92.08%
		VBAC Delivery	59610	$2,281.10	$2,462.17	92.65%

State	Date Searched	Service Description	CPT Code	Medicaid Rate	Medicare Rate	Comparison
Michigan	3/18/2025	Vaginal Delivery	59400	$2,220.73	$2,337.61	95.00%
		Cesarean delivery	59510	$2,475.76	$2,606.06	95.00%
		VBAC Delivery	59610	$2,335.79	$2,458.73	95.00%
Minnesota	3/18/2025	Vaginal Delivery	59400	$1,387.89	$2,148.52	64.60%
		Cesarean delivery	59510	$1,387.89	$2,360.28	58.80%
		VBAC Delivery	59610	$1,387.89	$2,222.46	62.45%
Missouri	3/18/2025	Vaginal Delivery	59400	$1,802.10	$2,229.52	80.83%
		Cesarean delivery	59510	$1,987.76	$2,480.56	80.13%
		VBAC Delivery	59610	$1,882.18	$2,339.71	80.45%
Montana	3/21/2025	Vaginal Delivery	59400	$3,199.23	$2,348.31	136.24%
		Cesarean delivery	59510	$3,556.14	$2,607.76	136.37%
		VBAC Delivery	59610	$3,352.74	$2,459.04	136.34%
Nebraska	3/21/2025	Vaginal Delivery	59400	$1,853.20	$2,059.83	89.97%
		Cesarean delivery	59510	$2,316.50	$2,265.66	102.24%
		VBAC Delivery	59610	$2,223.84	$2,133.74	104.22%
Nevada	3/21/2025	Vaginal Delivery	59400	$2,251.97	$2,304.71	97.71%
		Cesarean delivery	59510	$2,490.53	$2,554.44	97.50%
		VBAC Delivery	59610	$2,361.65	$2,408.15	98.07%
New Hampshire	3/21/2025	Vaginal Delivery	59400	$2,435.95	$2,350.61	103.63%
		Cesarean delivery	59510	$2,690.47	$2,606.21	103.23%
		VBAC Delivery	59610	$2,546.58	$2,457.06	103.64%
New Jersey	3/21/2025	Vaginal Delivery	59400	$2,426.12	$2,516.52	96.41%
		Cesarean delivery	59510	$2,696.50	$2,794.16	96.50%
		VBAC Delivery	59610	$2,542.20	$2,634.75	96.49%
New Mexico	3/21/2025	Vaginal Delivery	59400	$3,555.08	$2,334.78	152.27%
		Cesarean delivery	59510	$3,756.09	$2,602.98	144.30%
		VBAC Delivery	59610	$3,742.28	$2,455.84	152.38%

State	Date Searched	Service Description	CPT Code	Medicaid Rate	Medicare Rate	Comparison
New York	3/21/2025	Vaginal Delivery	59400	$2,238.52	$2,225.77	100.57%
		Cesarean delivery	59510	$2,486.34	$2,464.45	100.89%
		VBAC Delivery	59610	$2,356.27	$2,323.01	101.43%
North Carolina	3/21/2025	Vaginal Delivery	59400	$1,549.75	$2,184.80	70.93%
		Cesarean delivery	59510	$1,503.26	$2,417.30	62.19%
		VBAC Delivery	59610	$1,549.75	$2,278.35	68.02%
North Dakota	3/21/2025	Vaginal Delivery	59400	$2,468.16	$2,198.30	112.28%
		Cesarean delivery	59510	$2,724.51	$2,424.34	112.38%
		VBAC Delivery	59610	$2,566.42	$2,283.97	112.37%
Oklahoma	3/21/2025	Vaginal Delivery	59400	$2,128.12	$2,203.80	96.57%
		Cesarean delivery	59510	$2,363.19	$2,445.01	96.65%
		VBAC Delivery	59610	$2,227.82	$2,305.31	96.64%
Oregon	3/21/2025	Vaginal Delivery	59400	$2,828.10	$2,227.64	126.95%
		Cesarean delivery	59510	$3,128.25	$2,462.00	127.06%
		VBAC Delivery	59610	$2,947.66	$2,320.12	127.05%
Pennsylvania	3/21/2025	Vaginal Delivery	59400	$2,025.00	$2,270.24	89.20%
		Cesarean delivery	59510	$2,025.00	$2,521.64	80.30%
		VBAC Delivery	59610	$2,025.00	$2,377.92	85.16%
Rhode Island	3/21/2025	Vaginal Delivery	59400	$815.00	$2,368.75	34.41%
		Cesarean delivery	59510	$815.00	$2,624.37	31.06%
		VBAC Delivery	59610	$846.45	$2,473.94	34.21%
South Dakota	3/21/2025	Vaginal Delivery	59400	$2,220.16	$2,154.37	103.05%
		Cesarean delivery	59510	$2,445.01	$2,370.63	103.14%
		VBAC Delivery	59610	$2,302.69	$2,232.71	103.13%
Tennessee	3/25/2025	Vaginal Delivery	59400	$4,240.86	$2,120.43	200.00%
		Cesarean delivery	59510	$4,684.88	$2,342.44	200.00%
		VBAC Delivery	59610	$4,414.67	$2,207.33	200.00%

State	Date Searched	Service Description	CPT Code	Medicaid Rate	Medicare Rate	Comparison
Utah	3/21/2025	Vaginal Delivery	59400	$2,117.06	$2,276.87	92.98%
		Cesarean delivery	59510	$2,117.06	$2,528.97	83.71%
		VBAC Delivery	59610	$2,219.16	$2,384.83	93.05%
Vermont	3/21/2025	Vaginal Delivery	59400	$1,934.29	$2,192.79	88.21%
		Cesarean delivery	59510	$2,133.20	$2,418.50	88.20%
		VBAC Delivery	59610	$2,009.69	$2,278.50	88.20%
Virginia	3/21/2025	Vaginal Delivery	59400	$2,336.19	$2,264.81	103.15%
		Cesarean delivery	59510	$2,597.65	$2,507.43	103.60%
		VBAC Delivery	59610	$2,449.16	$2,363.49	103.62%
Washington	3/21/2025	Vaginal Delivery	59400	$2,406.07	$2,333.07	103.13%
		Cesarean delivery	59510	$2,406.07	$2,583.06	93.15%
		VBAC Delivery	59610	$2,512.99	$2,434.77	103.21%
West Virginia	3/21/2025	Vaginal Delivery	59400	$2,357.83	$2,348.84	100.38%
		Cesarean delivery	59510	$2,638.80	$2,626.06	100.49%
		VBAC Delivery	59610	$2,489.58	$2,478.55	100.45%
Wisconsin	3/21/2025	Vaginal Delivery	59400	$1,149.32	$2,101.95	54.68%
		Cesarean delivery	59510	$1,149.32	$2,312.03	49.71%
		VBAC Delivery	59610	$1,222.55	$2,177.41	56.15%
Wyoming	3/21/2025	Vaginal Delivery	59400	$2,069.78	$2,270.54	91.16%
		Cesarean delivery	59510	$2,308.79	$2,512.67	91.89%
		VBAC Delivery	59610	$2,178.68	$2,368.28	91.99%

Note: Medicaid reimbursement rates for codes 59400, 59510, and 59610 have been pulled from publicly available state Medicaid fee schedules in 2025. The states that do not use global billing are not included. These rates are the fee-for-service rates and do not reflect managed care rates as those are not publicly available. The rates are compared to the locally adjusted Medicare rates. For states with more than one MAC, the MAC representing the larger portion of the state was chosen (e.g. not individual cities).

APPENDIX C: AMA POLICY

The following AMA policy is relevant to this Board Report:

Disparities in Maternal Mortality D-420.993

1. Our American Medical Association will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States.
2. Our AMA will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US.
3. Our AMA encourages and promotes to all state and county health departments to develop, implement, and sustain a maternal mortality surveillance system that centers around health equity.
4. Our AMA will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

Maternal and Child Health Care H-420.986

The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.

Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns H-420.995

Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (2) favors educating the public to the long-term benefit of antepartum care and hospital birth, as well as the hazards of inadequate care; and (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.

Classification and Surveillance of Maternal Mortality H-420.948

1. Our American Medical Association will encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates while ensuring appropriate nondiscrimination and privacy safeguards.
2. Our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process while ensuring appropriate nondiscrimination and privacy safeguards.
3. Our AMA encourages data collection on pregnancy and other reproductive health outcomes of incarcerated people and research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates.
4. Our AMA supports legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process.
5. Our AMA opposes the separation of infants from incarcerated pregnant individuals post-partum.
6. Our AMA supports solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together.

Patient Navigation Programs H-373.994

1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:
    a. The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.

b. Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
c. Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
d. Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
e. Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care.
3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.

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13. ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy H-60.891

During the 2025 American Medical Association (AMA) Annual Meeting, the House of Delegates (HOD) referred for report, Board of Trustees Report 17-A-25, "Antidiscrimination Protections for LGBTQ+ Youth in Foster Care." The report recommended that Resolve 2 of Resolution 224-A-24[2] be adopted and the remainder of the report be filed. The resolve recommended:

> RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System (AFCARS) only when strong privacy protections exist.

The report further explored considerations for integrating sexual orientation and gender identity (SOGI) data into AFCARS, emphasizing the need for strong privacy protections in response to Resolve 2 of Resolution 224-A-24. BOT Report 17-A-25 received broad support from delegates through both online testimony and in-person discussion within the Reference Committee. However, some delegates expressed concern that the AMA should reassess the potential safety risks associated with collecting SOGI data from LGBTQ+ youth in foster care, particularly in light of the current political climate. When BOT Report 17-A-25 was originally drafted, the current presidential administration had been newly sworn into office. While several federal protections for gender identity and gender-affirming care were still in place, some policies were rescinded via executive orders. This updated report seeks to reevaluate those risks in the context of the post-2024 policy landscape, including the revocation of key protections, while still acknowledging and incorporating relevant pre-2024 considerations.

DISCUSSION

In recent years, the medical community has increasingly recognized the importance of collecting SOGI data as a means of advancing equitable care and closing health disparity gaps. For LGBTQ+ youth in foster care, who are both overrepresented in the system and more likely to face trauma and instability, this data can be a lifeline. It allows health care professionals to better understand their needs, tailor care, and advocate for resources that can improve health outcomes and placement success.

Yet in today's volatile political climate, marked by efforts at the federal level and within many states to ban gender-affirming care and penalize both health care professionals and caregivers, the collection of SOGI data carries new risks. These include threats to patient privacy, legal vulnerability, and the potential misuse of data in ways that could cause harm to the very youth that are supposed to be supported.

[2] https://www.ama-assn.org/system/files/a24-resolutions.pdf#page=29

Emerging Risks: Privacy, Politics, and Policy Gaps

The legal and political landscape surrounding LGBTQ+ health and wellbeing, specifically gender-affirming care has shifted dramatically in recent years and most notably, within the past several months. As of mid-2025, more than half of U.S. states have enacted or proposed legislation restricting or outright prohibiting access to gender-affirming care for minors.[3] In several of these jurisdictions, physicians, mental health professionals, and even parents or guardians have faced the threat of prosecution, loss of licensure, or other legal consequences for supporting a child's gender identity.[4]

These state-level developments are occurring alongside significant changes at the federal level. In February 2025, the U.S. Department of Health and Human Services (HHS) rescinded earlier guidance that had strengthened the interpretation of Health Insurance Portability and Accountability Act (HIPAA) protections for gender-affirming care.[5] This reversal has created uncertainty around the confidentiality of SOGI data, particularly how such data may be interpreted, accessed, or weaponized by government authorities in states with hostile policies toward transgender individuals. It raises legitimate concerns for health care professionals and patients alike about the safety of disclosing or documenting sensitive identity-related information.

The regulatory environment has been further complicated by a series of executive actions issued following the change in presidential administration in January 2025. Within the first two weeks of the new administration, four executive orders were signed that significantly impact the rights, protections, and daily realities of transgender individuals. These executive orders represent a coordinated federal approach to rolling back prior protections and reshaping how gender identity is recognized or dismissed across institutions.

- **Executive Order 14168 – Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government**
  Issued January 20, 2025, this order mandates that all references to "gender identity" be removed from federal policies and documents, instead defining "sex" strictly according to biological assignment at birth. This redefinition could have broad implications across federal agencies, including health care, education, housing, and civil rights enforcement.
- **Executive Order 14183 – Prioritizing Military Excellence and Readiness**
  Signed January 27, 2025, this order reinstates a ban on transgender individuals serving in the U.S. military, reversing inclusive policies established under previous administrations.
- **Executive Order 14187 – Protecting Children From Chemical and Surgical Mutilation**
  Signed January 28, 2025, this directive seeks to limit access to gender-affirming care for individuals under the age of 19, restrict federal funding to health care professionals offering such care, and explore avenues to reduce insurance coverage for these services under federal programs.
- **Executive Order 14190 – Ending Radical Indoctrination in K-12 Schooling**
  Signed January 29, 2025, this order directs federal agencies to recommend the withdrawal of funding from educational institutions that support "gender ideology," potentially impacting Title IX protections, school-based health services, and inclusive policies for transgender and gender-diverse students.

While several aspects of these executive orders are being challenged in federal court, and some provisions have been temporarily blocked, the political intent and cultural impact are already evident.[6] Health care professionals in multiple states have reported increased barriers to care for transgender patients, including heightened scrutiny, patient hesitancy, and administrative confusion over what care can legally be provided or documented.[7]

[3] https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map
[4] https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-gender-affirming-care-transgender-youth-us
[5] https://www.hhs.gov/sites/default/files/ocr-rescission-february-20-2025-notice-guidance.pdf
[6] https://healthlgbtq.org/advocacy_brief/overview-2025-executive-actions-impacting-lgbtq-health/#:~:text=Since%20taking%20office%20in%20January,serve%20people%20fairly%20and%20safely
[7] https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-gender-affirming-care-transgender-youth-us

These challenges are compounded by growing concerns over the misuse of electronic health records and SOGI data. In states such as Missouri[8] and Florida,[9] state officials have reportedly sought access to patient health records to identify individuals receiving gender-affirming care, particularly minors. The potential for this type of surveillance raises profound ethical and legal concerns, especially within foster care systems where youth may already lack consistent advocacy and privacy protections. As electronic health records (EHR) become more interoperable across health care professionals and state lines, the likelihood that sensitive data might be shared, intentionally or unintentionally, only increases.

It is important to recognize that federal privacy laws like HIPAA set a floor, not a ceiling. States may introduce laws that either enhance or undermine these protections. For example, while HIPAA provides general safeguards around protected health information, it does not explicitly prohibit disclosure in all cases, particularly when law enforcement or state authorities claim a legal right to access records.[10] Likewise, Title IX's application to transgender rights has been subject to shifting interpretations under different administrations, and its protection is not uniformly enforced across states.

However, it is important to reiterate that most foster youth data systems are outside of health care, and are thus not governed by HIPAA. This distinction underscores a critical gap: youth in foster care often have their data shared between educational, child welfare, and legal systems, which lack the robust data security standards found in clinical settings. Therefore, even if health systems adopt best practices, the downstream data environment remains fragmented and legally vulnerable. Data fed into these systems involve nonprofit and government agencies involved in foster care, with only occasional overlap with health care professionals and health care organizations.

In this environment, LGBTQ+ youth in foster care are at a particularly precarious intersection of visibility and vulnerability. On one hand, collecting SOGI data can affirm their identities, improve placement outcomes, and tailor mental and behavioral health support. On the other, this same data, if improperly secured or accessed in a hostile jurisdiction, could expose them to discrimination, stigma, or even separation from affirming caregivers, contributing to mental health crises.[11]

Navigating this climate demands caution, clarity, and ongoing legal awareness. The benefits of SOGI data collection remain substantial, but so do the risks and both must be weighed thoughtfully as we consider how best to support vulnerable youth while upholding our ethical obligations to do no harm.

Looking Ahead with Care and Caution

In an ideal policy environment, collecting SOGI data would be a clear and uncontroversial step toward achieving health equity. When conducted thoughtfully, such data collection empowers clinicians to deliver more personalized, affirming, and effective care, especially for LGBTQ+ youth who are disproportionately represented in foster care and face elevated risks of trauma, discrimination, and poor health outcomes.

