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REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-I-25

Subject: Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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. That our American Medical Association (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.

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. (Modify HOD Policy)

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

Fiscal Note: Less than $500.

REFERENCES

[1] "U.S. Overdose Deaths Decrease Almost 27% in 2024." National Center for Health Statistics. U.S. Centers for Disease Control and Prevention. May 14, 2025. Available at https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2025/20250514.htm
[2] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008
[3] SUDORS Dashboard: Fatal Drug Overdose Data. U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html Last accessed July 3, 2025.
[4] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008
[5] The AMA Substance Use and Pain Care Task Force, in recommendations issued in 2015, 2019 and 2021, detailed many clinical and policy-related aspects of the multifaceted, public health approach needed. See, generally, https://end-overdose-epidemic.org/task-force-recommendations/
[6] Fischer, L.S., Asher, A., Stein, R. *et al.* Effectiveness of naloxone distribution in community settings to reduce opioid overdose deaths among people who use drugs: a systematic review and meta-analysis. *BMC Public Health* 25, 1135 (2025). https://doi.org/10.1186/s12889-025-22210-8
[7] Karsten MB. A Case for Needle Exchange Programs: Not Letting Perfection be the Enemy of the Good. *Georgetown Medical Review*. 2023;7(1). doi:10.52504/001c.83277
[8] John R. Pamplin II, Saba Rouhani, Corey S. Davis, Carla King, and Tarlise N. Townsend: Persistent Criminalization and Structural Racism in US Drug Policy: The Case of Overdose Good Samaritan Laws
American Journal of Public Health 113, S43_S48, https://doi.org/10.2105/AJPH.2022.307037
[9] "Top addiction researcher Nora Volkow on NIH cuts, optimism, and the limits of RFK Jr.'s 12-step experience." STAT News. March 13, 2025. Available at https://www.statnews.com/2025/03/13/nora-volkow-nida-addiction-researcher-qa-rfk-12-step-recovery-overdose-death-declines
[10] Tanz LJ, Stewart A, Gladden RM, Ko JY, Owens L, O'Donnell J. Detection of Illegally Manufactured Fentanyls and Carfentanil in Drug Overdose Deaths — United States, 2021–2024. MMWR Morb Mortal Wkly Rep 2024;73:1099–1105. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a2

[11] 2025 National Drug Threat Assessment. U.S. Drug Enforcement Administration. Available at https://www.dea.gov/sites/default/files/2025-07/2025NationalDrugThreatAssessment.pdf
[12] Vickers-Smith RA, Gelberg KH, Childerhose JE, et al. Fentanyl Test Strip Use and Overdose Risk Reduction Behaviors Among People Who Use Drugs. *JAMA Netw Open.* 2025;8(5):e2510077. doi:10.1001/jamanetworkopen.2025.10077
[13] Gozdzialski, L., Wallace, B. & Hore, D. Point-of-care community drug checking technologies: an insider look at the scientific principles and practical considerations. *Harm Reduct J* **20**, 39 (2023). https://doi.org/10.1186/s12954-023-00764-3
[14] Cash RE, Kinsman J, Crowe RP, Rivard MK, Faul M, Panchal AR. Naloxone Administration Frequency During Emergency Medical Service Events — United States, 2012–2016. MMWR Morb Mortal Wkly Rep 2018;67:850–853. DOI: http://dx.doi.org/10.15585/mmwr.mm6731a2
[15] CBP: America's Front Line Against Fentanyl. U.S. Customs and Border Protection. Last Modified: May 22, 2025. Last accessed July 9, 2025. Available at https://www.cbp.gov/frontline/cbp-america-s-front-line-against-fentanyl
[16] "Justice Department Highlights DEA Drug Seizures for First Half of 2025, Successful Operations Over the Last Several Weeks." News release. U.S. Department of Justice. July 15, 2025. Available at https://www.justice.gov/opa/gallery/justice-department-highlights-dea-drug-seizures-first-half-2025-successful-operations
[17] Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report
[18] *See,* for example, "FACT SHEET: Biden-Harris Administration Announces New Actions to Counter the Scourge of Fentanyl and Other Synthetic Drugs." July 31, 2024. Available at https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2024/07/31/fact-sheet-biden-%E2%81%A0harris-administration-announces-new-actions-to-counter-the-scourge-of-fentanyl-and-other-synthetic-drugs/; and also Statement of Drug Policy Priorities. White House Office of National Drug Control Policy. April 1, 2025. Available at https://www.whitehouse.gov/wp-content/uploads/2025/04/2025-Trump-Administration-Drug-Policy-Priorities.pdf
[19] Recent DEA Seizures of Pill Presses. U.S. Drug Enforcement Administration. April 9, 2024. Available at https://www.dea.gov/stories/2024/2024-04/2024-04-09/recent-dea-seizures-pill-presses
[20] State Approaches to Addressing the Opioid Epidemic: Findings from a Survey of State Medicaid Programs. Kaiser Family Foundation. February 6, 2024. Available at https://www.kff.org/medicaid/issue-brief/state-approaches-to-addressing-the-opioid-epidemic-findings-from-a-survey-of-state-medicaid-programs
[21] See, New rules enable telemedicine treatment for opioid-use disorder. March 12, 2024. Available at https://www.ama-assn.org/delivering-care/nation-s-overdose-epidemic/new-rules-enable-telemedicine-treatment-opioid-use
[22] For a comprehensive review of state laws, *see* Harm Reduction and Overdose Prevention 50-State Survey. Network for Public Health Law. Current as of August 1, 2023. Available at https://www.networkforphl.org/wp-content/uploads/2024/10/50-State-Survey-Harm-Reduction-Laws-in-the-United-States.pdf
[23] Flavin L, Rosen JG, St John K, Hallowell BD, Weidele HR, Krieger MS, McKenzie M, Green TC, Rich JD, Park JN. Bystander Presence and Naloxone Administration During Fatal Opioid-involved Overdoses in Rhode Island: Implications for Naloxone Coverage Among Families and Peers. J Addict Med. 2025 Apr 25:10.1097/ADM.0000000000001502. doi: 10.1097/ADM.0000000000001502. Epub ahead of print. PMID: 40277214; PMCID: PMC12217843.
[24] Gage CB, Powell JR, Ulintz A, et al. Layperson-Administered Naloxone Trends Reported in Emergency Medical Service Activations, 2020-2022. *JAMA Netw Open.* 2024;7(10):e2439427. doi:10.1001/jamanetworkopen.2024.39427
[25] DRUG MISUSE: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. U.S. Government Accountability Office. GAO-21-248. Available at https://www.gao.gov/assets/gao-21-248.pdf

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-I-25

Subject: Laser Surgery
(Resolution 210-I-24)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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.~~ (Modify Current HOD Policy)

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". (Modify Current HOD Policy)

    2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined

by AMA Policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-I-25

Subject: Stark Law Self-Referral Ban

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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. (New HOD Policy)

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." (New HOD Policy)

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. (New HOD Policy)

Fiscal Note: Less than $500.