However, the current political and legal landscape demands a more measured approach. Without robust, enforceable safeguards at the federal level, the collection of SOGI data, however well-intentioned, may inadvertently expose LGBTQ+ youth and the professionals who support them to serious risks, including legal threats, privacy breaches, or punitive action from hostile jurisdictions. Given this landscape, interim protective actions should include stronger de-identification protocols, tiered data access permissions, and the implementation of consent pathways even when not

[8] https://missouriindependent.com/2024/07/08/judge-rules-missouri-ag-has-no-right-to-medical-records-of-transgender-minors-at-wash-u/#:~:text=By:%20Annelise%20Hanshaw%20%2D%20July%208,AG%20investigation%20of%20transgender%20care

[9] https://www.hrc.org/press-releases/federal-court-blocks-first-state-law-restricting-health-care-for-transgender-adults-state-of-florida-loses-federal-challenge-as-court-blocks-law-targeting-adults-and-adolescents#:~:text=A%20federal%20district%20court%20has,individuals%20just%20for%20being%20transgender

[10] https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=Covered%20entities%20may%20disclose%20protected,requests;%20(2)%20to%20identify

[11] https://www.finance.senate.gov/chairmans-news/state-attorneys-general-misused-medicaid-authority-to-persecute-teens-seeking-gender-affirming-care-finance-inquiry-finds-politicized-requests-for-patient-information-caused-spike-in-teen-crisis-mental-health-calls

required by law. Institutional review boards (IRBs), health systems, and state agencies must be proactive in reviewing the implications of data collection policies, particularly in politically hostile environments.

Physicians hold a dual responsibility: to advance equitable care while actively protecting the safety and dignity of vulnerable populations. This means ensuring that data collection practices do not outpace the infrastructure, legal protections, and ethical frameworks necessary to support them. Where protections are lacking or inconsistent across states, caution must guide the physician's actions.

Moving forward, physicians should prioritize trauma-informed, consent-based, and context-aware approaches to SOGI data collection, especially for minors in systems of care. Advocacy for clearer national standards, stronger privacy laws, and enhanced training must continue alongside clinical efforts.

Ultimately, the health and well-being of LGBTQ+ youth in foster care depend not just on what is known, but on how responsible action is taken given that knowledge. Now more than ever, leadership in medicine requires not only clinical skill, but also moral clarity, legal awareness, and a steadfast commitment to protecting those most at risk.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of BOT Report 17-A-25 and the remainder of the report be filed:

> That our AMA support advocacy efforts by youth, families, foster care organizations, foster care workers, health care professionals, and public health authorities to establish and strengthen youth-centered privacy protections for sexual orientation and gender identity (SOGI) data across foster care systems, including the safe collection, aggregation, and use of such data for reporting and health equity purposes, with clearly defined safeguards and actionable standards to ensure both ethical protection and meaningful utilization.

14. AMA EFFORTS ON MEDICARE PAYMENT REFORM AND INCREASING TRANSPARENCY OF AMA MEDICARE PAYMENT REFORM STRATEGY

Informational report; no reference committee hearing

HOUSE ACTION: FILED

This report is submitted for the information of the House of Delegates (HOD). At the 2023 American Medical Association (AMA) Annual Meeting of the HOD, the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. In addition, the House adopted Policy 400.981, "Increasing Transparency of AMA Medicare Payment Reform Strategy," which calls on the AMA to:

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

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

The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models.

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy; regulatory advocacy; federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

The AMA shares its members' deep frustration over persistent Medicare payment cuts. While Congress mitigated approximately half of the 2024 cuts initially implemented in January 2024, physicians continue to sound the alarm that two decades of annual reductions are jeopardizing practice viability and limiting patient access to care. Unfortunately, the final 2025 Medicare Physician Fee Schedule imposed an additional 2.83 percent cut.

An early draft of a year-end legislative package in December 2024 included a proposal to address 2.5 percent of the scheduled cut. However, the larger draft proposal collapsed under political pressure largely resulting from an Elon Musk tweet, and the scaled-down spending package that ultimately passed, failed to address the payment cuts. As a result, physicians faced Medicare cuts for the fifth consecutive year, which went into effect on January 1, 2025. Meanwhile, the MEI increased by 3.5 percent in 2025, further widening the gap between what Medicare pays physicians and the actual cost of delivering quality care.

The financial stability of physician practices and the long-term sustainability of our nation's health care system are at serious risk. Medicare physician payment rates have effectively plummeted 33 percent from 2001 to 2025, when adjusted for inflation in practice costs. Addressing this widening gap is essential to ensure physicians can continue providing high-quality care to Medicare patients.

Fixing our unsustainable Medicare payment system remains an urgent advocacy and legislative priority for the AMA. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reform could not be clearer. With Congress failing to reverse these cuts, millions of seniors will find it more difficult to access high-quality care, and physicians will be less able to accept new Medicare patients. The impact will be especially detrimental in rural and underserved areas and for small, independent physician practices that care for our nation's most vulnerable patients.

As a result of the continued advocacy by the AMA, Federation partners, and the broader physician community, common sense legislation has been introduced to reform the broken Medicare payment system. These bills reflect elements of the AMA-developed framework, "Characteristics of a Rational Medicare Physician Payment System."

Medicare Reform: Automatic Annual Inflation-Based Updates

The AMA and our Federation partners continue to press Congress to reverse the 2.83 percent cut that took effect on January 1, 2025. At the same time, we are urging lawmakers to enact automatic, annual inflation-based payment updates to ensure that Medicare payment keeps pace with rising practice costs.

Medicare Payment Reform: Budget Neutrality

In 2024, the GOP Doctors Caucus introduced H.R. 6371, a bill that would have addressed long-standing flaws in Medicare's budget neutrality policies. Strongly supported by the AMA, this legislation sought to compel CMS to correct inaccurate utilization projections and raise the budget neutrality threshold from $20 million to $53 million. While this bill did not pass, the AMA is now advocating for similar provisions in the 119th Congress to help mitigate the compounding impact of flawed budget adjustments on physician payment.

Medicare Payment Reform: Revising the MIPS Program

The AMA, working with Federation organizations, has also developed legislative language to reform MIPS. These reforms would target the program's disproportionate burden on small and rural practices, seek to provide physicians with more timely and actionable data from CMS, and streamline MIPS to make it more clinically relevant and less administratively complex.

119th Congress AMA Advocacy Highlights

In January 2025, Representatives Greg Murphy, MD (R-NC), and Jimmy Panetta (D-CA) introduced H.R. 879, the Medicare Patient Access and Practice Stabilization Act. Backed by more than 120 bipartisan cosponsors, the bill sought to reverse the 2.83 percent Medicare payment cut and replace it with a two percent increase. The following month, the AMA led a broad coalition of more than 80 organizations, including all 50 state medical associations and the Medical Society of the District of Columbia, in a sign-on letter urging Congress to pass the bill. In March, the AMA and its partners pressed for H.R. 879 to be included in the continuing resolution. That effort ultimately failed because the White House insisted on a "clean package" so neither H.R. 879 nor any related provisions made it into the final package. The cut remained in place, further destabilizing physician practices.

In April, Senator Roger Marshall (R-KS) introduced the Senate companion bill, S. 1640. AMA advocacy staff were highly involved in drafting this legislation, ensuring it was responsive to the real-time 2025 Medicare cuts.

National Advocacy Conference – February 2025

At the February 2025 National Advocacy Conference, the AMA launched its "Fix Medicare Now" campaign with a kickoff event at the Cannon House Office Building. Lawmakers including Representatives Murphy, Panetta, Schrier, Miller-Meeks, Joyce, Ruiz, Bera, and Kennedy joined to show their support. More than 350 physicians participated in Capitol Hill meetings, urging lawmakers to pass H.R. 879 and take Senate action. The AMA amplified its message with a full-page ad in The Hill and distributed advocacy kits that emphasized the 33 percent drop in Medicare payments since 2001, adjusted for inflation. The event also featured remarks from other key Representatives, including Conaway, Onder, Krishnamoorthi, Dexter, Morrison, DeGette, and McCormick.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Action Network, and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics and a new "Medicare basics" series of papers describing in plain language specific challenges
presented by current Medicare payment policies and recommendations for reform.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics from January through the end of June 2025 result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 85+ million in earned media and ad impressions
- 2.2+ million media and ad engagements
- 670,000+ pageviews
- 633,000+ site users
- 68,000+ contacts to Congress
- 150+ third-party media placements and grass top contacts made in key Congressional districts

H.R. 1

H.R. 1, the One Big Beautiful Bill Act (OBBBA) initially included strong Medicare physician payment reform provisions, including a 75 percent MEI update for 2026 and a permanent annual update of 10 percent MEI thereafter. These provisions marked the first time since the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 that physician payment updates would be permanently built into baseline Medicare rates.

The AMA advocacy team was instrumental in the development and inclusion of these House-passed Medicare provisions. Section 44304, which linked the update to inflation in practice costs using the MEI, reflected AMA policy and decades of advocacy, and was recently echoed in recommendations by the Medicare Payment Advisory Commission.

These provisions passed the House of Representatives. However, the Senate scaled the proposal back to a temporary 2.5 percent update for 2026.

The final version of H.R. 1, passed by the Senate, retained only the temporary one-year 2.5 percent conversion factor update—with no permanent, inflation-adjusted fix. Still, the inclusion of any update represented forward movement and provides important momentum for continued advocacy in the 119th Congress.

Advocacy with MedPAC and Looking Forward

The AMA has continued to engage directly with the Medicare Payment Advisory Commission (MedPAC) to push for reforms aligned with physician needs. Earlier in 2025, MedPAC signaled a notable shift by recommending an MEI minus 1 percent update for 2026, a departure from its longstanding reluctance to support any inflation-based adjustments. By June, MedPAC went further, voting to recommend permanent annual payment updates tied to MEI growth. This marked a major policy milestone and a clear acknowledgment of the financial pressures facing physicians under the current system.

Call to Action

Congress must urgently address a broken Medicare payment system that places enormous financial pressure on physicians and threatens access to care. The AMA continues to urge lawmakers to:

- Reverse the 2.83 percent payment cut;
- Enact a positive update to keep up with inflation; and
- Implement a long-term fix that ensures payment adequacy and stability.

Physician practices have lost 33 percent to inflation since 2001. Physician ownership of practices has also collapsed, dropping from 61 percent in 2001 to under 50 percent in 2016. This erosion threatens the viability of community-based care.

Fixing this system will remove a major financial stressor for physicians, protect patient access, and stabilize our health care infrastructure. The House-passed provisions of H.R. 1 will serve as a critical foundation for comprehensive reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to practice sustainability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—especially in rural and underserved communities, where practices treat four times as many Medicare patients as those in metropolitan areas.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

STRATEGIC REVIEW OF MEDICARE PAYMENT REFORM ADVOCACY

In response to Resolution 233-A-25, the AMA is actively in the process of implementing a comprehensive review of its Medicare payment reform strategy. This includes identifying options for engaging external advocacy consultants and refining internal processes to identify barriers, uncover strategy gaps, and generate targeted recommendations. While the execution plan is still in the early stages at the time this report was drafted, the AMA remains committed to advancing this work and will provide further updates at I-25.

CONCLUSION

The AMA will continue pressing Congress to fix the broken Medicare physician payment system and protect patient access to care. Despite ongoing challenges, sustained engagement from physicians remains critical. We urge all physicians to stay informed, follow Advocacy Update, participate in grassroots advocacy, and use resources such as FixMedicareNow.org to make their voices heard.

15. PROTECTING EVIDENCE-BASED MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND BIOMEDICAL RESEARCH REPORT

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED
See Policy D-440.905

At the 2025 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-440.905, "Protecting Evidence-based Medicine, Public Health Infrastructure and Biomedical Research," that asks our AMA:

> To affirm that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
>
> To assertively and publicly lead the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.
>
> To report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.

Reference Committee B heard extensive and strong testimony in support of Policy D-440.905 and this report is being submitted to the HOD as information as directed in the policy. (Note: Because of approval deadlines, this report was prepared in September of 2025.)

Since the January 2025 inauguration, the Trump Administration has taken a number of unprecedented actions to reduce funding for biomedical research, eliminate programs promoting public health and health equity, and shift policies regarding the regulation of vaccines. In addition to actions already taken by the Administration, they have proposed a significant reorganization of the Department of Health and Human Services (HHS) which, if approved by Congress, would reduce the Department's total discretionary funding by over $31 billion in Fiscal Year (FY) 2026 compared to FY 2025 and result in the elimination of several HHS programs. The Administration has already engaged in an unprecedented reduction in force of HHS employees across all agencies, resulting in the termination or incentivized retirement of tens of thousands of federal employees as of the drafting of this report. The proposed changes seek to redirect HHS to focus on Trump Administration priorities, such as chronic disease reduction efforts and eliminating work on diversity, equity, and inclusion programs and gender-focused research and care.

Biomedical Research

Reductions in support for biomedical research at the National Institutes of Health (NIH) have been a significant focus of the Trump Administration, with the Administration terminating $1.8 billion in grants within its first 40 days. The Administration has focused on eliminating funding for grants which it deems to not align with the Administration's priorities. About 30 percent of NIH funding for the National Institute on Minority Health and Health Disparities (NIMHD) was terminated, as were a number of previously awarded grants for gender-focused research.

In another unprecedented early move, the Administration moved forward with a new policy to cap indirect research expenses at 15 percent of the total grant award. This cap is expected to have a dramatic impact on medical research (especially higher-cost medical research), as it constrains resources necessary to carry out research projects. The indirect expenses cap has the potential to impact the number of research institutions that are able to carry out research projects, leaving only large, well-funded institutions capable of funding research.

The Trump Administration has also proposed a significant reorganization of the NIH that would reduce the number of institutes and centers that comprise the NIH from 27 to eight by eliminating some institutes and centers (including NIMHD) and consolidating others. The Administration is also proposing to cut $18 billion from NIH's appropriated funds—a 44 percent reduction in funding from FY 2025 levels. However, the ultimate decision regarding NIH funding levels and programmatic reorganization lies with Congressional appropriators, who, as of the date of this report, are just beginning the Congressional appropriations process. There are some early signals that Congress will reject significant funding cuts for scientific research, but the final status of NIH appropriations and potential reorganization will remain unknown until the conclusion of the FY 2026 appropriations process.

Evidence-Based Medicine

The Trump Administration has taken a number of actions that call into question the current evidence base underlying the practice of medicine. Other Administration actions directly contradict the current evidence base. To date, this has been most evident with HHS Secretary Robert F. Kennedy, Jr.'s approach to vaccine review and recommendations. At the onset of the current measles outbreak, Secretary Kennedy appeared to suggest alternative options to the measles vaccine, including treatment with Vitamin A supplementation, which lacks evidence demonstrating its utility as a treatment for measles. Shortly after his installation as Commissioner of the U.S. Food and Drug Administration (FDA), Dr. Marty Makary, along with FDA Chief Medical and Scientific Officer and Director of the Center for Biologics Evaluation and Research Dr. Vinay Prasad, announced a significant policy change regarding FDA's approach to review of COVID-19 vaccines. Announced in the New England Journal of Medicine (NEJM), the policy change would require any new COVID-19 vaccine for those under 65 or without additional risk factors to undergo a placebo-controlled randomized clinical trial. This policy change was made without the traditional opportunity for public review and comment and raised significant concern among the scientific and medical communities. Soon after this change in approach to reviewing COVID-19 vaccines was announced, Secretary Kennedy announced that COVID-19 vaccines were being removed from the Centers for Disease Control and Prevention's (CDC) recommended immunization schedule for healthy children and pregnant women, leading several top CDC officials to resign.

Outside of FDA, the Administration has taken further actions that have raised concern about its impact on vaccine hesitancy, including the abrupt removal of the full membership of the CDC's

Advisory Committee on Immunization Practices (ACIP) prior to their scheduled June 2025 meeting. In defense of the removal, the Secretary claimed that the ACIP members had significant conflicts of interest with pharmaceutical companies and were therefore biased in their assessments and recommendations. The members were quickly replaced by Secretary Kennedy without the traditional process of public nomination, and the new ACIP members include several individuals who have been the subject of some controversy over their positions on vaccination and who bring their own conflicts of interest to the panel. Historically, anyone joining ACIP must disclose any possible conflicts of interest and is subject to strict rules about their relationships with industry during their time on the committee. In an effort to further increase transparency, HHS launched a public tool sharing conflicts reported by ACIP members—however, as of the drafting of this report, the tool has yet to be updated with all of new members' disclosures. While the scheduled ACIP meetings proceeded as planned, the agenda ultimately included controversial topics previously thought to be settled science, such as the inclusion of thimerosal in influenza vaccination and mRNA vaccine technologies. In addition, meetings of ACIP Vaccine Work Groups have been paused and, on July 31, 2025, Secretary Kennedy notified several representatives of ACIP liaison organizations (such as the AMA, the American Academy of Pediatrics, the Infectious Diseases Society of America, the American Academy of Family Physicians, the American

Nurses Association, and the Association of Immunization Managers) that they would no longer be permitted to serve on ACIP's Work Groups. The liaisons play a crucial role in ensuring that evidence-based science is applied as work group recommendations are developed and presented to ACIP voting members. On August 5, 2025, Secretary Kennedy cancelled $500 million in HHS contracts for mRNA vaccine development and announced the beginning of a coordinated wind-down of mRNA vaccine development activities under the Biomedical Advanced Research and Development Authority.

ACIP convened on September 18 and 19, 2025, and took several noteworthy votes. The committee declined to recommend the COVID-19 vaccine for any category of individuals. Instead, ACIP recommended that vaccination for COVID-19 be determined by "individual-based- decision-making" for those 65 and older, which the committee vote said was also known as "shared clinical decision making." For those aged six months to 64 years, COVID-19 vaccination should be "based on individual-based-decision making—with an emphasis that the risk-benefit of the vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors." ACIP did not take a vote on whether the updated COVID-19 vaccines should be made available under the Vaccines for Children (VFC) program. In the same meeting, ACIP recommended that children aged 12-47 months be immunized for varicella by standalone vaccination, rather than by the combination measles, mumps, rubella, and varicella (MMRV) vaccine. Multiple organizations, including the AMA, issued statements expressing concern with both the data used by ACIP in support of these recommendations and the recommendations themselves.

Regarding the evidence base at large, the "Make Our Children Healthy Again Assessment" (also known as the "MAHA report") issued on May 22, 2025, by Secretary Kennedy's MAHA Commission stated that the current evidence base for medical practice has been too strongly influenced by pharmaceutical companies and therefore is not clinically valid. This criticism was focused strongly on several well-respected, peer-reviewed medical journals, as well as specialty practice guidelines. While not accusatory of physicians directly, the report suggests that physicians can ultimately harm patients by relying on a faulty and biased evidence base.

Finally, in an act that has implications for all of HHS and its sub-agencies, on March 3, 2025, Secretary Kennedy rescinded longstanding agency policy (commonly known as the "Richardson Waiver") regarding voluntary adherence to Administrative Procedure Act (APA) rulemaking processes. The APA exempts certain agency actions—those relating to "agency management or personnel or to public property, loans, grants, benefits, or contracts"—from standard notice and comment rulemaking requirements, but under the Richardson Waiver (which had been HHS policy since 1971) HHS followed notice and comment processes when taking those actions anyway. The repeal of the Richardson Waiver will not impact processes for actions that are subject to the APA's rulemaking requirements under the terms of the statute, but it may change the processes HHS follows for actions such as grantmaking decisions and methodologies, changing eligibility standards for benefit programs administered by HHS (subject to statutory limitations), and awarding contracts.

Public Health Infrastructure

Immediately following his inauguration, President Trump moved quickly to begin dismantling many programs, communications efforts, and research projects within the CDC, raising the alarm within the public health, scientific, and medical communities. As part of its significant reduction in force efforts, the Administration has terminated approximately 2,400 employees at CDC alone, along with several thousand employees across other HHS agencies impacting public health. Adding to the disruption, Susan Monarez was fired from her post as Director of the CDC on August 27, 2025—less than a month after the United States Senate voted to confirm her appointment on July 29, 2025.

As with many other health care agencies, the Administration has proposed a significant reorganization to CDC, including additional funding reductions and program eliminations. This reorganization proposal includes the creation of a new agency, the Administration for a Healthy America (AHA). The Administration is proposing to combine several functions of the CDC, Health Resources and Services Administration, Agency for Healthcare Quality and Research (AHRQ), and other agencies into the new AHA, with a focus on primary care and chronic disease reduction. The new AHA would also incorporate health workforce, environmental health, mental health, and maternal health programs, among others. However, this proposal also recommends eliminating a significant number of programs within each of these agencies, raising concerns about adequate resources and staffing for a significant number of federal health care efforts.

The Administration has also taken actions, or proposed actions, relating to funding for HIV/AIDS initiatives. The Administration initially included $400 million in cuts to the President's Emergency Plan for AIDS Relief (PEPFAR), a global HIV/AIDS relief program, as part of a $9 billion rescissions package under consideration by Congress. However, the PEPFAR cuts were dropped from the bill before final passage by Congress. On the domestic front, the Administration's proposed budget for FY 2026 would largely maintain funding at FY 2025 levels for HIV care, treatment, and pre-exposure prophylaxis programs, but would eliminate HIV prevention and surveillance efforts at the CDC. As with the proposals relating to funding and structural reorganization at the NIH, the final decision on whether to adopt the Administration's proposals with respect to CDC's HIV/AIDS prevention and surveillance efforts lies with Congress. There are indications that Congress will ultimately preserve CDC prevention and surveillance funding—on July 31, 2025, the Senate Committee on Appropriations, in a broadly bipartisan vote, approved an FY 2026 HHS funding bill that essentially maintains funding for the CDC's National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention at FY 2025 levels.

AMA Advocacy Actions through September 2025

The AMA has been engaged in advocacy to affirm our commitment to biomedical research, evidence-based medicine, and public health since President Trump's inauguration in January 2025.

Advocacy has been aimed at both the Administration directly and at Congress. An outline of specific advocacy actions as of October 1, 2025, is provided below. The AMA will continue to strongly advocate as a leader of the Federation of Medicine throughout the duration of this Administration.

- March 5, 2025 Letter to NIH on Indirect Expense Cap: The AMA joined numerous other physician and health care organizations in opposing the 15 percent cap on indirect research costs imposed by NIH on grantees. The letter highlighted the severe detrimental impact this cap would have on biomedical research and the United States' standing as a global leader in biomedical innovation.
- May 29, 2025 Letter to Secretary Kennedy on COVID-19 Vaccine Review: The AMA wrote to Secretary Kennedy expressing serious concern with the announced policy changes regarding review of COVID-19 vaccines and requirement for placebo-controlled randomized clinical trials (RCT) for new vaccines. The AMA noted that the announcement lacked transparency and opportunity for public input, while also highlighting the ethical concerns regarding RCTs when existing vaccines are available. Additionally, we highlighted the concerns about maintaining access to vaccines for those who want them—an early promise of Secretary Kennedy.
- June 12, 2025 Statement on ACIP: The AMA issued a statement on new members of the ACIP selected without transparency and proper vetting.
- June 13, 2025 Letter to Senator Cassidy on ACIP: The AMA wrote to Senator Cassidy requesting the Senator inquire as to the circumstance of the termination of the sitting members of ACIP.
- June 18, 2025 Letter to Secretary Kennedy on ACIP: The AMA led a Federation sign-on letter to Secretary Kennedy opposing his removal of all sitting members of ACIP. The letter called for the previously appointed members to be reinstated and for the appointment process to follow its long-standing tradition of a transparent public nomination process.
- June 25, 2025 Open Letter to the Public on Fall Respiratory Season: The AMA joined over 70 medical specialty groups in an open letter to the public urging the public to vaccinate for the fall respiratory season. The letter also highlighted concerns about the Administration's approach to vaccine recommendations.
- July 9, 2025 Friends of ARHQ Sign-On Letter in Support of USPSTF: The AMA joined Friends of ARHQ in writing to Congress to support the work of the United States Preventive Services Task Force (USPSTF) and urging Congress to protect USPSTF from political interference.
- July 27, 2025 Letter to Secretary Kennedy on USPSTF: The AMA wrote to Secretary Kennedy expressing deep concern regarding recent reporting that the Secretary intends to remove all of the members of the USPSTF. The letter highlights the essential role of the USPSTF in making evidence-based recommendations for clinical prevention of disease and the role these recommendations play in terms of health insurance coverage of preventive services.
- August 1, 2025 Joint Statement on ACIP Workgroups: ACIP Medical Association Liaisons, of which AMA is a part, issued a joint statement regarding ouster from ACIP vaccine workgroups.
- August 28, 2025 Statement on CDC: The AMA issued a statement on turmoil and leadership changes at the CDC.
- September 3, 2025 Statement on Florida Vaccine Mandates: The AMA issued a statement opposing Florida's plan to end vaccine mandates.

- September 19, 2025 Statement on MMRV Vaccine: The AMA issued a statement on Advisory Committee on Immunization Practice (ACIP) meeting on new MMRV vaccine recommendations.

Beyond the formal letters listed above, the AMA spoke out against reported changes Secretary Kennedy is considering making to the USPSTF. The AMA's media statement and interviews have emphasized the critical role this organization has in developing best practices for physicians to provide evidence-based care. National media including Reuters, NPR, CBS News, PBS News, and other outlets featured the AMA's concerns. Additional coverage is likely if further actions are taken by government. Media coverage of the USPSTF statement generated 285 media stories, 986 million media impressions and an estimated $9.1 million in publicity value (estimated traditional and online media across print publications, radio, television, news services, news websites, and blogs).

Since June, the AMA's leadership on vaccine advocacy has drawn widespread media attention. National coverage surged following Secretary Kennedy's controversial dismissal of CDC vaccine experts, prompting calls from senators and medical organizations for a formal review of ACIP. AMA's concerns and expertise are featured prominently in major outlets like CNN and USA Today. The AMA's letter to the American people on the importance of vaccines to battle influenza, respiratory syncytial virus, and COVID-19 was picked up by outlets like Medscape. Following Secretary Kennedy's July 31 exclusion of liaison organizations from ACIP Working Groups the AMA joined seven other medical association in a joint statement protesting the move. Media coverage of AMA's ACIP statements generated 2,551 media stories, 7.9 billion media impressions, and an estimated $72 million in publicity value.

AMA social media supported the AMA's advocacy responses by quickly producing text-based images featuring key quotes from official releases and amplifying related content across channels. For the July 27, 2025, USPSTF announcement, the AMA published a text image alongside the release, then amplified a video on July 28 and an AMA News story on July 29. In response to ACIP developments, the AMA supported the June 9 announcement of changes with a text image and release. For the ACIP liaison announcement, the AMA shared a text image and statement on August 1, followed by amplifying the AMA News story on August 2 and a video on August 3. In response to H.R. 1 (the "One Big Beautiful Bill Act"), the AMA posted a sounding-the-alarm carousel and video on July 2, and followed up with a text image and statement on July 3.

Given the significant influence Congress will have over protecting the funding to, and structure of, federal research and public health agencies, the AMA has engaged in substantial advocacy with Congress to ensure federal agencies, advisory committees, and task forces remain independent, non-partisan, and protected from political interference to the most significant extent possible. The AMA is also advocating to protect critical programs from elimination and to ensure continued bipartisan support for biomedical research functions at NIH.

Over the past five years, the AMA has partnered with CDC on an annual flu campaign to encourage the American public to get vaccinated against the flu, with a focus on Black and Hispanic populations. However, with the CDC unable to participate this year, the AMA will be the sole sponsor of the campaign. The campaign has been very successful. Over the past five years, the campaign has had over 350 million digital and broadcast impressions, $50 million in donated media, and 1.27 million site sessions on GetMyFlushot.org. Those aware of the campaign are significantly more likely to agree that getting vaccinated helps protect their loved ones and is the most effective way of preventing the flu. They were also significantly more likely (58 percent versus 45 percent) to receive a flu vaccine compared to those who did not see any of the campaign's public service announcements. Furthermore, a recent study published in JAMA Network Open found an increase in vaccination rates among Black and Hispanic older adults from 2019 to 2022. The annual flu campaign is tangible evidence of AMA support for, and effectiveness in promoting, flu vaccination.

State Activity

Over the past several years, states have increasingly considered legislation that undermines evidence-based medicine, weakens public health infrastructure, and interferes with the patient-physician relationship. These measures have included efforts to curtail the authority of public health authorities, discourage vaccinations, and restrict access to abortion care and gender-affirming care for minors.

State legislative activity slowed during the period between adoption of Policy D-440.905 in June and the writing of this report. At the time of writing, 42 of the 50 state legislatures had adjourned for the year, and, of the eight state legislatures still in session, six had finalized their FY2026 state budgets and two had passed deadlines for introducing new legislation. Nevertheless, significant legislation impacting public health and medical practice was enacted earlier

in 2025. States including Idaho, Kansas, North Dakota, and Tennessee enacted laws restricting the authority of public health departments and numerous states passed laws governing vaccines, including legislation to establish liability of vaccine manufacturers in Texas; to expand nonmedical exemptions for mandated vaccines in North Dakota, Texas, Utah, and West Virginia; and to prohibit adolescents from consenting to vaccines in Alabama. However, positive legislation improving vaccine access was enacted in Colorado, Maine, Maryland, and Louisiana. On September 3, 2025, the governor and surgeon general of Florida announced a plan to end *all* vaccine and immunization requirements in Florida, pending approval by both the state Department of Health and the state legislature.

Notably, this year the United States experienced its largest measles outbreak in 30 years, with three deaths and 1,319 confirmed cases across 40 jurisdictions, due in part to declining vaccination rates. Measles has been officially "eliminated" from the United States since 2000 but this status may be at risk if the current outbreak is not contained. CDC data show national kindergarten immunization rates have dropped from roughly 95 percent pre-pandemic to just under 93 percent in 2023-24, while non-medical exemptions rates reached all-time highs. In Texas, for example, exemption requests surged sharply, with 153,000 requests in the 2023-2024 school year, nearly double the number in 2019. Relaxation of vaccine mandates and promotion efforts—such as the Louisiana Department of Health's decision to scale back vaccine campaigns—poses significant risks for preventable disease resurgence.

Meanwhile, in the area of reproductive health, Arkansas and Wyoming enacted laws restricting access to abortion medication, while Colorado, New York, Vermont, and Washington passed legislation protecting such access. In addition, bills amending exceptions for medical emergencies were enacted in Tennessee and Texas, insurance coverage of abortion care was expanded in Colorado and the District of Columbia, and shield law protections were strengthened in Colorado, the District of Columbia, Maine, North Carolina, Vermont, and Washington. On gender-affirming care, Kansas enacted the "Help Not Harm Act," banning care for minors effective July 1, 2025, while New Hampshire expanded the scope of its existing restriction.

The AMA, through the Advocacy Resource Center (ARC), continues to prioritize state advocacy to defend the patient-physician relationship and public health. The AMA works in close partnership with state medical associations, national medical specialty associations, and public health coalitions to safeguard access to vaccines, abortion, and gender-affirming care. The ARC provides direct advocacy support to Federation members through letters and written testimony, legislative analysis, and strategy support. Often this work is conducted behind-the-scenes with Federation staff. The ARC also facilitates collaboration through regular coalition calls, webinars, and in-person convenings that bring together Federation members, subject matter experts, and allied organizations to share information and collaborate on strategy. For example, to address troubling vaccine legislation introduced in several states earlier this year, the ARC convened over 60 staff members from state and specialty medical associations for a virtual strategy session to share information and collaborate on strategies. Such strategy calls are held on a weekly basis during legislative sessions on a wide range of topics. Additionally, AMA initiatives stemming from the work of the Task Force to Protect the Patient-Physician Relationship—public opinion research to refine messaging on abortion laws, research on workforce impact of criminalizing medical care, and more—has been disseminated to Federation organizations to inform state advocacy efforts. The AMA's sustained engagement with state partners ensures that the AMA remains at the forefront of defending science-based public health policy at the state level, even amid heightened challenges to vaccine confidence, misinformation, and the erosion of public health infrastructure.

CONCLUSION

Through the efforts described in this report, the AMA continues to assertively and publicly advance the goals of Policy D-440.905 by supporting the integrity of evidence-based medicine and resisting encroachments that threaten biomedical research and public health infrastructure. Due to the amount of time between the drafting of this report and the interim HOD meeting, this report is not representative of the full breadth of federal and state activity, or the AMA's advocacy efforts, with respect to evidence-based medicine, biomedical research, and public health infrastructure. In particular, additional congressional action on appropriations is expected, which could significantly impact funding levels and program eliminations.