REPORT 04 OF THE BOARD OF TRUSTEES (I-25)
American Medical Association (AMA) Efforts on Addressing and Reducing Patient Boarding in Emergency Departments (EDs)
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2024 Interim Meeting, the AMA House of Delegates adopted alternate Resolution 201, which established Policy D-130.957, "Addressing and Reducing Patient Boarding in EDs." This report responds to the directive to report back at the 2025 Interim Meeting on progress made addressing and reducing patient boarding in EDs, recognizing that more recent developments may not be reflected due to report preparation timelines.

ED boarding, which occurs when patients remain in the ED after admission or placement in observation status, is a growing national crisis, with more than 90 percent of EDs reporting crowded conditions. Boarding delays treatment, worsens patient outcomes, contributes to staff burnout, and increases violence against health care workers. The AMA's advocacy has included federal and state engagement, collaboration with the American College of Emergency Physicians and other organizations, and input on quality measurement initiatives. Recently, the AMA supported the "Addressing Boarding and Crowding in the Emergency Department Act of 2025," (H.R. 2936/S. 1974) bipartisan legislation that would enable public health data modernization grants to support the development of real-time hospital bed capacity tracking systems, establish public-facing dashboards to promote accountability and transparency, and promote pilot programs through the Center for Medicare and Medicaid Innovation to address causes of ED boarding. The AMA has also advanced multiple policy levers to mitigate the root causes of boarding including improving behavioral health and substance use disorder care, extending the Acute Care Hospital at Home Program, strengthening access to primary and specialty care, expanding social supports, reducing prior authorization and other administrative burdens, increasing workforce and post-acute care capacity, expanding telehealth flexibilities, increasing the efficiency of staff and practice workflows, strengthening Medicare reimbursement, and protecting Medicaid and affordable coverage options. The AMA has also prioritized physician well-being, working to reduce burnout and address the increased risk of workplace violence associated with boarding.

Sustained progress on ED boarding will require coordinated solutions at the federal, state, and local levels. The AMA will continue to advocate for policy and payment reforms, support the Agency for Healthcare Research and Quality's stakeholder convenings, and collaborate with industry partners to identify high-impact interventions that improve system-wide throughput and reduce the harmful impacts of boarding. This work advances the goals of Policy D-130.957 and positions the AMA as a national leader in addressing this significant public health challenge.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-I-25

Subject: Addressing and Reducing Patient Boarding in Emergency Departments (EDs)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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 by deletion of the sixth clause since it has been accomplished by this report and the remainder of the report be filed:

Fiscal Note: Less than $500.

REFERENCES

[1] Moore, C., & Heckmann, R. (2025, March 12). Hospital boarding in the ED: Federal, state, and other approaches. Health Affairs Forefront. https://doi.org/10.1377/forefront.20250310.355985.
[2] Weinick, R. M., Bruna, S., Boicourt, R. M., Michael, S. S., & Sessums, L. L. (2025, January). AHRQ summit to address emergency department boarding: Technical report. Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/wysiwyg/topics/ed-boarding-summit-report.pdf.
[3] "Emergency Department Crowding: High Impact Solutions." Emergency Medicine Practice Committee. American College of Emergency Physicians. May 2016.
[4] Raphelson, Samantha. "How The Loss Of U.S. Psychiatric Hospitals Led To A Mental Health Crisis." National Public Radio. November 30, 2017. https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis.
[5] Greenwood-Ericksen MB, Kocher K. Trends in Emergency Department Use by Rural and Urban Populations in the United States. JAMA Netw Open. 2019;2(4):e191919. doi:10.1001/jamanetworkopen.2019.1919. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2730472
[6] Mohr NM, Wu C, Ward MJ, McNaughton CD, Faine B, Pomeranz K, Richardson K, Kaboli PJ. Transfer boarding delays care more in low-volume rural emergency departments: A cohort study. J Rural Health. 2022 Jan;38(1):282-292. doi: 10.1111/jrh.12559. Epub 2021 Feb 28. PMID: 33644911; PMCID: PMC8715860. https://pmc.ncbi.nlm.nih.gov/articles/PMC8715860/#:~:text=Transfer%20boarding%20delays%20care%20more,departments:%20A%20cohort%20study%20%2D%20PMC.
[7] "Approved Facilities/Systems for Acute Hospital Care at Home." CMS QualityNet. January 26, 2024. https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.
[8] Federman, Alex D., Tacara Soones, Linda V. DeCherrie, Bruce Leff, and Albert L. Siu. "Association of a bundled hospital-at-home and 30-day post-acute transitional care program with clinical outcomes and patient experiences." JAMA Internal Medicine (2018).
[9] See Moore supra at 1.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-I-25

Subject: Information Blocking Rule

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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 that indicate debilitating, life-limiting, or terminal illnesses, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)
2. Our AMA supports the ability of patients to request physician or surrogate review of potentially life-altering report and result information prior to its release, when consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)
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. (Reaffirm HOD Policy)

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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-I-25

Subject: Codification of the Chevron Deference Doctrine

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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

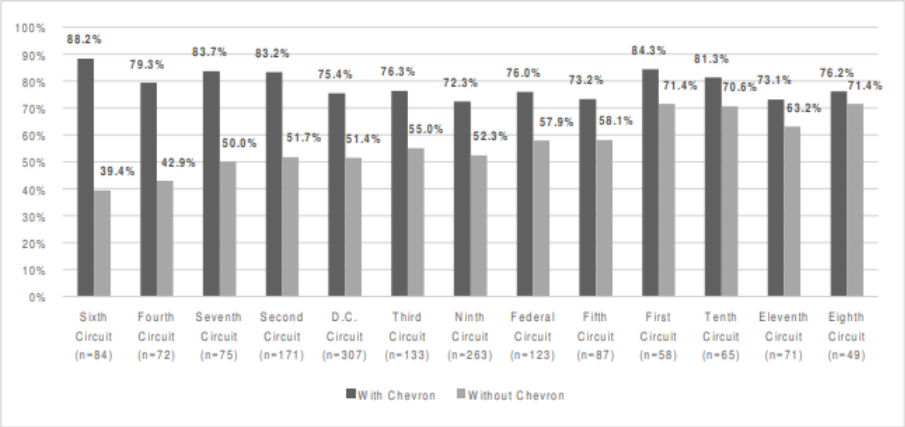
Risks of Executive Discretion

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."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-25

Subject: Support For Doula Care Programs

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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.[i]

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

[i] 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).