RECOMMENDATION

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

1. The third item of Policy D-440.905 be rescinded as having been accomplished by this report.

Fiscal note: Less than $500.

16. PRESERVATION OF MEDICAID

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-290.951

This report is presented for the information of the House of Delegates (HOD). At the 2025 American Medical Association (AMA) Annual Meeting of the HOD, the HOD adopted Policy H-290-951, "Preservation of Medicaid." The Policy calls for the following:

1. Our AMA elevate Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility, and request report back on the Board of Trustees' actions at I-25.

2. Our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

(Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON THE PRESERVATION OF MEDICAID

Addressing Threats and Preserving Medicaid

Medicaid provides coverage to millions of Americans and serves as a critical safety net for children, pregnant and postpartum women, seniors, people with disabilities and serious health conditions, and low-income people who do not have access to, or cannot afford, private health insurance coverage.

As the largest insurer for children, pregnant individuals, people with disabilities, and low-income seniors, Medicaid is not merely a funding mechanism—it is a lifeline. The AMA recognizes that efforts to restrict Medicaid are not abstract policy choices but decisions that fundamentally impact access to life-saving care. Medicaid plays an outsized role in reducing racial and geographic health disparities. Black, Latino, Indigenous, and rural populations are more likely to rely on Medicaid, and as such, face disproportionate harm when coverage is restricted or burdens are increased.

The AMA began sustained Medicaid advocacy in early January 2025, participating in a working coalition of national organizations including the Federation of American Hospitals, the American Hospital Association, Families USA, the American Health Care Association, America's Health Insurance Plans, and the Blue Cross Blue Shield Association. Weekly meetings were held to coordinate strategy and share intelligence. AMA also remained active in the Modern Medicaid Alliance. In February, AMA lobbyists began outreach to targeted Republican Congressional offices representing high Medicaid populations, expansion states, and members who had previously expressed concern about Medicaid cuts. In need of their votes, these targeted Members had significant influence with House and Senate Republican leadership. Although no formal legislative language had yet been released, these initial conversations laid the groundwork for engagement once text emerged. Simultaneously, advocacy staff activated grassroots coordination with state medical societies, distributing draft letters, messaging materials, and call-to-action templates. At the National Advocacy Conference, the AMA worked closely with state medical association delegations sharing

intelligence, state-level implementation challenges, and other relevant background information for use in raising Medicaid concerns in targeted Hill meetings.

As Congress moved toward drafting legislative text, AMA intensified its engagement with House and Senate leadership and key committee staff throughout late February and March. AMA's concerns about significant disruptions to Medicaid were clearly conveyed well before legislative text was finalized. When the House bill was released in early May, AMA issued a formal letter opposing the proposed Medicaid provisions, which aimed to reduce federal spending not by directly cutting eligibility or funding, but by increasing administrative burdens on patients and shifting costs to states. A second letter reiterated our opposition before final House consideration. While the final version of H.R. 1, the One Big Beautiful Bill Act (OBBBA), was far from ideal, it is notable that it did not include per capita caps, Federal Medical Assistance Percentage (FMAP) reductions, or elimination of the Medicaid expansion eligibility pathway. That outcome reflects, in part, the sustained and strategic advocacy efforts of AMA staff over several months.

Following House passage, AMA launched a grassroots campaign calling on the Senate to eliminate or revise the most harmful Medicaid provisions. Through the Physicians Grassroots Network , the Patients Access Network, and Federation channels, thousands of physicians and advocates contacted lawmakers. On June 20, AMA sent an additional letter to Senate leadership outlining opposition to provisions that would increase red tape, reduce patient access, and shift additional financial burdens to states. After Senate passage on July 2, AMA lobbyists reached out again to key House Republicans who had expressed concern with the bill's Medicaid policies, urging last-minute changes before final passage. Although the final bill was enacted over AMA's objections, our advocacy team led a sustained six-month campaign combining coalition coordination, targeted Hill engagement, grassroots mobilization, and strategic communications. This ensured AMA's position was heard at every stage and helped prevent even more damaging proposals from becoming law.

Summary of Medicaid Provisions Included in H.R. 1, OBBBA

On July 4, the OBBBA, that included many changes to Medicaid and CHIP, was signed into law. These changes include:

- Repealing regulatory requirements that streamline eligibility and enrollment processes for Medicaid and CHIP.
- Requiring more frequent eligibility checks for Medicaid expansion enrollees and also requiring states to regularly verify contact information, check for dual enrollment across states, and check enrollment against death files for all Medicaid enrollees.
- Mandating that certain categories of enrollees satisfy a community engagement requirement (i.e., "work requirement") as a condition of Medicaid eligibility.
- Reducing retroactive coverage requirements from three months to two months or, in the case of expansion enrollees, one month.
- Establishing new cost-sharing requirements for Medicaid expansion enrollees with incomes above the federal poverty line.
- Prohibiting all states from establishing new provider taxes; existing provider tax arrangements may continue as long as they are not altered. This takes effect on the date of enactment, July 4, 2025. Provider taxes—fees collected from health care providers by states—are used to draw down federal Medicaid matching funds. While often a routine financing tool, certain provider tax structures have drawn scrutiny from CMS and may be subject to reform, potentially jeopardizing state Medicaid budgets.
- For expansion states only, phasing down the permissible rate of existing provider taxes (excluding taxes on nursing facilities and intermediate care facilities) from six percent of net patient revenue to 3.5 percent by 0.5 percentage points per year. The phase-down begins October 1, 2027, and the reduction will be fully phased-in on October 1, 2031.
- Reducing federal contributions to states with identified improper and overpayments.
- Capping state directed payments, separate payments to providers for achieving state-defined policy goals, such as improving quality of care or enhancing access.
- Notably, H.R. 1 does not impose per capita caps, decrease FMAP rates, or eliminate the Medicaid expansion eligibility pathway.

Many of the proposed changes are not direct cuts to Medicaid funding or eligibility. Rather, they largely accomplish reductions in federal spending through policies that (1) increase administrative burdens on enrollees (such as more

frequent eligibility redeterminations or work requirements) that will cause disenrollments or (2) shift costs to the states (such as limiting the use of provider taxes) by limiting how states can draw down federal matching funds.

Nevertheless, the changes included in H.R. 1 are significant. According to the Kaiser Family Foundation, the Congressional Budget Office (CBO) estimates that, relative to its estimates of insurance coverage prior to the law being enacted, the law will increase the number of people without health insurance in 2034 by 10 million, because of changes to Medicaid (7.5 million), the ACA Marketplaces (2.1 million), and other policies and interactions among different provisions (0.4 million). These legislative changes come at a time when enhanced premium tax credits for ACA Marketplace enrollees are set to expire later this year. When combining the impact of the reconciliation law with that of expected expiration of the ACA's enhanced premium tax credits, CBO estimates show that the number of uninsured people will increase by more than 14 million in 2034. The estimate does not account for the effect of the Trump administration's ACA Marketplace Integrity and Affordability rule finalized earlier this year, so the overall change in the number of uninsured people could be even larger.

In a separate proposed rule, CMS proposed guardrails to close "loopholes" which would effectively end certain types of provider taxes in seven states. This proposed rule overlaps significantly with a provision that was included in the final version of the OBBBA. In comments, the AMA asked CMS to consider the rule altogether in light of the passage of the OBBBA, and to consider, as an alternative to eliminating the provider tax arrangements targeted by the rule, creating guardrails that would address CMS' core concerns by ensuring funds are spent on state Medicaid program improvements, rather than terminating this critical funding source altogether.

The AMA will continue to advocate for policies that promote coverage stability and protect access to care for Medicaid patients. In parallel, the AMA will help physicians support patients in maintaining eligibility under new administrative requirements. We will also seek opportunities to shape OBBBA implementation to mitigate its most harmful provisions.

AMA Public Statements on Medicaid in 2025

Letters to Congress:

- Letter to Senate regarding H.R. 1 (OBBBA). Included several pages of concerns about Medicaid changes (June 20, 2025).
- Letter to House leadership regarding H.R. 1 (OBBBA). Included several pages of concerns about Medicaid changes (May 20, 2025).
- Letter to House Energy & Commerce Committee regarding H.R. 1 (OBBBA). Included several pages of concerns about Medicaid changes (May 13, 2025).

Letters to CMS:

- Comment letter opposing proposed rule, titled "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole" (July 11, 2025).

Other AMA public statements:

- Social media posts:
  - X post on July 3, 2025 (following passage of H.R. 1), criticizing the bill and the Medicaid and CHIP cuts in particular.
  - X thread on July 2, 2025 (before final passage of H.R. 1 by the House), specifically criticizing the Medicaid and CHIP cuts and student loan provisions.
  - Video posted to Instagram of Dr. Mukkamala making statement about H.R. 1 on July 2, 2025.
- Statement by Dr. Mukkamala on July 3, 2025, following final passage of H.R. 1.
- Statement by Dr. Mukkamala on July 1, 2025, following Senate passage of H.R. 1.

CONCLUSION

In an effort to preserve Medicaid, the AMA provided early and consistent input to Congressional leaders and coalition partners during the development of H.R. 1. We clearly opposed provisions that would increase administrative burdens, reduce access through procedural disenrollments, or unduly shift financial responsibility to states. While the final legislation contains highly concerning policies, it notably excludes the most damaging proposals—such as per capita caps, FMAP reductions, or elimination of the Medicaid expansion pathway. That outcome reflects the sustained advocacy efforts of AMA staff and the broader Federation.

In recognition that our House has designated Medicaid as an "urgent and top legislative advocacy priority," the Board of Trustees will work to mitigate the impacts of H.R.1. To mitigate the impacts in the short term, we will work at the state level to support the adoption of legislation that fills funding gaps created by H.R. 1 and preserves access to care for patients. Simultaneously, we will work on establishing and disseminating tools to help physicians and patients navigate eligibility and enrollment in Medicaid. Overall, we will continue working to preserve and strengthen Medicaid for the patients and communities who rely on it.

RECOMMENDATION

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

The first item of Policy H-290-951, "Preservation of Medicaid" be amended by deletion as follows.

1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility~~, and request report back on the Board of Trustees' actions at I-25~~.

Fiscal note: Less than $500.

17. ESTABLISHING AN ADVISORY COMMITTEE ON AI/AN AFFAIRS

Informational report; no reference committee hearing

HOUSE ACTION: FILED

At the 2025 AMA Annual Meeting, the House of Delegates (HOD) adopted Resolution 604, Advisory Committee on Tribal Affairs, as amended, which directs the AMA to:

1. Establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), have close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) the Indian Health Service to advise the Board of Trustees on how to implement policy specific to AI/AN communities, and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation; and

2. Promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

This report is informational.

Resolution 604-A-25, as originally presented to the HOD, directed the creation of an advisory committee to address issues relevant to AI/AN physicians, medical students, and patients. While testimony favored creation of an advisory committee, the Board noted in its testimony that advisory committees are established by action of the Board, not by directive of the HOD (AMA Bylaw 5.3.9). The Board further testified that it was willing to consider establishing such an advisory committee.

In response to the actions of the HOD, your Board of Trustees is taking the necessary steps to form an Advisory Committee on AI/AN Affairs and report back at the 2026 Annual Meeting.

18. PUBLISHED METRICS FOR HOSPITALS AND HOSPITAL SYSTEMS

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-215.959

INTRODUCTION

At the 2024 Interim Meeting of the House of Delegates (HOD), Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", was adopted. The policy states:

> Our American Medical Association (AMA) will research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians, with report back to the House of Delegates no later than Annual 2026.

The underlying report (BOT 15-I-24) includes detailed information about existing publicly available metrics for hospitals and hospital systems and their potential impact on physicians and patients. The report recommended that the AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment and thus, this report serves to provide this information to the HOD.

BACKGROUND

Recent research shows that over 45 percent of U.S. physicians experience at least one symptom of burnout.[1] Burnout and job dissatisfaction rose sharply during the first two years of the COVID-19 pandemic, prompting many physicians to consider reducing their work effort, leaving their organization, or exiting the profession entirely.[2] Nearly one-quarter of all physicians noted an intent to leave their job, and a recent study found that the annual rate of physician turnover in the United States increased between 2010 and 2018.[3,4] Time spent in the electronic health record (EHR) and managing the inbox has been associated with burnout.[5,6] Following the pandemic's onset, primary care physicians (PCPs) saw a notable rise in EHR-related workload, including time spent on orders, chart review, notes, inbox management, and after-hours work.[6] Also during this period, all physician specialties experienced an increase in time spent in the EHR, with PCPs most affected.[7] Additional challenges, such as lack of inbox coverage, have made it difficult for physicians to fully disconnect from work during vacation—or take time off at all—further contributing to burnout and increased likelihood of reducing clinical hours or leaving their current practice.[8,9]

Overall, these trends are alarming for the U.S. health care system. Nearly one billion dollars in excess patient costs are tied to physician turnover.[10] Physician burnout and turnover also risks exacerbating existing health disparities, particularly for people living in rural areas and health systems caring for underserved communities. While many hospitals and hospital systems have begun to address the underlying system-level issues that cause burnout and turnover, much work remains to be done to address the work environment of physicians to reduce physician burnout and turnover.

Physician burnout and turnover have myriad causes and addressing these issues to reduce physician burnout (and lessen physician turnover) is a key pillar of the AMA's "You Are Why We Fight" campaign. Central to these efforts are AMA's collaborations over the past five years with more than 300 hospitals or hospital systems in measuring physician burnout and turnover, and incentivizing health systems to improve the physician experience through AMA's Organizational Biopsy and Joy in Medicine Health System Recognition Program (The Recognition Program). Currently, the AMA has developed a set of key metrics by which organizations can measure physicians' experience and work environment. These metrics are based on existing research, expert opinion, and data collected through the Organizational Biopsy. The AMA works directly with health systems to assess these metrics and make them accessible to physicians. The Recognition Program requires that organizations measure several of these key indictors and that these data are transparently shared back with physicians.

DISCUSSION

The AMA Organizational Biopsy

Overview

Since 2018, the AMA has completed research and development on metrics to support health systems in measuring the physician work environment and organizational well-being. Specifically, the AMA has worked to develop an assessment tool, the Organizational Biopsy, which provides health systems with a structured and validated survey tool to comprehensively measure organizational culture, practice efficiency, and other dimensions of the physician work environment. The Organizational Biopsy is available to all health systems, and the AMA offers a service delivery model that provides hands-on support to health systems for measurement and critical follow-up steps during the post-assessment period.

History and Background

Development of the Organizational Biopsy began in 2018 with a pilot of several health systems seeking a survey tool to measure system drivers of organizational well-being. The validated Mini-Z[11,12] is included in the Organizational Biopsy and has been a core component of the tool since its inception. Using data and feedback provided in the pilot, the AMA worked to continuously iterate on the tool to ensure actionable data that can guide health system strategies to improve the work environment of its physicians.

Importantly, the Organizational Biopsy measures system-level drivers of organizational well-being and physician burnout. While solutions that support individual resilience are an important contributor to physicians thriving, the AMA focuses primarily on the work environment, as burnout originates in systems. Organizations that survey with the AMA are provided with a comprehensive summary report and AMA health system partners gain access to AMA physician faculty to support them in follow-up steps and development strategies to address issues identified in the survey. More information about the AMA's approach to offering these metrics, data, and follow-up steps are included below.

Psychometric Evaluation

The Mini-Z is a 10-question tool adapted from the Minimizing Error Maximizing Outcome clinician survey. It was designed to assess workplace satisfaction, stress, and burnout by capturing factors including work control, value alignment with organizational leadership, teamwork, documentation time pressure, and EHR use.[13,14] In 2022, the tool was re-evaluated using new data, and the AMA conducted psychometric evaluation to re-validate it.[12]

Metrics

The Organizational Biopsy consists of over 75 questions that measure four overarching domains related to the physician experience. They include:

- Organizational culture (leadership, teamwork, trust, etc.)
- Practice efficiency (team structure, team stability, workflow design, workload control, etc.)
- Work intentions (intention to leave and/or reduce hours)
- Organizational support for individual resiliency (protected time off, work-life balance, etc.)

A complete list of the question set within the tool is available to participating organizations that contact the AMA to schedule a demonstration, access the question bank, and sign up to participate.

Key Performance Indicators

The AMA has identified six key performance indicators (KPIs) that should be used by organizations to regularly assess the state of organizational well-being. These KPIs were developed based on expert opinion, existing research, and correlations in the Organizational Biopsy data that indicated certain metrics are highly valuable in assessing the state of organizational well-being. These six indicators include:

- Burnout (as defined by the single-item Mini-Z assessment)
- Job satisfaction
- Job stress
- Work intentions (physician intent to leave the organization or reduce their clinical hours)
- Feeling valued (how valued do physicians feel by their organization?)
- Time spend (how much time are physicians spending on patient care, administrative work, etc.?)

These KPIs are published annually in the AMA national comparison report, which is provided to all health systems that have measured using the Organizational Biopsy. The national comparison report is also shared with AMA health system partners, and the AMA participates in a variety of national conferences and forums each year to share these data widely with the field and to urge organizations to adopt these key indicators.

Organizations that survey using the Organizational Biopsy receive their KPI results in their executive summary report. These KPIs are also presented to them by various data stratifications, including specialty, gender, and the number of years post-training so that organizations can more readily identify areas that may need additional support, resources, or interventions. More information about these reports can be found below.

The AMA continues to conduct research on emerging metrics to identify new metrics as they arise. This is an ongoing priority for the AMA and efforts to identify new areas for measurement and improvement based on emerging evidence will continue.

Service Delivery

When an organization collaborates with the AMA to distribute the Organizational Biopsy to their physicians, they are supported directly by a team of AMA staff to develop, draft, and distribute their survey. The AMA educates each organization on the KPIs and guides them in selecting questions from the Organizational Biopsy question bank that are actionable and based on organizational need. The service delivery team works closely with each organization to build and test their survey and provide support during the distribution of the survey, usually lasting around six weeks.

Reporting

All data collected through the Organizational Biopsy are stored in the AMA Data Lab, a dynamic and secure reporting platform that is proprietary to the AMA. The AMA offers a survey for practicing physicians and non-physician providers in addition to a resident/fellow survey. Each organization that surveys with the AMA is provided with a unique login to view a reporting dashboard that includes all their survey results, including their KPIs. Survey results are only shared in aggregate with participating organizations. AMA does not report aggregate data unless there are at least six total respondents in any aggregation. Response-level data is confidential and never shared with organizations to maintain the confidentiality of survey respondents. Names and emails are not collected in the survey. Organizations actively use this dashboard to report data back to their executive leadership teams and physicians. The dashboard is user-friendly and allows organizations to seamlessly analyze their survey results, pinpoint areas for improvement, and develop reports for internal reporting.

Organizations also receive customized executive summary reports of their data, which include aggregated findings of the KPIs and other measures included in their survey. The executive summary is paired with a virtual report-out in which AMA staff and physician faculty walk through salient findings and provide organizations with additional context for their results. The executive summary report also includes stratification of the KPIs by several demographics including specialty, gender, and number of years post-training. These initial stratifications allow the AMA to highlight specific areas and/or populations that are in greatest need of support or intervention. Organizations can further analyze their data using the Data Lab. AMA health system partners receive greater attention and support in follow-up from their Organizational Biopsy. The AMA often provides more detailed executive reports for health system partners, including specialty-specific reports and detailed statistical analysis to further inform their approaches to improving the physician work environment.

The AMA also develops an annual national comparison report for its Organizational Biopsy data. This report is developed using the previous year's data (i.e., the 2025 national comparison report includes 2024 data). This comprehensive report provides aggregate insights on the four domains of the Organizational Biopsy and the KPIs.

This report also includes data stratifications to highlight specific physician segments that may have different results (e.g., specialties with the highest burnout).

Support Post-Survey

After an executive summary report and virtual report-out are completed, organizations can continue to utilize the Data Lab for any additional reporting needs. Additionally, health systems have access to AMA STEPS Forward, a resource that offers physician-developed toolkits, playbooks, podcasts, and webinars to guide physicians and practices in mitigating burnout and improving practice efficiency.
AMA health system partners are provided with in-depth support from physician faculty to support the development of well-being strategic plans, conduct workshops, and advise on the implementation of interventions. The AMA also provides additional report-outs to health system partners, including reports to executive leaders when requested.

Sharing Results with Physicians Post-Survey

The AMA encourages all organizations that use the Organizational Biopsy to share survey results with their physicians as a critical next step in their work, recognizing that making these results accessible to their physicians is critical for several reasons:

1. Builds Trust and Organizational Credibility
   Transparency signals that leadership values honesty and openness. When health systems share well-being data with physicians, it demonstrates that the organization is committed to addressing the realities of physician experience. This transparency builds credibility and helps foster a culture of trust which is essential for engagement and retention.

2. Promotes Shared Accountability
   Sharing well-being data empowers physicians to be part of the solution. When physicians are aware of trends, challenges, and progress, they can participate meaningfully in developing interventions. This can lead to more collaborative, relevant, and accepted well-being initiatives.

3. Supports Data-Driven Improvements
   Physicians, as scientifically trained professionals, respect and respond to data. Transparency allows physicians to understand the scope of issues like burnout, dissatisfaction, or workload strain. Data shared openly can guide quality improvement efforts in a targeted, measurable way.

4. Normalizes Conversations About Burnout and Well-Being
   Many physicians hesitate to speak up about well-being issues due to stigma or fear of professional consequences. Sharing aggregate data encourages open dialogue, which is crucial for reducing stigma and fostering psychological safety.

5. Enables Benchmarking and Progress Tracking
   When well-being data is shared over time, physicians can see whether interventions are making a difference. This creates a sense of momentum and accountability for ongoing improvements.

6. Enhances Engagement and Morale
   When physicians feel heard and see their feedback reflected in data and subsequent changes, morale and engagement can improve.

Information about the importance of sharing data back with physicians and making it accessible to them is included in Organizational Biopsy materials and is identified as a core part of the survey process.

The AMA typically works with health systems on an annual basis to re-measure to determine whether improvements have led to better outcomes.
The Joy in Medicine Health System Recognition Program

Launched in 2019, the Joy in Medicine Health System Recognition Program (the Recognition Program) incentivizes health systems to improve the physician experience by providing public national recognition for organizations that have met a set of evidence-informed criteria centered on addressing the primary system drivers of physician burnout

and organizational well-being. Organizations self-attest through an annual application process to criteria involving bronze, silver, and gold levels of recognition. Organization must submit supporting documentation as evidence of their work. A review committee reviews each application to determine if an organization adequately meets recognition criteria requirements.

The Recognition Program provides a comprehensive roadmap to guide organizations through the existing research and interventions to improve organizational well-being—and thus, the physician experience. Measurement of various outcomes and processes are foundational to the program, as AMA asserts that this data can and should be used to understand unique organizational drivers of physician burnout within an organization and to help focus system-specific solutions.

Measures included in the Recognition Program criteria include:

- Burnout (using a validated tool)
- Intentions to leave or reduce work effort (via survey)
- Teamwork assessments (via surveys)
- Leadership skills assessments and their impact on direct team members (via surveys) and
- EHR audit log data to help illuminate the day-to-day experience of physicians and identify workload/workflow improvements.

The Recognition Program includes required criteria for health systems to share these data internally with their physicians as well as their executive leadership teams for shared decision making and increased accountability.

Specifically, the Recognition Program criteria states that to receive recognition at any level, organizations must "share survey results with the physicians that participated in the survey".[15] Organizations must attest in their application that they have done so, providing information on how, when, and where those results were made accessible to their physicians. This further incentivizes organizations, as organizations cannot receive recognition without doing so.

Organizational recognition is valid for two years. Since 2019, AMA has recognized more than 150 organizations for their efforts, and this body of work continues to gain a national spotlight in the efforts to improve physician well-being. Health system leaders have publicly noted the impact the Recognition Program has had on their efforts to improve conditions for their workforce and in providing them with a critical framework for addressing a complex issue. AMA continues to review emerging evidence and expert opinions to identify the most pressing issues related to organizational well-being and a thriving physician workforce. It is an ongoing priority to regularly evaluate our framework, seeking input from our health system partners and other stakeholders to ensure that the AMA remains the national leader in physician well-being.

AMA Research

Beginning in 2011, researchers from the AMA, Mayo Clinic, University of Colorado School of Medicine, and Stanford Medicine produced the only study to regularly measure physician burnout rates.[16] Since then, this study series has measured the prevalence of occupational burnout, professional fulfillment, and satisfaction with work-life integration among physicians and the general U.S. working population every three years. The most recent study found that in 2023, 45.2 percent of physicians reported at least one symptom of burnout compared to 62.8 percent in 2021, 38.2 percent in 2020, 43.9 percent in 2017, 54.4 percent in 2014, and 45.5 percent in 2011. Burnout among U.S. physicians peaked in 2021 during the earlier part of the COVID-19 pandemic and improved in 2023, returning to pre-pandemic levels seen in 2017. Despite this improvement, physicians remain at increased risk for burnout compared to the general U.S. working population.[1]

The AMA also continues to advance the science on the use of EHR user audit log data to better understand EHR use and its impact on the physician experience. This research helps stakeholders identify factors that support or hinder patient care; contribute to burnout and physicians' intent to reduce clinical hours, leave their practice, or exit medicine altogether; and inform improvements in workflow efficiency and resource allocation. Using audit log data, the AMA has defined and standardized key EHR use metrics[17,18], and examined factors such as cognitive load[19], documentation[20–22], inbox management[6,7,23], after-hours work[24], and work during vacation.[8] Studies also used these metrics to analyze variations by specialty.[25,26]

Additionally, the AMA has been a leading contributor to the literature on physicians' work intentions. Its published studies have examined the relationship between physicians' work intentions and stress[27] and work overload[3] during the COVID-19 pandemic, as well as factors such as work environment[28] , work control[29], and perceived pay fairness.[30]

AMA POLICY

The AMA has several policies related to accessible hospital and hospital system metrics aimed at improving the physician experience.

The AMA will study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

The AMA will also foster the creation of quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals (Policy D-215.988, "Capturing Physician Sentiments of Hospital Quality").

Further, the AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies (Policy H-450.962, "National Committee for Quality Assurance").

Additionally, the AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
The AMA will also advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS) (Policy H-405.955, "Support for the Quadruple Aim").

The AMA also recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians (Policy H-405.948, "Factors Causing Burnout").

CONCLUSION

The AMA has made substantial efforts to address and improve physician burnout, professional satisfaction, and workforce turnover. Such efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, research, educational resources, and hands-on support for health systems to regularly assess the state of their physician workforce.

The AMA has been tracking burnout and other key metrics nationally since 2011. At the organizational level, the AMA has worked over the past several years to develop a set of KPIs related to physician experience, burnout, and the work environment. These include: burnout, job satisfaction, job stress, feeling valued, work intentions, and overall time spent on various clinical and administrative tasks. These KPIs are published in the AMA's annual national comparison report and the AMA currently works with over 150 health systems in measuring these KPIs on an annual basis and reporting them back to their physicians. The Joy in Medicine Health System Recognition Program further incentivizes health systems to measure these KPIs and make them accessible to physicians by requiring that organizations do so to receive national recognition from the AMA.

RECOMMENDATIONS

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

1. Our American Medical Association supports the use of metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians.
2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be rescinded as being accomplished by this report.

Fiscal Note: Minimal

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19. ADDRESSING THE HISTORICAL INJUSTICES OF ANATOMICAL SPECIMEN USE

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy H-140.814

Resolution 017, "Addressing the Historical Injustices of Anatomical Specimen Use," was adopted at the 2024 Annual Meeting by the House of Delegates (HOD) and codified as H-140.820.[1] This report responds to a directive in section 6 of H-140.820 which asks our AMA to:

> Study and develop recommendations regarding regulations for ethical body donations including, but not limited to, guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue.

BACKGROUND

In the wake of the recent Harvard anatomical donation scandal, in which the school's former morgue manager was allegedly stealing and selling human body parts, concerns surrounding cadaveric donation policies have come under renewed scrutiny.[2,3] The history in the U.S. regarding procurement of bodies for dissection and educational purposes has included grave robbing,[4] the looting of native burial grounds,[5] and the use of bodies without consent.[6] Presently, several of America's most prestigious museums, including those at Harvard University, the University of California-Berkeley, and the Field Museum in Chicago, still claim stolen human remains, igniting fierce debate, criticism, and calls for their return.[6] Additionally, several U.S. states—including Ohio, Oregon, and Texas—allow medical education on "bodies without informed consent" that remain unclaimed and 12.4 percent of U.S. medical schools self-report using unclaimed bodies.[7] The use of bodies as anatomical specimens without informed consent raises questions about the ethics of body donation and anatomical specimen procurement and use.

DISCUSSION

Despite the historic injustices surrounding how bodies have been procured, there has not been any standardized policy guiding the ethical donation of human bodies and anatomical specimens. Due to the recent scrutiny related to a lack

of ethical body and anatomical specimen donation policies, the American Association for Anatomy (AAA) assembled a task force of experts to determine best practices and develop standards for body donation.[8] The task force developed foundational and aspirational recommendations which they published as "Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy".

The task force report grounds their best practices and foundational recommendations on informed consent as the fundamental ethical tenet underlying body donation.[8] Importantly, the report calls for body donation policies to include a mandatory standard for informed consent as a matter of justice and to not use the bodies of unclaimed individuals, despite what individual state laws may allow. Additionally, the task force identified core operational practices to be implemented with mechanisms for oversight that are pertinent for ensuring an ethical body donation policy. Core operational practices include the following:

1. *Outreach*: This covers all communications with body donors and their families, beginning with the initial engagement to request donations. Ethical outreach is premised on transparency and accountability, free from any form of coercion or enticement.

2. *Registration*: A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the registration process includes any disposition and distribution of bodies or body parts, including the locations, possible uses of the body or body parts (i.e. military, education, forensic, etc.), and financial aspects of body donation. Additionally, the registration process should outline the body donor eligibility and suitability criteria.

3. *Custody*: A transparent custody process is imperative for ensuring the ethical stewardship and management of the body entrusted to the end user (e.g. researchers, educators, clinicians).

4. *Tracking*: A tracking system should be put in place to ensure proper governance, oversight, and infrastructure (including registration and informed consent) during the use of donated bodies. Tracking systems should include a mechanism for monitoring body donation policies and procedures and a reporting mechanism for violations of these policies.

5. *Use*: Bodies should be used in a respectful, dignified, and ethical manner for education and research purposes.

6. *Disposition*: Final disposition of the body should be made in accordance with the wishes of the donor and their families.

7. *Memorialization*: A respectful memorial ceremony for the family in which the body donor is honored for their "altruism and commitment to education and research" should be held at the conclusion of the use of the body as well as governing oversight of the body donation policies.

To ensure that these core operational procedures are upheld, the task force calls for policy setting, dissemination, and training on the implementation of these guidelines. Additionally, the AAA conceives this guidance to be a "living document intended to be periodically modified and updated as the ethos and legislation of body donation evolve."[8] The AAA guidelines are intended to ensure transparency and accountability during every aspect of the body donation process from solicitation for use of bodies to the respectful disposition and memorial at the conclusion of use. The AAA guidelines were approved by the AAA's board of directors in 2024.

CONCLUSION

In response to the need for standardized policy guiding the ethical donation of human bodies and anatomical specimens the AAA recently published "Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy". The AAA guidance is grounded in key ethical principles, including privacy, respect, justice, and non-maleficence and is thoughtful, well-researched, and comprehensively addresses the issue by experts in the field.

RECOMMENDATIONS

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

1. Our AMA supports the guidelines set forth by the American Association for Anatomy's 2024 task force report Human Body Donation Program Best Practices and Recommended Standards.
2. That section 7 of H-140.820 be rescinded as having been accomplished by this report

Fiscal Note: Minimal – less than $500

REFERENCES

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8. Balta J. Champney TH, et. al. Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy. *Anat Sci Educ.* 2025;18:8–26.

20. AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATES

Informational report; no reference committee hearing

HOUSE ACTION: FILED

At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates. This informational report responds to the first directive of the policy:

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program (HOD EAP).

AMA received requests from 21 societies to participate in the HOD EAP program. Three societies did not meet the criteria outlined in the policy adopted by the House. The EAP awarded grants to the remaining 18 federation societies who requested grant funding for 280 delegates and alternate delegates. Included in the grant funding requests from approved societies were 18 medical student section delegates and 15 regional resident and fellow sectional delegates.

Based on grant funding requests, a total of $420,000 was made available for the June meeting and 50 percent or $210,000 was paid to societies in advance of the June 2025 Annual Meeting.