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 only when doulas provide non-clinical peripartum and birthing support and:
    a. possess licenses/certifications that include training specifically limited to nonclinical support and adhere to state certification requirements;
    b. retain 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. (New HOD Policy)

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

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.	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 o 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

	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. 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.	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 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. 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.
		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

	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.	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. o 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, labor/delivery, postpartum lactation, and newborn areas of care
Connecticut [39]	Allows for doulas to perform services but they may only be called certified	Training Pathway:

	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.	• 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	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

	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.	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. • 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: o Cultural Competency/Bias Training o HIPAA (Health Insurance Portability and Accountability Act) o Trauma-informed Care o CPR/Basic Life Support o Anatomy and Physiology (Pregnancy and Birth) Legacy Doula Pathway: • Active doula (five perinatal doula experiences in the past three years) • Completion of courses below: o Cultural Competency/Bias Training o HIPAA (Health Insurance Portability and Accountability Act) o Trauma-informed Care o CPR/Basic Life Support o Anatomy and Physiology (Pregnancy and Birth)
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: o Birth Doula Training o Antepartum Doula Training o Postpartum Doula Training o Lactation Support o Childbirth Education o Foundations on Anatomy of Pregnancy and Childbirth o Nonmedical Comfort Measures, Prenatal Support, and Labor Support Techniques o Postpartum Health o Reproductive Health Counseling o Pregnancy Loss and Support o Cultural Competency o HIPAA Training o Adult and Children/Infant CPR Certification o 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.	Experience Pathway: • Submission of three letters of recommendation from clients to

	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. 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.	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 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 • 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	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 whom the prospective MassHealth doula provided doula services (either paid or volunteer) within the last five years o 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: o 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 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 possess a current certificate issued by a national or Missouri-based doula training organization

	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.	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-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: o 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. o 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. 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	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: • 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

	certification, and completing 20 hours of continuing education in the Nevada Birth Doula Competencies.	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	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

	• Annually submits evidence that the applicant is a certified doula Enroll as a Medicaid provider. Must pass a background check. Must have liability insurance.	facilitating access to NJ-specific community-based resources • Relevant readings associated with classroom hours, cultural competency, 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.	Training Pathway: • 24-hour minimum training in all required competencies • Doula support provided at a minimum of three births Work Experience Pathway:

	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.	• 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.	
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. ○ At least four of those hours must be training directly related to racial bias, health disparities, and cultural competency. ○ 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. 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: o One hour of interprofessional collaboration. o One hour of Health Insurance Portability and Accountability Act (HIPAA) compliance. o 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. • 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 • 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 o 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 o 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. 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.	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 • 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

	Must be recertified every two years.	• 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: • 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 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.

	Must renew certification every two years.	
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). Must recertify every two years and complete a minimum of 15 hours of continuing education from an approved training entity.	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 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	Training Pathway: • Successfully complete training and education programs approved by the secretary that collectively introduce students to the key principles of the following topics: o Role of a birth doula

	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: o History of obstetrics o Trauma-informed care o Social determinants of health o Adverse childhood experiences o Other training and education that enhances the applicant's knowledge of culturally congruent care or culturally congruent ancestral practices, training, and education. • 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.	o Prenatal and birth care o Postpartum care o Communication and interpersonal skills o Doula safety and self-care o 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: o An attestation on forms provided by the department that they have completed training that is substantially equivalent to the required training or o 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 the United States may be certified by endorsement. An applicant shall

	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.	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.	
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%
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%
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%
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%
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.

REFERENCES

[1] Chen A. Doula Medicaid Project. National Health Law Program. Published April 17, 2025. Accessed July 23, 2025. https://healthlaw.org/doulamedicaidproject/.
[2] Doula State Certification. Family Planning. Published June 27, 2025. Accessed July 23, 2025. https://www.vdh.virginia.gov/family-planning/doula-state-certification/.
[3] Medicaid and CHIP Payment and Access Commission. Doulas in Medicaid: Case Study Findings. MACPAC; 2023. Accessed July 23, 2025. https://www.macpac.gov/wp-content/uploads/2023/11/Doulas-in-Medicaid-Case-Study-Findings.pdf.
[4] Falconi AM, Ramirez L, Cobb R, Levin C, Nguyen M, Inglis T. Role of Doulas in Improving Maternal Health and Health Equity Among Medicaid Enrollees, 2014–2023. American Journal of Public Health. 2024;114(11):1275-1285. doi: https://doi.org/10.2105/ajph.2024.307805.
[5] Rudowitz R, Burns A, Hinton E, Mohamed M. 10 Things to Know About Medicaid. KFF. Published February 18, 2025. Accessed July 23, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.
[6] *Id*.
[7] State Plan Amendments (SPA) | Medicaid. Medicaid.gov. Published June 23, 2025. Accessed July 23, 2025. https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/state-plan-amendments-spa.
[8] Center for Medicaid and CHIP Services. 2024 Medicaid and CHIP Beneficiaries at a Glance: Maternal Health. Centers for Medicare & Medicaid Services. Published May 2024. Accessed July 23, 2025. https://www.medicaid.gov/medicaid/benefits/downloads/2024-maternal-health-at-a-glance.pdf.
[9] Chen A, Robles-Fradet A. NHeLP's Doula Medicaid Project: Current State Efforts at Expanding Access to Doula Care. National Health Law Program. Published June 2025. Accessed July 23, 2025. https://docs.google.com/spreadsheets/d/1vsZTIecerW5t49Gg01pya2fURuZ-L6tDimC2e3QeIeE/edit?gid=1534310451#gid=1534310451.
[10] Medicaid and CHIP Payment and Access Commission, *supra* note 3.
[11] Tsai D. Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). Centers for Medicare & Medicaid Services. Published December 7, 2021. Accessed July 23, 2025. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.
[12] Medicaid and CHIP Payment and Access Commission, *supra* note 3.
[13] *Id*.
[14] Knocke K, Chappel A, Sugar S, De Lew N, Sommers B. Doula Care and Maternal Health: An Evidence Review. Assistant Secretary for Planning and Evaluation; 2022. Accessed July 23, 2025. https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf.
[15] AAPC. Doula Birth Worker Services HCPCS Code range T1032-T1033. Codify by AAPC. Published 2025. Accessed July 23, 2025. https://www.aapc.com/codes/hcpcs-codes-range/567/?srsltid=AfmBOoqi5XLS-jMl8SAUyGljg45dlEihEN2zsfYQ7nun_XZrWxuR5SAN.
[16] Services D. Doula Services.; 2022. Accessed July 23, 2025. https://providers.anthem.com/docs/gpp/CA_CAID_DoulaProviderManual.pdf?v=202306231849.
[17] Tsai, *supra* note 11.
[18] Chen A, Rohde K. Doula Medicaid Training and Certification Requirements: Summary of Current State Approaches and Recommendations for Improvement. National Health Law Program. Published March 16, 2023. Accessed July 23, 2025. https://healthlaw.org/doula-medicaid-training-and-certification-requirements-summary-of-current-state-approaches-and-recommendations-for-improvement/.
[19] DONA International . Birth Doula Certification a Doula's Guide . DONA International ; 2023. Accessed July 23, 2025. https://www.dona.org/wp-content/uploads/2023/04/Updated-Birth-Doula-Certification-Overview-04-15-2023.pdf.
[20] CAPPA. Certified Labor Doula (CLD) | CAPPA. CAPPA. Published July 29, 2020. Accessed July 23, 2025. https://cappa.net/training-certification/certified-labor-doula-cld/.
[21] National Doula Certification Board . Certified Professional Doula (CPD) Initial Certification Requirements Step 1 -Educational Validation. Accessed July 23, 2025. https://www.doulaboard.org/wp-content/uploads/2023/07/Certified-Professional-Doula.pdf.
[22] International Doula Institute. Standards of Practice – Birth Doula . Published February 15, 2023. Accessed July 25, 2025. https://internationaldoulainstitute.com/standards-of-practice-birth-doula/.

[23] Herbert K. Private Insurance Coverage of Doula Care: Spring 2025 State of the States. National Health Law Program. Published April 21, 2025. Accessed July 23, 2025. https://healthlaw.org/private-insurance-coverage-of-doula-care-spring-2024-state-of-the-states/.
[24] Knocke K, Chappel A, Sugar S, De Lew N, Sommers B. Doula Care and Maternal Health: An Evidence Review. Assistant Secretary for Planning and Evaluation; 2022. Accessed July 23, 2025. https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf.
[25] NYC Health. Hospital Doula-Friendliness Guidebook.; 2024. Accessed July 25, 2025. https://www.nyc.gov/assets/doh/downloads/pdf/ms/hospital-doula-friendliness-guidebook.pdf.
[26] *Id*.
[27] Skopec L, Pugazhendhi A, Zuckerman S. Updated Medicaid-To-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees. Health Affairs. 2025;44(5):531-538. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2024.01530.
[28] McMorrow S, Holahan J, Berenson RA. Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty. Urban Institute. Published October 18, 2021. Accessed August 1, 2025. https://www.urban.org/research/publication/commercial-health-insurance-markups-over-medicare-prices-physician-services-vary-widely-specialty.
[29] American Medical Association. Medicare physician payment continues to fall further behind practice cost inflation. Published January 2025. Accessed August 1, 2025. https://fixmedicarenow.org/sites/default/files/2025-01/Medicare%20Gap%20Chart_2025.pdf.
[30] Arrington J. One Big Beautiful Bill Act.; 2025. Accessed July 23, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1.
[31] Arizona Department of Health Services. Article 9: Doula Certification. Accessed July 23, 2025. https://www.azdhs.gov/documents/licensing/special/doulas/doulas-rules.pdf.
[32] Scott J. Arizona State Plan Amendment - 24-0006. Centers for Medicare & Medicaid Services. Published August 23, 2024. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/AZ-24-0006.pdf.
[33] Bureau of Licensing for Professions and Occupations. Doula Certification Reciprocity Application.; 2025. Accessed July 24, 2025. https://www.azdhs.gov/documents/licensing/special/doulas/doula-reciprocity-application.pdf?v=20230808.
[34] Johnson L., Irvin M. Certified Community-Based Doula Certification Act.; 2025. Accessed July 24, 2025. https://arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2025R%2FPublic%2FACT965.pdf.
[35] California Department of Health Care Services. Doula Services Frequently Asked Questions. DHCS. Published March 11, 2025. Accessed July 24, 2025. https://www.dhcs.ca.gov/provgovpart/Pages/Doula-Providers-Enrolling-As-A-Doula-FAQ.aspx#:~:text=The%20Department%20of%20Health%20Care,Childbirth%20education.
[36] Medi-Cal. Doula Services. Published March 2025. Accessed July 24, 2025. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/0075B242-F893-41DB-A418-4129A274E46C/doula.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
[37] Colorado Administrative Code. 10 CCR 2505-10-8.734 - Doula Services. Published September 30, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/colorado/10-CCR-2505-10-8.734.
[38] Colorado Department of Health Care Policy & Financing. Health First Colorado Doula Benefit: Provider Training. Published 2019. Accessed July 24, 2025. https://drive.google.com/file/d/1gOCSLtazqTtwSxTOyxNrZgjuktYwryiN/view.
[39] General Statutes of Connecticut. Chapter 377a Doulas. Published July 1, 2023. Accessed July 24, 2025. https://www.cga.ct.gov/2024/sup/chap_377a.htm.
[40] Delaware Certification Board . Certified Doula for Medicaid Reimbursement. Published 2022. Accessed July 24, 2025. https://www.decertboard.org/doula.
[41] Delaware Certification Board. DCB Doula for Medicaid Reimbursement Application.; 2023. Accessed July 24, 2025. https://www.decertboard.org/sites/default/files/2024-01/DCB_Doula_Application_23_0.pdf.
[42] Chen A. Doula Medicaid Project: February 2024 State Roundup. National Health Law Program. Published February 21, 2024. Accessed July 24, 2025. https://healthlaw.org/doula-medicaid-project-february-2024-state-roundup.
[43] SIU School of Medicine. Pathways & Requirements Illinois Medicaid-Certified Doula Program. Published 2025. Accessed July 24, 2025. https://www.siumed.edu/fcm/pathways-requirements.