Following the meeting, the actual number of delegates and alternate delegates that attended the meeting was reconciled with the initial requests and final payments were calculated to reflect actual attendance for each participating society.

For example, if a qualifying association had requested grant funding for four delegates and four alternates, two regional medical student delegates and one resident delegate, that society would be eligible for grant money for 11 attendees or $16,500. The initial payment would have been calculated and paid at 50 percent of the requested amount or $8,250.

Assuming only nine of those included in the initial request attended the meeting, the total grant would be recalculated at $1,500 times 9 attendees or $13,500 and the final payment would be the difference between the recalculated grant amount and the first installment payment or $5,250. This ensures that grant funding is used solely for actual delegates and alternate delegates attending the meeting.

The total number of delegates and alternate delegates attending the meeting from the 18 approved societies was 246, including 14 residents and 16 students and the grant amounts paid totaled $368,400 (one delegate attended for only three of five days).

The grant period is one year; the same 18 societies will be receiving grant money in November as well.

21. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED
See Policy D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2025 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2025 Interim Meeting:

American College of Occupational and Environmental Medicine
American Gastroenterological Association
American Geriatrics Society
American Orthopaedic Association
American Psychiatric Association
American Roentgen Ray Society
American Society of Nuclear Cardiology
Society of Cardiovascular Computed Tomography
The Triological Society

The Society of Hospital Medicine was also reviewed at this time because it failed to meet the requirements in June of 2025 and was granted a one-year grace period.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B),

the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Nuclear Cardiology, and Society of Cardiovascular Computed Tomography
meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the Society of Hospital Medicine met all guidelines and is in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that The Triological Society did not meet all guidelines and is not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Nuclear Cardiology, Society of Cardiovascular Computed Tomography, and Society of Hospital Medicine retain representation in the American Medical Association House of Delegates.

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5.2 The Triological Society be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

Fiscal Note: Less than $500

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American College of Occupational and Environmental Medicine*	568 of 2,242 (25%)
American Gastroenterological Association*	1,604 of 7,804 (20%)
American Geriatrics Society*	578 of 2,579 (22%)
American Orthopaedic Association*	331 of 1,702 (20%)
American Psychiatric Association*	7,646 of 27,920 (27%)
American Roentgen Ray Society*	2,214 of 11,681 (19%)
American Society of Nuclear Cardiology	1,308 of 3,949 (33%)
Society of Cardiovascular Computed Tomography	473 of 1,947 (24%)

Society of Hospital Medicine	2,169 of 11,881 (18%)
The Triological Society*	108 of 574 (19%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
   (a) represent a field of medicine that has recognized scientific validity;
   (b) not have board certification as its primary focus; and
   (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 **Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of

Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

22. PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED
See Policy H-35.960

At the 2024 Annual Meeting, Board of Trustees Report 14 was adopted as amended creating Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties" and the remainder of the report was filed:

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.

Two additional recommendations from this report were referred for further study:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)

Board of Trustees Informational Report 15-A-25 provided an overview of existing data on the topic and discussed the AMA's research on the subject which was in progress at the time of the Informational Report. This report, in response to the two items referred for further study, shares the findings from this research, and makes specific recommendations.

BACKGROUND

This is the third Board of Trustees report on this topic at issue. At the 2024 AMA Annual Meeting, Board of Trustees Report 14-A-24 examined the educational preparation of nurse practitioners and physician assistants, provided an overview of initial certifications and optional certifications for each profession, and summarized existing workforce studies and data on specialties and practice settings of each profession along with the alignment of such to the certification of the respective nurse practitioner or physician assistant. Testimony on Board of Trustees Report 14 called on the AMA to engage in further workforce research, particularly as related to specialty switching by nurse practitioners and physician assistants. This testimony prompted referral of these recommendations to the Board of Trustees for study.

Together Board of Trustees Informational Report 15-A-25 and this report share findings from this additional research, including new data that adds to this body of research. Board of Trustees Informational Report 15-A-25 provided a detailed summary of existing data on nurse practitioners and physician assistants, including information on their areas

of practice by specialty, specialty certifications, and alignment of their certification to their specialty, as well as data on specialty switching by physician assistants. In preparation for this report, and to fill in gaps in existing data on specialty switching, the AMA engaged with a trusted vendor to conduct further workforce research on these topics. Findings from this research are described in this report.

The research project conducted by the AMA included both qualitative and quantitative research of nurse practitioners and physician assistants. The qualitative research was conducted through two national online bulletin board discussion groups consisting of 25 physician assistants and 24 nurse practitioners, respectively. The discussion groups were conducted over a four-day period from April 8-11, 2025, and were intended to explore general attitudes on relevant topics related to specialty switching and provide direction for the subsequent quantitative research. The quantitative research consisted of two national surveys (Surveys), one of 502 nurse practitioners (Nurse Practitioner Survey) and one of 500 physician assistants (Physician Assistant Survey) and was conducted July 16-August 4, 2025.

Findings from this research both confirm information from existing data and provide new data that were not otherwise available.

Specialty Switching

Findings from the Surveys filled significant gaps in data on specialty switching by nurse practitioners and physician assistants. While baseline data on specialty switching by physician assistants is available in the National Commission on Certification of Physician Assistants (NCCPA) *Statistical Profile of Board-Certified Physician Assistants by Specialty*, there is no publicly available data on specialty switching by nurse practitioners. These surveys, therefore, provided new information on specialty switching by nurse practitioners and expanded existing data from NCCPA on specialty switching by physician assistants which were discussed in BOT Report 15-A-25.

Nurse Practitioner Survey Results

Based on the Nurse Practitioner Survey, 35 percent of nurse practitioners have switched specialties at least once during their career with 13 percent switching more than once – seven percent switched twice and six percent switched three or more times.

	All NPs	Among 35% who switched
Switched Once	22%	61%
Switched Twice	7%	19%
Switched 3+	6%	20%

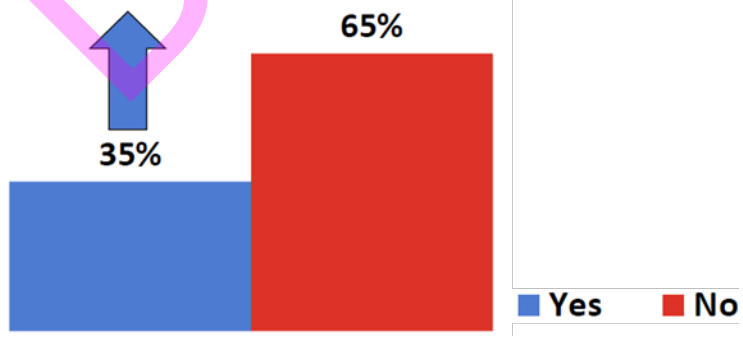

Figure 2. Prior to practicing in your current medical specialty, did you practice as an NP in a different medical specialty?

When it comes to nurse practitioners, switching specialties occurred relatively evenly across age groups, with those ages 50 or older slightly more likely to have switched specialties at some point in their career: under 40 (34 percent), ages 40-49 (33 percent), ages 50 and older (39 percent). The data also show that specialty switching occurs evenly across years in practice with nurse practitioners in practice 16 years or longer slightly more likely to change specialties than early career nurse practitioners. When looking at specialty switching by the number of years the nurse practitioner had been practicing in a specialty, the Nurse Practitioner Survey found that those new to a specialty were more likely to switch specialties compared to those who had been practicing in that specialty for 11 years or longer. Finally, of

nurse practitioners with a family or adult population certification, 38 percent have switched specialties at least once, compared to 29 percent of nurse practitioners with another population certification. The table below provides more details on these and other demographics.

	All (100%)	Men (15%)	Women (85%)	Under 40 (31%)	Ages 40-49 (33%)	Ages 50+ (36%)	Non-Hispanic White (79%)	Persons of Color (20%)
% Yes NPs	35%	37%	35%	34%	33%	39%	35%	38%

	Years in Practice 5 or Less (20%)	Years in Practice 6-10 (32%)	Year in Practice 11-15 (19%)	Years in Practice 16+ (29%)	Years in Specialty 5 or Less (27%)	Years in Specialty 6-10 (30%)	Year in Specialty 11-15 (18%)	Years in Specialty 16+ (25%)
% Yes NPs	32%	35%	34%	39%	48%	39%	23%	27%

Figure 3. Demographics of nurse practitioners who have switched specialties. *Prior to practicing in your current medical specialty, did you practice as an NP in a different medical specialty?*

Nurse practitioners who switched specialties, on average, report practicing in their prior specialty for four years before switching. This was true for nurse practitioners practicing in both primary care specialties and other specialties. In addition, the Nurse Practitioner Survey found that a total of 45 percent of nurse practitioners switched out of primary care – 29 percent switched out of primary care and currently work in a specialty, and the remaining 16 percent remain in primary care but switched to a different primary care specialty or switched to a different specialty and then switched back to primary care.

The Nurse Practitioner Survey also inquired among those respondents who switched specialties to share reasons for their decision to switch. Common reasons for switching specialties included more work/life balance (38 percent), a new professional challenge (35 percent), felt burnt out in previous specialty (29 percent), and better pay (22 percent).

The Nurse Practitioner Survey also sought to understand nurse practitioner sentiment on whether switching specialties was common, perceived as easy, and whether nurse practitioners who have not switched specialties in their career were likely to consider changing or switching from their current specialty. Overall, 78 percent of nurse practitioners said it was common for nurse practitioners to switch specialties, and 65 percent said it was easy to do so. However, among the 65 percent of nurse practitioners who have not switched specialties, 72 percent indicated that they were not likely to consider changing or switching from their current specialty over the course of their career.

Finally, the Nurse Practitioner Survey examined nurse practitioner perceptions and experiences around additional training and certifications to practice in a specialty. Interestingly, 66 percent of nurse practitioner respondents indicated "yes" when asked whether nurse practitioners should be required to complete additional certifications or training in their new specialty. However, a majority of these nurse practitioners indicated that additional training could be acquired on the job (65 percent) as opposed to before they start practicing in their medical specialty (35 percent). When asked whether they would obtain additional training or certifications to practice in a new specialty, 50 percent of all surveyed nurse practitioners said they were only interested in learning on the job and not interested in additional formal education, while 47 percent said they would be willing to go back to school to complete additional training, and three percent said they did not feel any additional training was necessary to practice in a new specialty.

A majority of nurse practitioners (59 percent of all nurse practitioners surveyed) also indicated that they received additional training from a physician to practice in their current specialty, including for the following: assess, evaluate, and diagnose patients (38 percent); interpret diagnostic tests (37 percent); develop patient treatment plans (30 percent); order diagnostic tests and screenings (30 percent); prescribe medications (29 percent); perform in-office diagnostic procedures (26 percent); and perform in-office surgical procedures (23 percent). Regarding whether specialty switching impacted the cost of care, over half of nurse practitioners (56 percent) said that specialty switching had no impact on the cost of care.

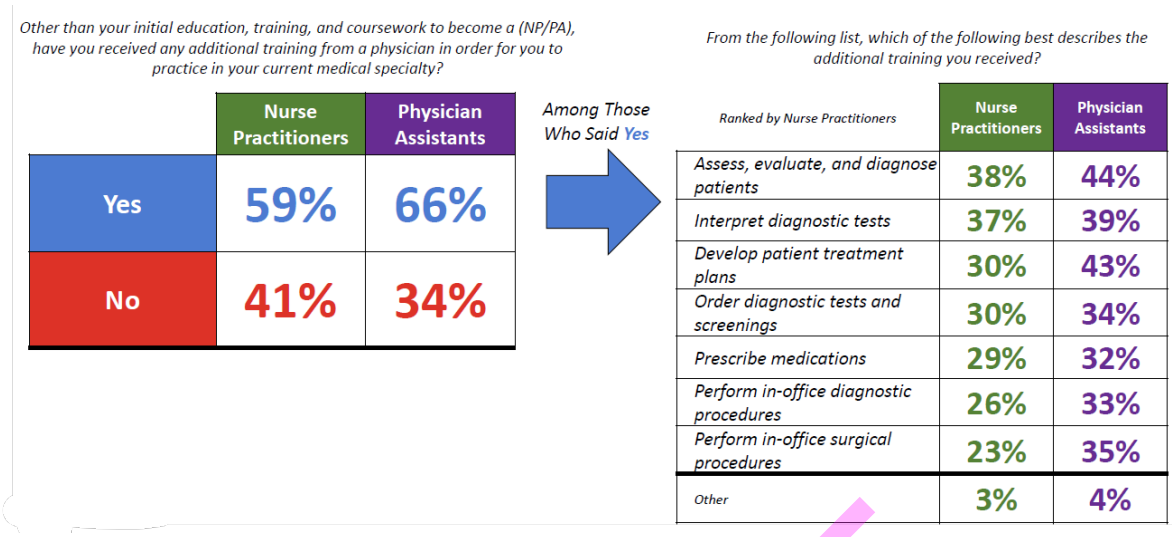

Figure 4.

Physician Assistant Survey Results

Similarly, the Physician Assistant Survey found that 42 percent of surveyed physician assistants report having switched a specialty at least once during their career with 19 percent switching more than once – eight percent switched twice, and ten percent switched three or more times.

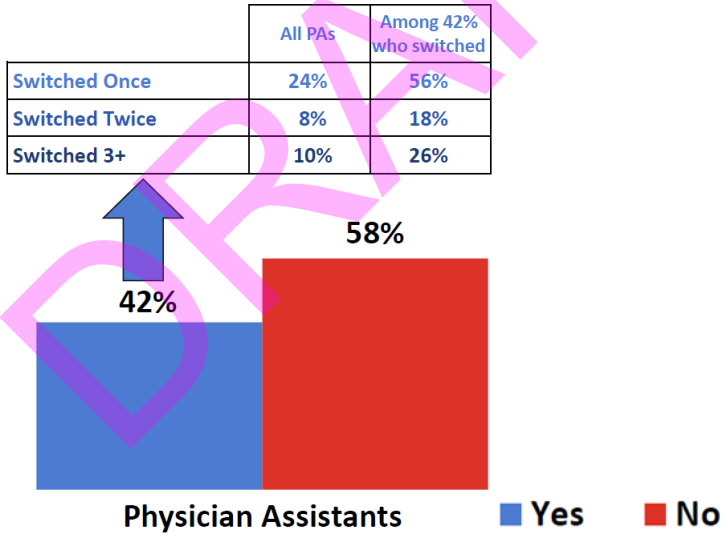

Figure 2. Prior to practicing in your current medical specialty, did you practice as a PA in a different medical specialty

Physician assistants older than 40 were more likely to switch specialties at some point during their career than those under 40 years of age. Similarly, early career physician assistants were less likely to have switched specialties compared to mid-career or late career physician assistants.

Interestingly, this is inconsistent with American Academy of Physician Assistant (AAPA) data finding that physician assistants with less than five years of experience were most likely to change specialties.[1] Generally speaking, when looking at years of practice in a specialty, there was consistency across groups. The table below provides more details on these and other demographics.

	All (100%)	Men (30%)	Women (70%)	Under 40 (58%)	Ages 40-49 (23%)	Ages 50+ (19%)	Non-Hispanic White (79%)	Persons of Color (20%)
% Yes PAs	42%	33%	46%	35%	53%	54%	40%	50%

	Years in Practice 5 or Less (32%)	Years in Practice 6-10 (22%)	Year in Practice 11-15 (17%)	Years in Practice 16+ (29%)	Years in Specialty 5 or Less (41%)	Years in Specialty 6-10 (22%)	Year in Specialty 11-15 (16%)	Years in Specialty 16+ (21%)	Primary Care (28%)	Other Specs (72%)
% Yes PAs	29%	40%	38%	61%	44%	41%	35%	47%	43%	42%

Figure 6. Demographics of physician assistants who have switched specialties. *Prior to practicing in your current medical specialty, did you practice as a PA in a different medical specialty?*

Physician assistants who switched specialties, on average, report practicing in their prior specialty for three to four years before switching. In addition, the Physician Assistant Survey found that a total of 46 percent of physician assistants switched out of primary care – 29 percent switched out of primary care and currently work in a specialty, and the remaining 17 percent remain in primary care but switched to a different primary care specialty or switched to a different specialty and then switched back to primary care.