[44] Indiana Code. 12-7-2-69.7 Doula. Published 2024. Accessed July 24, 2025. https://law.justia.com/codes/indiana/title-12/article-7/chapter-2/section-12-7-2-69-7/.
[45] Iowa Health & Human Services. Maternal Health Doula Project. Published March 31, 2025. Accessed July 24, 2025. https://hhs.iowa.gov/programs-and-services/family-health/maternal-health/programs/doula.
[46] KanCare. Doula Enrollment Instructions . Accessed July 24, 2025. https://portal.kmap-state-ks.us/Documents/Provider/Forms/Doula/Doula_Attestation_Form_Packet.pdf.
[47] Humana. Humana Healthy Horizons in Kentucky Provider Maternal Health Resources. Published 2025. Accessed July 24, 2025. https://provider.humana.com/medicaid/kentucky-medicaid/maternal-health.
[48] Louisiana Administrative Code. Title 48, § V-17301 - Qualifications for Registration. Published February 1, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/louisiana/La-Admin-Code-tit-48-SS-V-17301.
[49] Louisiana Administrative Code. Title 48 Public Health General Part I. General Administration Subpart 3. Licensing and Certification. Published May 2025. Accessed July 24, 2025. https://www.doa.la.gov/media/52pfpizc/48v2.pdf.
[50] Miller D. Requires Medicaid Coverage for Certain Doula Services. Vol H.B. 454.; 2025. Accessed July 24, 2025. https://www.legis.la.gov/legis/BillInfo.aspx?s=25rs&b=HB454&sbi=y.
[51] State of Maine. H.P. 1008 - L.D. 1523 Resolve, to Develop MaineCare Coverage for Doula Services. Published June 19, 2025. Accessed July 24, 2025. https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP1008&item=3&snum=132.
[52] Maryland Code of Regulations. Md. Code Regs. 10.09.39.01 - Definitions. Published February 21, 2022. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/maryland/COMAR-10-09-39-01.
[53] Scott J. Delaware State Plan Amendment 24-0001. Centers for Medicare & Medicaid Services. Published June 20, 2024. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/DE-24-0001.pdf.
[54] Title 10 Maryland Department of Health Subtitle 09 Medical Care Programs. Accessed July 24, 2025. https://health.maryland.gov/regs/SiteAssets/Lists/Proposed%20Regulations/NewForm/10.09.39%20Text%20-%20Draft.pdf.
[55] Maryland Code of Regulations. 10.09.36.03 - Conditions for Participation. Published September 18, 2023. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/maryland/COMAR-10-09-36-03.
[56] Massachusetts Regulations. 130 CMR, § 463.404 - Provider Eligibility. Published November 8, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/massachusetts/130-CMR-463-404.
[57] Michigan Medicaid Policy. Medicaid Coverage of Doula Services. Published January 1, 2023. Accessed July 24, 2025. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2022-Bulletins/Final-Bulletin-MMP-22-47-Doula.pdf.
[58] Michigan Department of Health and Human Services. Michigan Department of Health and Human Services Doula Initiative Doula Provider Frequently Asked Questions Guidance.; 2023. Accessed July 24, 2025. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Maternal-and-Infant-Health/Doula-Provider-FAQ-Guidance_Final.pdf.
[59] Minnesota Statutes. 148.995 Definitions. Published 2024. Accessed July 24, 2025. https://www.revisor.mn.gov/statutes/cite/148.995.
[60] Minnesota Department of Health. Minnesota Doula Registry. Published December 17, 2024. Accessed July 24, 2025. https://www.health.state.mn.us/facilities/providers/doula/index.html.
[61] Missouri Code of State Regulations. 13 CSR 70-25.160 - Doula Services. Published April 30, 2025. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/missouri/13-CSR-70-25-160.
[62] Neumann C. Generally Revise Health Care Laws Related to Doulas. MT SB 319.; 2025. Accessed July 24, 2025. https://www.billtrack50.com/billdetail/1753924.
[63] Nevada Certification Board. Birth Doula Certification Requirements. Published March 14, 2025. Accessed July 24, 2025. https://nevadacertboard.org/certs/doula/requirements/.
[64] Nevada Certification Board. Birth Doula Competencies, Scope of Work, and Service Provision for NCB Certified Doulas.; 2022. Accessed July 24, 2025. https://nevadacertboard.org/wp-content/uploads/2022/09/Birth-Doula-Competencies-508.pdf.
[65] Whitley B. Relative to Doula and Lactation Service Provider Certification. Vol NH SB 337.; 2024. Accessed July 24, 2025. https://www.billtrack50.com/billdetail/1655188.
[66] Teresa Ruiz M. Doula Care.; 2021. Accessed July 24, 2025. https://www.njleg.state.nj.us/bill-search/2020/S4229/bill-text?f=S4500&n=4229_I1.
[67] NJMIHIA. Approved Trainings for Enrollment as a NJ FamilyCare Community Doula.; 2025. Accessed July 24, 2025. https://www.nj.gov/humanservices/dmahs/info/NJFC_Approved_Doula_Trainings.pdf.

[68] New Jersey Department of Human Services. Steps for Individual Doulas to Enroll in FFS NJ FamilyCare (Medicaid).; 2021. Accessed July 24, 2025. https://www.nj.gov/humanservices/dmahs/info/NJFC_Doula_Steps.pdf.
[69] NMHealth. Doula Program. Published 2025. Accessed July 24, 2025. https://www.nmhealth.org/about/phd/fhb/mch/doula/.
[70] NMHealth. Becoming a Certified Doula New Mexico Department of Health Doula Certification Toolkit. Published June 2025. Accessed July 24, 2025. https://www.nmhealth.org/publication/view/guide/9154/.
[71] NMHealth. Frequently Asked Questions (FAQs). Accessed July 24, 2025. https://www.nmhealth.org/publication/view/help/9088/.
[72] New York State Department of Health. Non-Patient-Specific Standing Order for the Provision of Doula Services for Pregnant, Birthing and Postpartum Persons. Published June 10, 2025. Accessed July 24, 2025. https://www.health.ny.gov/health_care/medicaid/program/doula/doula_standing_order.htm.
[73] New York State Department of Health. Pathway Options to Enroll as a NYS Medicaid Doula Services Provider.; 2024. Accessed July 24, 2025. https://www.health.ny.gov/health_care/medicaid/program/doula/docs/visualize_enrollment_pathways.pdf.
[74] Ohio Administrative Code. 4723-24-02 - Doula certification. Published September 30, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/ohio/Ohio-Admin-Code-4723-24-02.
[75] Oklahoma Health Care Authority. 317:30-5-1216. Eligible providers. Published 2024. Accessed July 24, 2025. https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers-and-specialties/doula/doula-providers.html.
[76] Oregon Health Authority. Birth Doulas. Accessed July 24, 2025. https://www.oregon.gov/oha/ei/pages/thw_birthdoulas.aspx.
[77] Oregon Health Authority. 950-060-0150 Birth Doula Certification Curriculum Standards. Accessed July 24, 2025. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=301070.
[78] Pennsylvania Certification Board. Certified Perinatal Doula Application . Published January 2024. Accessed July 24, 2025. https://www.pacertboard.org/sites/default/files/2025-06/PCB_Doula_App_24.pdf.
[79] Hughes R. Pennsylvania State Plan Amendment 25-0003. Centers for Medicare & Medicaid Services . Published April 2, 2025. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/PA-25-0003.pdf.
[80] Rhode Island Certification Board. Certified Perinatal Doula (CPD). Published 2022. Accessed July 24, 2025. https://www.ricertboard.org/certified-perinatal-doula-cpd.
[81] South Dakota Department of Social Services. South Dakota Medicaid Billing and Policy Manual Doula Services.; 2025. Accessed July 24, 2025. https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Doula_Services.pdf.
[82] Scott J. South Dakota State Plan Amendment 24-0017. Centers for Medicare & Medicaid Services. Published January 15, 2025. Accessed July 24, 2025. https://dss.sd.gov/docs/medicaid/medicaidstateplan/Approved/Doula_Services.pdf.
[83] TN Department of Health. Doula Services Advisory Committee. Published 2023. Accessed July 24, 2025. https://www.tn.gov/health/health-program-areas/fhw/get-involved-with-fhw/taskforces-and-committees/doula-services.html.
[84] Texas Doula Association. HB 1575 Information. Published 2023. Accessed July 24, 2025. https://www.txdoulas.org/our-work-1.
[85] Scott J. Texas State Plan Amendment - 24-0006. Centers for Medicare & Medicaid Services. Published November 22, 2024. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/TX-24-0006.pdf.
[86] Escamilla L, Clancy T. Utah State Legislature S.B. 284 Medicaid Doula Services. Published May 11, 2025. Accessed July 24, 2025. https://le.utah.gov/~2025/bills/static/SB0284.html.
[87] Vermont Legislature. VT S0053 An act relating to certification of community-based perinatal doulas and Medicaid coverage for doula services. Published June 11, 2025. Accessed July 24, 2025. https://www.billtrack50.com/billdetail/1822405#:~:text=%C2%A7%204176.,%C2%A7%204177.
[88] Administrative Code of Virginia. 12VAC5-403-70. Certification not required. Published January 6, 2022. Accessed July 24, 2025. https://law.lis.virginia.gov/admincode/title12/agency5/chapter403/section70/.
[89] Virginia Department of Health. State-Doula Certification Program. Published June 27, 2025. Accessed July 24, 2025. https://www.vdh.virginia.gov/family-planning/doula-state-certification/.
[90] Virginia Certification Board. State-Certified Doula (SCD). Published 2022. Accessed July 24, 2025. https://www.vacertboard.org/doula.

[91] Washington State Legislature. Chapter 18.47 RCW Birth Doulas. Published October 1, 2023. Accessed July 24, 2025. https://app.leg.wa.gov/RCW/default.aspx?cite=18.47&full=true.
[92] Washington State Legislature. Chapter 246-835 WAC Birth Doula. Published December 26, 2024. Accessed July 24, 2025. https://app.leg.wa.gov/WAC/default.aspx?cite=246-835&full=true.
[93] Byrd M. Provider Qualifications and Enrollment, Rates and Reimbursement Standards. Government of the District of Columbia Department of Health Care Finance; 2022. Accessed July 24, 2025. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-25

Subject: Antidiscrimination Protections for LGBTQ+ Youth in Foster Care

Presented by: David H. Aizuss, MD

Referred to: Reference Committee B

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[1] 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

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

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.

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.[2] 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.[3]

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.[4] 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

[2] https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map
[3] https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-gender-affirming-care-transgender-youth-us
[4] https://www.hhs.gov/sites/default/files/ocr-rescission-february-20-2025-notice-guidance.pdf

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.[5] 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.[6]

These challenges are compounded by growing concerns over the misuse of electronic health records and SOGI data. In states such as Missouri[7] and Florida,[8] 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.[9] 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

[5] https://healthlgbtq.org/advocacy_brief/overview-2025-executive-actions-impacting-lgbtq-health/#:~:text=Since%20taking%20office%20in%20January,serve%20people%20fairly%20and%20safely

[6] https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-gender-affirming-care-transgender-youth-us

[7] 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

[8] 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

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

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.[10]

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 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.

[10] 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

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 strengthen youth-centered privacy protections for sexual orientation and gender identity (SOGI) data in foster care. (New HOD Policy)

Fiscal Note: To be determined

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-25

Subject:	Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee B

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," and asks our AMA to do the following:

> 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 August 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 the then newly appointed FDA Chief Medical and Scientific Officer 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.

* On July 29, 2025, Dr. Prasad stepped down from all roles at the FDA and was replaced in his role as director of the FDA's Center for Biologics Evaluation and Research by Dr. George Tidmarsh (in an acting capacity).

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.

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. On July 29, 2025, the United States Senate voted to confirm Susan Monarez as director of the CDC. 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 August 6, 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 August 6, 2025, are outlined 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 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.

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 in July. 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.

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.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-I-25

Subject: Preservation of Medicaid

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

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~~. (Modify Current Policy)

Fiscal note: Less than $500.

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

May 13, 2025

The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
348 Cannon House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Pallone:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our perspective on the Committee on Energy and Commerce Budget Reconciliation text.

The AMA strongly supports section 44304 of the Committee's recommendations, which provides a positive modification to the conversion factor under the Medicare physician fee schedule. Physician practices have faced a 33 percent loss in purchasing power since 2001, severely straining their sustainability. Congress has adopted several temporary physician payment updates to help address steep pay cuts that took effect starting in 2021, but each of these updates led to a steep cliff as the payment update expired and reverted to the reduced payment rate as if there had been no legislative provision at all. Section 44304 provides the first Medicare physician payment update that is permanently built into baseline Medicare rates since the passage of the Medicare and CHIP Reauthorization Act (MACRA) in 2015. As recommended by the Medicare Payment Advisory Commission, it links the Medicare update to inflation in medical practice costs as measured by the Medicare Economic Index (MEI). The proposed 2026 update, 75 percent of MEI, is significantly higher than any of the annual physician payment updates in MACRA. It has been decades since Medicare physician payment updates were linked to the MEI and the AMA strongly supports it.

Under current law, the update for most physician practices will lead to rates being below their 2024 levels at the end of the budget window in 2035. It is absolutely vital that this issue be addressed. It should come as no surprise that physician ownership of their practices has collapsed dramatically over the past quarter century. In 2001, 61 percent of physicians were owners. By 2016, fewer than half of physicians had ownership stakes in their practices, and since 2018 more physicians are employees than owners. Physicians should not be forced to leave community-based practice because it is not financially sustainable, and addressing this erosion is essential to strengthening the Medicare program and protecting patient access to care.

We further view these provisions as a foundational step toward comprehensive Medicare physician payment reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to maintaining practice stability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—particularly in rural and underserved communities. Medical practices in the most rural locations treat four times as many Medicare patients as metropolitan practices. The AMA remains

committed to working with Congress to achieve lasting reforms so patients and physicians have the Medicare program they deserve.

The AMA is very pleased to see the inclusion of language requiring additional levels of transparency from pharmacy benefit managers, as well as efforts to constrain pharmacy benefit managers (PBM) compensation in ways that serve to increase costs to patients. The AMA has consistently expressed concern regarding the opaque way PBMs operate and the impact PBM business practices have on access to medically necessary drugs for patients. We have also been deeply concerned about the impacts of the business practices of both prescription drug manufacturers and PBMs on costs to both patients and the health care system at large. As such, we strongly support efforts to mandate greater transparency regarding the business practices of PBMs. This lack of transparency has made it difficult to understand exactly how PBMs operate and the nature of their contracting with manufacturers and health plans and in turn has made it difficult to determine appropriate legislative or regulatory action to limit their continued ability to manipulate the system for their own financial gain.