The Physician Assistant Survey also inquired among those respondents who switched specialties to share reasons for their decision to switch. Common reasons identified by physician assistants for switching specialties included more work/life balance (54 percent), felt burnt out in previous specialty (41 percent), and better pay (29 percent).

The Physician Assistant Survey also sought to understand physician assistant sentiment on whether switching specialties was common, perceived as easy, and whether physician assistants who have not switched specialties in their career were likely to consider changing or switching from their current specialty. Overall, 91 percent of physician assistants said it was common for physician assistants to switch specialties, and 82 percent said it was easy to do so. However, among the 58 percent of physician assistants who have not switched specialties in their career, 57 percent indicated that they were not likely to consider changing or switching from their current specialty over the course of their career.

Finally, the Physician Assistant Survey examined physician assistant perceptions and experiences around additional training and certifications to practice in a specialty. When asked whether physician assistants should be required to complete additional certifications or training to practice in a new specialty, 68 percent said “no.” This sentiment was stronger among younger physician assistants and those in practice 10 years or less.

	All (100%)	Men (30%)	Women (70%)	Under 40 (58%)	Ages 40-49 (23%)	Ages 50+ (19%)	Non-Hispanic White (79%)	Persons of Color (20%)
% Yes PAs	32%	30%	34%	35%	28%	30%	31%	37%

	Years in Practice 5 or Less (32%)	Years in Practice 6-10 (22%)	Year in Practice 11-15 (17%)	Years in Practice 16+ (29%)	PA Switch Specs: Yes (42%)	PA Switch Specs: No (58%)	Specialty: Prim Care (28%)	Specialty: Other (72%)
% Yes PAs	36%	37%	27%	28%	25%	38%	28%	34%

Figure 7. *Do you think when a PA switches specialties they should be required to complete additional certifications or training in their new specialty in order to practice in it?*

Of those physician assistants who indicated that additional certifications or training should be required (32 percent), 89 percent indicated that it could be acquired on the job, whereas only 11 percent thought it should be done before they start practicing in the new specialty.

When it comes to additional training to practice in a new specialty, among all the physician assistants surveyed, 75 percent said they were only interested in learning on the job and not interested in additional formal education, 17 percent said they would be willing to go back to school to complete additional training, and eight percent said they did not feel like any additional training was necessary to practice in a new specialty.

A majority of all surveyed physician assistants (66 percent) also indicated that they received additional training from a physician to practice in their current specialty, including the following: assess, evaluate, and diagnose patients (44 percent); develop patient treatment plans (43 percent); interpret diagnostic tests (39 percent); perform in-office surgical procedures (35 percent); order diagnostic tests and screenings (34 percent); perform in-office diagnostic procedures (33 percent); and prescribe medications (32 percent) (see Figure 4). Regarding whether specialty switching impacted the cost of care, 60 percent of physician assistants said that specialty switching had no impact on the cost of care.

Nurse Practitioner and Physician Assistant Certifications

AMA research also sought to better understand the population certifications acquired by nurse practitioners and whether their population certification had an impact on specialty switching. The findings from the Nurse Practitioner Survey are generally consistent with existing data on nurse practitioners around population certification, which shows that a majority of nurse practitioners attain a Family Nurse Practitioner (FNP) certification upon graduation. Data from the Nurse Practitioner Survey provides more details by age, showing a shift among younger nurse practitioners away from certifications as a FNP toward other certifications, including Adult-Gerontology Acute Care and Psychiatric/Mental Health. The data also show a clear difference by gender with women more likely to have a certification as a FNP (72 percent) compared to men
(57 percent). As discussed in earlier reports on this topic, all nurse practitioners must obtain certification in a specific population focus for licensure. While a majority of nurse practitioners obtain FNP certification, data from other workforce research shows a growing shift of nurse practitioners away from primary care toward specialties. For example, after examining state licensing renewal forms, the Oregon Center for Nursing found that only 25 percent of nurse practitioners practice in primary care.[2] While other workforce studies have found that newly graduated nurse practitioners are more likely to enter specialty or subspecialty care rather than primary care.[3]

Table 1. Nurse practitioners by top three population certifications (age and gender)

Population Certification	Total	Ages 26-39	Ages 40-49	Ages 50+	Women	Men
Family (FNP)	70%	64%	71%	74%	72%	57%
Adult-Gerontology Acute Care (AGACNP-BC	6%	11%	5%	3%	6%	8%
Psychiatric/Mental Health (PMHNP)	5%	8%	4%	3%	4%	10%

While workforce research exists on post graduate training completed by physician assistants, there is limited data on Certificates of Added Qualifications (CAQs), which are optional certificates that physician assistants can earn after completing a certain number of hours working in a specialty and passing an examination. The Physician Assistant Survey found that most physician assistants do not have CAQs, with 83 percent of respondents indicating they did not have a current or active CAQ. Younger physician assistants were less likely to have a CAQ compared to their older counterparts, with only 13 percent of those ages 26-39 reporting having a CAQ compared to 27 percent of those 50 years or older. Of note, CAQs are separate from the PA-C certification, which is the single, general certification offered to physician assistants who have graduated from an accredited program and passed the Physician Assistant National Certifying Examination. CAQs are also distinct from the optional post-graduate training that 5.7 percent of physician assistants complete after graduating from their initial physician assistant program.

Ranked by All Physician Assistants	Physician Assistants	Years in Practice: 5 or Less	Years in Practice: 6-10	Years in Practice: 11-15	Years in Practice: 16+
Emergency Medicine	4%	2%	1%	9%	7%
Orthopedic Surgery	3%	1%	1%	6%	5%
Dermatology	2%	1%	3%	4%	3%
Pediatrics	2%	1%	0%	1%	5%
Psychiatry	2%	2%	3%	1%	3%
Other	2%	3%	3%	3%	1%
Cardiovascular and Thoracic Surgery (CVTS)	1%	0%	0%	3%	2%
Hospital Medicine	1%	0%	2%	2%	2%
Obstetrics and Gynecology (OBGYN)	1%	1%	0%	1%	2%
Occupational Medicine	1%	1%	1%	1%	2%
Palliative Medicine and Hospice Care	1%	0%	0%	1%	1%
Nephrology	0%	0%	1%	1%	1%
Do not have any current/active CAQ's	83%	91%	86%	80%	76%

Figure 1. *Which, if any, of the following Certificates of Added Qualifications (CAQ's) do you have that are active/current? (Physician assistants were provided with a list of all CAQs offered by NCCPA and an "other" category. Respondents could select more than one.)*

This table depicts the total number of surveyed physician assistants with CAQs by specialty and by years in practice. For example, 4 percent of all physician assistants reported having a CAQ in emergency medicine, and 2 percent of physician assistants who have been in practice for five years or less reported having a CAQ in emergency medicine. Additionally, 83 percent of surveyed physician assistants do not have any current/active CAQs and 91 percent of surveyed physician assistants in practice for five years or less do not have any current/active CAQs.

DISCUSSION

Nurse practitioners and physician assistants commonly argue that scope expansions for their respective professions are necessary to overcome workforce shortages in primary care. Contrary to their advocacy argument, however, existing data show that an increasing number of nurse practitioners and physician assistants are moving away from primary care to specialties like dermatology, cardiology, psychiatry, and emergency medicine. Moreover, this is often done without any additional training or certification in these specialties. The Surveys provide new workforce data on specialty switching by nurse practitioners and physician assistants that were not previously available.

The data confirms that nurse practitioners and physician assistants are indeed switching specialties during their career; this occurs at all ages and at all career stages. Moreover, with few exceptions, this occurs without the nurse practitioner or physician assistant completing any additional formal education, training, or certifications in the specialty. Research also shows that nurse practitioner population certification may not always align with their current specialty. Likewise, physician assistants, who complete a generalist education with a single certification available upon graduation, rarely complete post-graduate training or optional CAQs in a specialty in which they are practicing. Rather, data from this survey confirm that nurse practitioners and physician assistants rely almost exclusively on physicians providing on-the-job training to practice in their current specialty. The data further show that nurse practitioners and physician assistants prefer this arrangement over completing additional formal training in a specialty.

This reliance on physicians to train nurse practitioners and physician assistants when they enter a new specialty speaks directly to the importance of physician supervision and collaboration of nurse practitioners and physician assistants to ensure patient safety and high-quality care. The data contributes to AMA's existing body of research on the distribution and impact of nurse practitioners and physician assistants on primary care in rural areas. Finally, this research confirms the need to continue educating policymakers and lawmakers on the education and training of nurse practitioners, including the concept of specialty switching and provides valuable data to support this work. Indeed, this data contributes to our expanding resources on scope of practice and will be instrumental in our advocacy efforts supporting physician led care, including strong physician supervision and collaboration of nurse practitioners and physician assistants.

CONCLUSION

The data described in this report adds to the existing research described in Board of Trustees Report 14-A-24 and Board of Trustees Informational Report 15-A-25. Altogether these reports provide a summary of the educational preparation of nurse practitioners and physician assistants, including initial certifications and optional certifications for each profession, as well as rich data on nurse practitioners and physician assistants in terms of their areas of practice by specialty, specialty certifications, alignment of their certification to their specialty, and specialty switching. Overall, the findings from this research support our policy on physician-led care, including the need for physician supervision or collaboration of nurse practitioners and physician assistants. The findings also support the need to continue educating lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching,

RECOMMENDATION

The Board of Trustees recommends that Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties," be amended by addition and the remainder of the report be filed.

Policy H-35.960 "Physician Assistant and Nurse Practitioner Movement Between Specialties"

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.
6. Our AMA will continue to support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career.
7. Our AMA will continue to support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care.

Fiscal Note: Less than $500.

REFERENCES

[1] American Academy of Physician Assistants. *PAs and Specialty Change: Preparation, Motivation, and Scope,* 2024, at 5.
[2] Oregon Center for Nursing (2020). Primary Care Workforce Crisis Looming in Oregon: Nurse Practitioners Vital to Filling the Gap, But Not Enough to Go Around. Portland, OR, Oregon Center for Nursing, pg. 16.
[3] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017

23. ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION OBSERVER STATUS IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED
See Policy G-600.025

The Board of Trustees has received a request from the Accreditation Council for Continuing Medical Education (ACCME) to be considered for Official Observer status in the House of Delegates (HOD) of the American Medical Association (AMA). The ACCME's request has been considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

DISCUSSION

As part of its request, ACCME submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

The AMA and ACCME collaborate to support physician lifelong learning through the CME system. The AMA owns and administers the AMA PRA Category 1 Credit™, while the ACCME accredits educational providers that deliver CME activities eligible for that credit. Together, our organizations align standards and policies to ensure that CME remains independent, evidence-based, and free from commercial influence. In addition, the AMA is one of seven ACCME Member Organizations that nominate individuals to serve on the ACCME Board of Directors.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

The ACCME ecosystem of accredited education providers spans all 50 states, 3 U.S. territories, and the District of Columbia, as well as 18 countries. The partnership between the AMA and ACCME helps maintain a trusted, high-quality system that supports continuous physician education and improved patient care.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

The ACCME would bring a valuable viewpoint to the HOD by offering expertise in physician lifelong learning, professional development, and competency-based education. Moreover, ACCME can provide real-world insight into how education influences clinical practice, quality improvement, and patient safety.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The ACCME mission is to assure and advance quality learning for healthcare professionals that drives improvements in patient care, and does not represent narrow religious, social, cultural, economic, or regional interests.

CONCLUSION

The Board of Trustees appreciates the long-standing relationship with ACCME. The AMA's core mission to promote the art and science of medicine and the betterment of public health is complementary to the ACCME vision of a community of education providers that support healthcare professionals in delivering optimal healthcare for all. Further, ACCME is working to drive transformation in the learning environment, support educators across the CME ecosystem, and simplify and align regulatory systems.

RECOMMENDATION

The Board of Trustees recommends that the Accreditation Council for Continuing Medical Education be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Fiscal Note: Minimal

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Intealth (ECFMG)	2011
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013
PIAA	2013
Society for Academic Continuing Medical Education	2003
United States Professional Association for Transgender Health	2024
US Pharmacopeia	1998
World Medical Association	2024

24. AMENDING VACCINE-RELATED POLICIES

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF THE REPORT FILED
See Policies D-40.991, D-330.896, D-440.955, D-440.981, H-60.923, H-60.969, H-185.969, H-430.979, H-440.808, H-440.830, H-440.836, H-440.851, H-440.852, H-440.860, H-440.872, H-440.875, H-440.877, H-440.881, H-440.889, H-440.921, H-440.958, H-440.970 and H-440.993.

American Medical Association (AMA) Policy allows for the Board of Trustees to exercise its authority to take appropriate action and make decisions that are necessary to best represent the interests of patients and physicians and to advocate for science and public health.

At the September 2025 AMA Board of Trustees meeting, the Board voted to support the Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP) recommendations as of May 1, 2025, as well as national medical specialty society recommendations on vaccines. While there are numerous AMA policies adopted by the House of Delegates (HOD) that support ACIP vaccine recommendations, the reality is that ACIP has changed dramatically, both in their composition and in the way that they function, since these policies were adopted. The Board's decision was necessary to ensure that the AMA can continue to communicate evidence-based vaccine recommendations to our members and their patients.

In keeping with policy G-600.071, the Board is bringing forth this report outlining the affected policies, which reference ACIP, with recommendations for amendment where appropriate for action by the HOD.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Fiscal Note: $1,000.

Appendix

Policy Number	Title	Text	Recommendation
H-440.860	Financing of Adult Vaccines: Recommendations for Action	1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing. 2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related a. Develop a data-driven rationale for improved	Amend. Insurance-related 1. Provide assistance to providers in creating efficiencies in vaccine management by: v. Providing model vaccine coverage contracts for purchasers of health insurance. vi. Creating simplified rules for eligibility verification, billing, and reimbursement. vii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers. viii. Eliminating provider/public confusion over insurance

Policy Number	Title	Text	Recommendation
		vaccine administration fees. b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs. c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc. d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given. Federal-related a. Increase federal resources for adult immunization to: i. Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations. ii. Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered. iii. Fund an adequate universal reimbursement rate for all federal and state immunization programs. b. Optimize use of existing federal resources by, for example: i. Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding.	payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP) recommended vaccines <u>as of May 1, 2025, and national medical specialty society recommended vaccines</u>. a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations. b. Improve accountability by adopting performance measurements. c. Work with businesses that purchase private insurance to include all ACIP recommended immunizations <u>as of May 1, 2025, and national medical specialty society recommended vaccines</u> as part of the health plan. d. Provide incentives to encourage providers to begin immunizing by, for example: i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations. ii. Simplifying payment to and encouraging immunization by nontraditional providers. iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility). Manufacturer-related Market stability for adult vaccines is essential. Thus: v. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines.

Policy Number	Title	Text	Recommendation
		ii. Capitalizing on public health preparedness funding. c. Ease federally imposed immunization burdens by, for example: i. Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B. ii. Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient. iii. Simplifying the reimbursement process to eliminate payment-related barriers to immunization. d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations. State-related a. State Medicaid programs should increase state resources for funding vaccines by, for example: i. Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees. ii. Establishing and requiring payment of a minimum reimbursement rate for administration fees. iii. Increasing state contributions to vaccination costs. iv. Exploring the possibility of mandating immunization coverage by third party payers. b. Strengthen support for adult vaccination and appropriate budgets accordingly.	vi. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets. vii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP recommend adult vaccines as of May 1, 2025, and national medical specialty society recommended adult vaccines. viii. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

Policy Number	Title	Text	Recommendation
		Insurance-related 1. Provide assistance to providers in creating efficiencies in vaccine management by: i. Providing model vaccine coverage contracts for purchasers of health insurance. ii. Creating simplified rules for eligibility verification, billing, and reimbursement. iii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers. iv. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines. a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations. b. Improve accountability by adopting performance measurements. c. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan. d. Provide incentives to encourage providers to begin immunizing by, for example: i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations. ii. Simplifying payment to and encouraging immunization by nontraditional providers.	

Policy Number	Title	Text	Recommendation
		iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility). Manufacturer-related Market stability for adult vaccines is essential. Thus: i. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines. ii. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets. iii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines. iv. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization. 3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.	
H-60.969	Childhood Immunizations	1. Our American Medical Association will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set	Amend. 1. Our American Medical Association will lobby Congress to provide both the resources and the programs necessary, using the recommendations

Policy Number	Title	Text	Recommendation
		forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine. 2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics. 3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards. 4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. 5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age. 6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013. 7. Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention.	of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine. 2. Our AMA ~~endorses~~ supports the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices as of May 1, 2025, and ~~approved~~ recommended by ~~both~~ the American Academy of Family Physicians and the American Academy of Pediatrics. 3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards. 4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. 5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age. 6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013. 7. Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention.