The AMA would also like to share our views on proposed changes to the Medicaid and Children's Health Insurance Program (CHIP) programs included in the reconciliation legislation. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, the AMA has a strong interest in ensuring that Medicaid remains a reliable source of health insurance coverage for low-income Americans and other vulnerable patients.

The AMA commends the Committee on the inclusion of section 44302, which streamlines the enrollment process for eligible out-of-state providers under Medicaid and CHIP and will increase the ability of children enrolled in Medicaid and CHIP to receive the care they need from the appropriate providers, even if those providers are located in a different state. However, after reviewing the proposed changes to the Medicaid and CHIP programs, we note the potential for unintended consequences that could affect patients, rural and underserved communities, and the providers who serve them. Medicaid and CHIP—like any large health insurance program[4]—lose money to waste, fraud, and abuse, and the AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However,

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[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).

[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.

changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that any Medicaid reform should avoid jeopardizing patient access to health care.

With respect to changes that could result in the denial or loss of coverage under Medicaid or CHIP for eligible patients, the AMA is particularly concerned with sections 44101, 44102, 44108, and 44141. These provisions create additional administrative burdens for patients and could result in more patients being denied or losing coverage under Medicaid or CHIP for failing to comply with administrative requirements, despite meeting all substantive criteria for eligibility.

The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] The proposed changes may increase the risk of wrongful denials or disenrollments, disrupting patients' access to care and potentially affecting the continuity of care physicians strive to provide. To limit patient churn and help ensure continuity of care, AMA policy supports 12-month continuous eligibility in Medicaid and CHIP.

With respect to the community engagement requirements established under section 44141, the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and have not consistently achieved improved employment outcomes.[6] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

The group most affected by the new work requirements is the Medicaid expansion population. Over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for exemption from the requirement, such as being the parent of a dependent child.[7] Evidence from work requirement programs implemented in multiple states shows that the administrative burdens of demonstrating compliance with work requirements can result in coverage interruptions even among

[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.

[6] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.

[7] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

individuals who are working or otherwise exempt.[8] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[9]

Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[10] and has filled a gap in the health care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[11]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in expansion states in health care coverage, access, utilization, and mortality.[12] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[13] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[14] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[15]

For all these reasons, we would urge the Committee to reconsider the proposed changes that create additional administrative barriers for all Medicaid and CHIP patients. To the extent additional program integrity measures are necessary, we would recommend that the Committee consider adding safeguards to ensure that such measures do not result in eligible patients losing coverage under Medicaid and CHIP.

Another change that we note could impact timely access to care for some patients is the modification to retroactive coverage requirements contained in section 44122. Under current law, states are required to

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[8] https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care; https://familiesusa.org/wp-content/uploads/2025/03/Medicaid-Work-Reporting-Requirements-Fact-Sheet.pdf; Benjamin Sommers, Anna Goldman, Robert Blendon, et al., Medicaid Work Requirements—Results from the First Year in Arkansas, 381 New England Journal of Medicine 11, 1073-82.

[9] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

[10] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[11] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.

[12] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.

[13] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.

[14] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.

[15] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.

provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program. The proposed change would reduce this requirement to one month of retroactive coverage. To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

The proposed changes to Medicaid and CHIP also include additional provider screening requirements. While current regulations require states to verify provider eligibility upon enrollment or reenrollment, section 44105 would expand this exponentially to require provider eligibility databases to be checked every month, by every state, for every provider. Such a requirement would necessitate increased staffing, resources, and expenditures at a time when efficiency in Medicaid is at a premium. The AMA favors these eligibility checks to be conducted upon provider enrollment and reenrollment, so as to avoid inefficiencies and undue administrative burden which could ultimately threaten patient access to Medicaid services.

In a similar vein, section 44106 adds a requirement to screen providers against the Social Security Administration's Death Master File (DMF). We believe being listed in the DMF could be an important data point to flag further inquiry into the provider's eligibility. However, we are also aware that false positives (names of living individuals) are erroneously added to the DMF at an average rate of 5,500 per month. The AMA recommends that any use of the DMF to determine provider eligibility would use the occurrence of a provider's name in the DMF as a trigger for further inquiry before pursuing any action adverse to that provider's participation in Medicare or Medicaid. Otherwise, should a provider be automatically barred from participation based on a false positive, that provider would suddenly be cut off from access to the program and more importantly, from their patients. Resolving the false positive by confirming the living provider's eligibility status could require an extended amount of time given the scale of these programs and state staffing levels. Such a delay would unnecessarily disrupt patient care, place strain on small provider practices, particularly those with limited administrative capacity, and could ultimately force some physician practices to close, exacerbating the problem of patient access to their provider or to any care under these programs.

Again, while the AMA generally supports program integrity initiatives in Medicaid and CHIP, we would recommend that the Committee include safeguards to ensure that physician practices and other providers are not erroneously barred from participating in these programs. These safeguards could include giving providers notice and an opportunity to appeal before they are adversely affected. Preventing providers who are without fault from participating in Medicaid and CHIP threatens beneficiary access to care and, in some cases, the continued viability of providers.

Another matter that raises concern is the new cost sharing requirements included in section 44142. While the new cost sharing requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other basic necessities, such as food and rent.[16] This is especially the case for individuals with chronic conditions who may require more frequent medical care and thus be charged more copayments. As physicians, we

[16] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

fear that the proposed cost sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

The AMA appreciates the Committee's ongoing efforts to strengthen the nation's health care system and urges careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

May 20, 2025

The Honorable Mike Johnson
Speaker
United States House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
House Democratic Leader
United States House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson and Leader Jeffries:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our comments on numerous parts of the combined legislation accompanying the Concurrent Resolution on the Budget for Fiscal Year 2025, specifically House Concurrent Resolution 14. Since the House of Representatives is considering this comprehensive piece of legislation under a condensed legislative calendar, this letter intentionally focuses on the policy issues that are central to the AMA's advocacy platform. More specifically, my colleagues and I are pleased to offer our expertise and perspective on provisions within the legislative proposal pertaining to Medicare physician payment, Pharmacy Benefit Manager (PBM) transparency, Medicaid and the Children's Health Insurance Program (CHIP), artificial intelligence (AI), the Affordable Care Act (ACA) marketplaces, and federal support of medical student loans.

Medicare

The AMA strongly supports section 44304 which provides a positive modification to the conversion factor under the Medicare physician fee schedule. Since 2001, Medicare physician payment updates have fallen 33 percent below inflation in the costs of running a medical practice as measured by the Medicare Economic Index (MEI), severely straining practice sustainability. Congress has adopted several temporary physician payment updates to help address steep cuts that took effect starting in 2021, but each of these updates led to a severe cliff as the payment update expired and reverted to the reduced payment rate as if there had been no legislative provision at all. Section 44304 provides the first Medicare physician payment update that is permanently built into baseline Medicare rates since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015.