Policy Number	Title	Text	Recommendation
H-440.877	Distribution and Administration of Vaccines	1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record. 2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply. 3. Physicians and other qualified health care providers should: a. Incorporate immunization needs into clinical encounters, as appropriate. b. Strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines. c. Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws. d. Ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists	Amend. 1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record. 2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP and national medical specialty society recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP and national medical specialty society recommendations must be ensured timely access to adequate vaccine supply. 3. Physicians and other qualified health care providers should: a. Incorporate immunization needs into clinical encounters, as appropriate. b. Strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines. c. Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations as of May 1, 2025, or national medical specialty society ~~professional~~ guidelines and consistent with state laws.

Policy Number	Title	Text	Recommendation
		e. Maintain professional competencies in immunization practices, as appropriate. 4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law. 5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician. 6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers. 7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community. 8. Our American Medical Association encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.	d. Ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists e. Maintain professional competencies in immunization practices, as appropriate. 4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law. 5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician. 6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers. 7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community. 8. Our American Medical Association encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.
H-440.970	Nonmedical Exemptions from Immunizations	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in their group and the community at large.	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in their group and the community at large.

Policy Number	Title	Text	Recommendation
		2. Therefore, our AMA: a. Supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications. b. Supports legislation eliminating nonmedical exemptions from immunization. c. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance. d. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present. e. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common. f. Recommends that states have in place: i. an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the	2. Therefore, our AMA: a. Supports the immunization recommendations of national medical specialty societies as well as those of the Advisory Committee on Immunization Practices (ACIP) as of May 1, 2025, for all individuals without medical contraindications. b. Supports legislation eliminating nonmedical exemptions from immunization. c. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance. d. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present. e. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common. f. Recommends that states have in place: i. an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP as of May 1, 2025, or national

Policy Number	Title	Text	Recommendation
		recommendations of the ACIP). ii. policies that permit immunization exemptions for medical reasons only. 3. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: a. Eliminate non-medical exemptions from mandated immunizations. b. Limit medical vaccine exemption authority to only licensed physicians.	medical specialty society guidelines). ii. policies that permit immunization exemptions for medical reasons only. 3. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: a. Eliminate non-medical exemptions from mandated immunizations. b. Limit medical vaccine exemption authority to only licensed physicians.
H-440.836	Role of Pharmacists in Improving Immunization Rates	1. Our American Medical Association believes that physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient. 2. Our AMA believes that vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: a. establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of	Amend. 1. Our American Medical Association believes that physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient. 2. Our AMA believes that vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: a. establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of services provided by the pharmacies; and

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		services provided by the pharmacies; and b. encourage patients to contact a primary care physician to ensure continuity of care. 3. Our AMA believes that state educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices.	b. encourage patients to contact a primary care physician to ensure continuity of care. 3. Our AMA believes that state educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations as of May 1, 2025, and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices, such as national medical specialty society guidelines.
H-440.830	Education and Public Awareness on Vaccine Safety and Efficacy	1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have	Amend. 1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

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		resulted in a resurgence of vaccine-preventable diseases and deaths. 2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.	2. Our AMA: (a) ~~supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b)~~ recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (~~c~~b) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.
H-440.958	Universal Immunization for Hepatitis B Virus	Our AMA: (1) supports the recommendations of Advisory Committee on Immunization Practice for the prevention of Hepatitis B; (2) encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition; (3) supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection; (4) encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation; and (5) encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.	Amend. Our AMA: (1) supports the recommendations of Advisory Committee on Immunization Practice through May 1, 2025, and national medical specialty society guidelines for the prevention of Hepatitis B; (2) encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition; (3) supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection; (4) encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation; and (5) encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.
H-440.851	Influenza Vaccine Availability and Distribution	Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support	Amend. Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) and national medical specialty societies; (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size

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		federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.	medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate ~~current~~ ACIP recommendations as of May 1, 2025, or national medical specialty society recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ~~ACIP~~ recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.
H-185.969	Insurance Coverage for Immunizations	Our American Medical Association endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles.	Amend. Our American Medical Association ~~endorses~~ supports laws requiring insurance companies to provide coverage for immunization schedules ~~endorsed~~ developed by the Advisory Committee on Immunization Practices through May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies ~~American Academy~~

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			~~of Family Physicians, and American Academy of Pediatrics~~, with no co-pays or deductibles.
D-440.981	Appropriate Reimbursements and Carve-outs for Vaccines	1. Our American Medical Association will continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services. 2. Our AMA will continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients. 3. Our AMA will encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine. 4. Our AMA will seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices. 5. Our AMA will advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.	Amend. 1. Our American Medical Association will continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services. 2. Our AMA will continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients. 3. Our AMA will encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine. 4. Our AMA will seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices through May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, or clearly state in large bold font in their notices to patients and businesses that they do not follow ~~the federal advisory body on~~ evidence-based vaccine recommendations ~~the Advisory Committee on Immunization Practices~~. 5. Our AMA will advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.
H-440.881	Liability Protection for Adult Vaccines	Our American Medical Association supports the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices for routine use in the adult population.	Amend. Our American Medical Association supports the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices as of

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			May 1, 2025, or national medical specialty societies for routine use in the adult population.
H-440.889	Smallpox: A Scientific Update	Our American Medical Association strongly supports the Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data.	Amend. Our American Medical Association recognizes that routine vaccination for smallpox is not recommended for the general public but people at high risk of occupational exposure to orthopoxviruses are recommended to receive routine vaccination. ~~strongly supports the Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine, in light of the available science and data~~.
D-440.955	Insurance Coverage for HPV Vaccine	Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.	Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices as of May 1, 2025 or as supported by national medical specialty society guidelines; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.
H-440.921	Pneumococcal Vaccination	Our American Medical Association encourages physicians to expand their use of pneumococcal vaccine per current Advisory Committee on Immunization Practices recommendations.	Amend. Our American Medical Association encourages physicians to expand their use of pneumococcal vaccine per ~~current~~ Advisory Committee on Immunization Practices as of May 1, 2025, or national medical specialty society recommendations.
H-440.875	Assuring Access to ACIP/AAFP/AAP -Recommended Vaccines	1. It is our American Medical Policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR). 2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health	Amend. 1. ~~It is our American Medical Policy that A~~all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations ~~in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).~~

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		care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine. 3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines. 4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers). 5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines. 6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices. 7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered	2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine. 3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines. 4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ~~ACIP~~ recommended vaccines, and the timely distribution of ~~ACIP~~ recommended vaccines to providers). 5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ~~ACIP~~ recommended vaccines. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

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		benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines. 8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis. 9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.	
H-60.923	Meningococcal Vaccination for School Children	Our American Medical Association supports efforts to require that school children receive meningococcal vaccine as recommended by the Advisory Committee on Immunization Practices guidelines.	Amend. Our American Medical Association supports efforts to require that school children receive meningococcal vaccine as recommended by the Advisory Committee on Immunization Practices as of May 1, 2025, or as supported by national medical specialty society guidelines.
D-330.896	Covering Vaccinations Through Medicare	Our American Medical Association will advocate that Medicare cover the full cost of all vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices (ACIP) at the point of care and outside of budget neutrality requirements.	Amend. Our American Medical Association will advocate that Medicare cover the full cost of all vaccinations administered to Medicare patients at the point of care and outside of budget neutrality requirements, that are recommended by the Advisory Committee on Immunization Practices (ACIP) as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, ~~at the point of care and outside of budget neutrality requirements~~.

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D-40.991	Acceptance of TRICARE Health Insurance	Our AMA: 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for	Amend. 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and

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		services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.	(b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies.
H-430.979	Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities	1. Our American Medical Association, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance. 2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities. 3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens. 4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.	Retain.

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		5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation. 6. Our AMA will advocate: a. for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication. b. for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines. c. for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor. d. that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft.	

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		distance from anyone else if local transmission rate is above low risk as determined by the CDC. e. that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.	
H-440.872	HPV Associated Cancer Prevention	1. Our American Medical Association; a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and b. encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs. 2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public. 3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.	Amend. 1. Our American Medical Association; a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and b. encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs. 2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public. 3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers. 4. Our AMA;

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		4. Our AMA; a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits; b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups , including but not limited to low-income and pre-sexually active populations; and c. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education. 6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations, to people who are incarcerated for the prevention of HPV-associated cancers. 7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines. 8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact	a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits; b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups , including but not limited to low-income and pre-sexually active populations; and c. recommends HPV vaccination for all groups for whom national medical specialty societies or the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education. 6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, to people who are incarcerated for the prevention of HPV-associated cancers. 7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines. 8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of

Policy Number	Title	Text	Recommendation
		of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.	broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.
H-440.852	Smallpox: A Scientific Update	Our American Medical Association will remain engaged with the CDC, the Advisory Committee on Immunization Practices (ACIP), and the Federation on smallpox vaccination and support a commitment to monitor the current status of smallpox and smallpox vaccination in the world and in the United States and develop appropriate recommendations as necessary.	Retain.
H-440.993	Smallpox Vaccination Policy	Our AMA supports the recommendations of the Public Health Service Advisory Committee on Immunization Practices that systematic programs of routine vaccination for smallpox for hospital and health personnel no longer be required.	Amend. Our AMA supports the recommendations~~ of the Public Health Service Advisory Committee on Immunization Practices~~ that systematic programs of routine vaccination for smallpox for hospital and health personnel no longer be required.

H-440.808	Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19	COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our American Medical Association: 1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials: a. Vaccine is widely accessible. b. Equity-centered privacy protections are in place to safeguard data collected from individuals. c. Provisions are in place to ensure that vaccine credentials do not exacerbate inequities. d. Credentials address the situation of individuals for whom vaccine is medically contraindicated. 2. Recommends that decisions to mandate COVID-19 vaccination, including, but not limited to for school attendance for children and college/university students, be made only: a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application. b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention. c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination. d. Implementation of the mandate minimizes the potential to exacerbate	Retain

Policy Number	Title	Text	Recommendation
		inequities or adversely affect already marginalized or minoritized populations. 3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust. 4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection. 5. Encourages U.S. government entities to offer vaccines, including COVID-19 vaccines, to all individuals seeking to enter the United States; encourage equitable access to vaccines developed for this and future pandemics; apply immigration requirements for COVID-19 vaccines in the same manner as other vaccines; and require adherence to CDC's evidence-based travel guidelines and public health mitigation measures.	

REPORT OF THE SPEAKERS

The following reports were presented by Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker.

1. ONLINE REFERENCE COMMITTEES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS NOT ADOPTED
REMAINDER OF THE REPORT FILED

The American Medical Association Policy G-600.045, "Online Reference Committee Hearings in the House of Delegates," asks that our AMA:

> Convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days.

DISCUSSION

The 21-day window for Online Reference Committees (ORCs) to be open for comment was established by Speakers' Report 1-A-24, "Report of the Resolution Modernization Task Force Update." Utilization data from the 2024 Interim Meeting and 2025 Annual Meeting show that the majority of comments are made during the first several days of the ORCs being open followed by a flurry of activity the last few days and hours prior to the close of the ORCs. After reviewing this data, your Speakers have determined that reducing the window that ORCs are open to 14 days, would allow more time for reference committees to develop and post Preliminary Reference Committee reports while providing delegations and caucuses with a similar timeframe to comment that has been previously utilized and more time to review the preliminary recommendations.

RECOMMENDATION

Your Speakers recommend that Policy G-600.045, "Online Reference Committee Hearings in the House of Delegates," be amended by addition and deletion and the remainder of the report be filed:

1. Our American Medical Association will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for ~~21~~ 14 days.

Fiscal note: Minimal

2. ELECTION COMMITTEE REVIEW OF ELECTION RULES FOR CLARIFICATION

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF THE REPORT FILED
See Policy G-610.090

The American Medical Association's (AMA) policy G-610.090, "AMA Election Rules and Guiding Principles," has undergone significant changes over the last several years. Much of this work was done by Election Task Forces 1 and 2. The feedback on the elections rules changes has been positive. However, there are a few areas that have elicited questions over the last several election cycles. Therefore, your Speakers asked the Election Committee to identify areas within the rules in need of clarification. After careful consideration, the Election Committee recommended several clarifications.

DISCUSSION

Election complaint process

Although the necessary elements of an election complaint and to whom it must be reported are clearly delineated in policy, the formal complaint filing process is not stated in policy. Election monitoring uses a complaint-based process to identify allegations of election rule violations. Your Speakers and the Office of General Council are available for queries from candidates in interpreting the rules. Such queries are not formal complaints. The Election Committee recommends additional clarity regarding who has standing to file an election complaint for HOD elections and what the statute of limitations for filing should be. Further, clarification should include that a formal complaint must be made in writing, with receipt acknowledged within twenty-four hours.

The Elections Committee suggests that a formal complaint may only be made using the form on the AMA election website with the contents of the form submitted to the Speaker, Vice Speaker and/or the Office of General Counsel by a voting member of the HOD. Further, per House rules, action on a substantiated complaint that is announced to the HOD is ultimately adjudicated by the electorate. Therefore, the Election Committee recommends that all formal complaints must be submitted prior to the start of the election session at which the candidate is on the ballot.

Campaign-related presentations

Individuals running for an AMA office participate in a multitude of activities at AMA sponsored meetings and can be members of many different groups, formal and informal. Election rules do not preclude candidates from active involvement in these various activities and groups. However, questions have been raised regarding what is meant by a campaign-related presentation, as discussed under the interview rules, particularly regarding appearances before groups of which a candidate is a member. Candidates should not be impeded from actively participating in any group of which they are a member.
The Election Committee recommends clarification that a campaign-related presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election during a non-sponsoring group meeting. This allows candidates to make a general introduction and to further participate in non-sponsoring group meetings.
Sponsoring group

While a sponsoring group is clearly defined in our election policy, your Election Committee provides this clarification of sponsoring groups: a delegation, not a caucus, is the only group that may sponsor a candidate.

CONCLUSION

AMA election policy promotes fairness across campaigns. Your Election Committee has offered several clarifications.

RECOMMENDATION

Your Speakers recommend that the following clarifications be made to the AMA election policies and the remainder of the report be filed:

1. A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.
2. A campaign presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election to a non-sponsoring group. A candidate may attend and participate in the business of a non-campaign-related meeting or event of a non-sponsoring group or non-endorsing group, but the candidate shall not engage in campaigning of any kind.

Fiscal note: Minimal

3. SPEAKER RECORDED INTERVIEWS FOR AMA ELECTIONS

Informational report; no reference committee hearing

HOUSE ACTION: FILED

The American Medical Association policy G-610.090, "AMA Election Rules and Guiding Principles," encourages your Speakers to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

In accordance with this guidance, your Speakers have recorded and posted virtual candidate interviews for the last three election cycles. These recorded interviews require significant staff resources to schedule, record, produce and post the videos. In addition, the candidates as well as your Speakers spend time preparing for and recording them. Candidates in contested elections also participate in a number of virtual interviews with official interviewing groups that require further availability away from their already busy schedules.

In assessing the effectiveness of conducting these videos, data was collected from the 2024 and 2025 election cycles which shows that utilization rates of the candidates' videos were low. Total unique viewers of all candidate recorded videos in 2024 was 751 with the most viewed individual candidate video getting 75. In 2025, there were 854 unique viewers with only 106 unique viewers for the most viewed individual candidate. It should be noted that the majority of officer candidate videos were viewed by roughly 60 individuals while most council candidate videos were viewed by roughly 35 individuals. In 2025, the most viewed candidate video was seen by less than 15 percent of delegates with most of the videos seen by less than 5 percent of delegates. This assumes that each unique viewer was a voting delegate, which is an unlikely assumption as these videos were publicly available.

CONCLUSION

Given the low viewership over the past two election cycles and the resources required to produce them, Speaker recorded virtual interviews of announced candidates will no longer be continued.