As recommended by the Medicare Payment Advisory Commission, section 44304 links the Medicare update to the MEI. The proposed 2026 update, 75 percent of the MEI, currently estimated to provide a 2026 payment update of 2.25 percent, is significantly higher than any of the annual physician payment updates in MACRA. It has been decades since Medicare physician payment updates were linked to inflation and the AMA strongly supports it. Importantly, this payment increase will be permanently built into the rates that Medicare pays for patient care delivered by medical practices instead of expiring at the end of the year like so many previous temporary updates. As a result, the AMA estimates that the cumulative growth in Medicare payment updates for physician practices from 2025 to 2035 will be 4.3 percent under section 44304 compared to 2.5 percent under current law, reflecting a nearly two percentage point increase.

Under current law, reductions in the conversion factor over the last five years to account for budget neutrality adjustments have led to payment rates falling to levels that make private practice unsustainable for many physicians. It is absolutely vital that this issue be addressed. It should come as no surprise that physician ownership of their practices has decreased dramatically over the past quarter century. In 2001, 61 percent of physicians were owners. By 2016, fewer than half of physicians had ownership stakes in their practices, and since 2018 more physicians are employees than owners. Physicians should not be forced to leave community-based practice because it is not financially sustainable, and addressing this erosion is essential to strengthening the Medicare program and protecting patient access to care.

We further view these provisions as a foundational step toward comprehensive Medicare physician payment reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to maintaining practice stability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries, particularly in rural and underserved communities. Medical practices in the most rural locations treat four times as many Medicare patients as metropolitan practices. The AMA remains committed to working with Congress to achieve lasting reforms that give patients and physicians the Medicare program they need and deserve.

PBM Transparency

The AMA is also pleased to see the inclusion of language requiring additional levels of transparency from PBMs, as well as efforts to constrain PBM compensation practices that serve to increase costs to patients. The AMA has consistently expressed concern regarding the opaque way PBMs operate and the impact PBM business practices have on access to medically necessary drugs for patients. We have also been deeply concerned about the impact of the business practices of both prescription drug manufacturers and PBMs on costs to both patients and the health care system at large. As such, we strongly support efforts to mandate greater transparency regarding the business practices of PBMs. This lack of transparency has made it difficult to understand exactly how PBMs operate and the nature of their contracting with manufacturers and health plans and in turn has made it difficult to determine appropriate legislative or regulatory action to limit their continued ability to manipulate the system for their own financial gain.

Medicaid and CHIP

The AMA would also like to share our views on proposed changes to the Medicaid and CHIP programs included in the reconciliation legislation. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in

[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).
[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, the AMA has a strong interest in ensuring that Medicaid remains a reliable source of health insurance coverage for low-income Americans and other vulnerable patients.

The AMA commends the inclusion in the Energy and Commerce title of section 44302, which streamlines the enrollment process for eligible out-of-state providers under Medicaid and CHIP and will increase the ability of children enrolled in Medicaid and CHIP to receive the care they need from the appropriate providers, even if those providers are located in a different state. However, after reviewing the proposed changes to the Medicaid and CHIP programs, we note the potential for unintended consequences that could affect patients, rural and underserved communities, and the providers who serve them. Like any large health insurance program, Medicaid and CHIP lose money to waste, fraud, and abuse.[4] The AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However, changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that Medicaid reforms should avoid jeopardizing patient access to health care.

Regarding changes that could result in the denial or loss of coverage under Medicaid or CHIP for eligible patients, the AMA is particularly concerned with sections 44101, 44102, 44108, and 44141. These provisions could create additional administrative burdens for patients. The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] The proposed changes may increase the risk of wrongful denials or disenrollments, disrupting patients' access to care and potentially affecting the continuity of care physicians strive to provide. To limit patient churn and help ensure continuity of care, the AMA has policy that supports 12 months of continuous eligibility in Medicaid and CHIP.

With respect to the community engagement requirements established under section 44141, the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and that they have not consistently achieved improved employment outcomes.[6] It should be noted that over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for an exemption from the requirement, such

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.
[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.
[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.
[6] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.

as being the parent of a dependent child.[7] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[8] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[9] and has filled a gap in the health care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[10]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in health care coverage, access, utilization, and mortality.[11] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[12] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[13] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[14]

For these reasons, we would urge the House to reconsider the proposed changes that create additional administrative barriers for all Medicaid and CHIP patients. To the extent additional program integrity measures are necessary, we would recommend that the House consider adding safeguards to ensure that such measures do not result in putting at risk eligible patients' coverage under Medicaid and CHIP.

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[7] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[8] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

[9] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[10] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.

[11] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.

[12] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.

[13] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.

[14] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.

Another change that we note could impact timely access to care for some patients is the modification to retroactive coverage requirements contained in section 44122. Under current law, states are required to provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program. The proposed change would reduce this requirement to one month of retroactive coverage. To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

The proposed changes to Medicaid and CHIP also include additional provider screening requirements. While current regulations require states to verify provider eligibility upon enrollment or reenrollment, section 44105 would expand this to require provider eligibility databases to be checked every month, by every state, for every provider. Such a requirement would necessitate increased staffing, resources, and expenditures at a time when efficiency in Medicaid is at a premium. The AMA supports these eligibility checks being conducted upon provider enrollment and reenrollment, so as to avoid inefficiencies and undue administrative burdens which could ultimately reduce patient access to Medicaid services.

In a similar vein, section 44106 adds a requirement to screen providers against the Social Security Administration's Death Master File (DMF). We agree that being listed in the DMF is an important data point to flag for further inquiry into the provider's eligibility. However, we are also aware that false positives (names of living individuals) are erroneously added to the DMF at an average rate of 5,500 per month. The AMA recommends that any use of the DMF to determine provider eligibility would use the occurrence of a provider's name in the DMF as a trigger for further inquiry before pursuing any action adverse to that provider's participation in Medicare or Medicaid. Otherwise, should a provider be automatically barred from participation based on a false positive, that provider would suddenly be cut off from access to the program and more importantly, from their patients. Resolving the false positive by confirming the living provider's eligibility status could require an extended amount of time given the scale of these programs and is highly contingent on state staffing levels. Such a delay could unnecessarily disrupt patient care, place strain on small provider practices, particularly those with limited administrative capacity, and could ultimately force some physician practices to close, exacerbating the problem of patient access to their provider or to any care under these programs.

Again, while the AMA generally supports program integrity initiatives in Medicaid and CHIP, we would recommend that Congress include safeguards to ensure that physician practices and other providers are not erroneously barred from participating in these programs. These safeguards could include giving providers notice and an opportunity to appeal before they are adversely affected. Preventing providers who are without fault from participating in Medicaid and CHIP threatens beneficiary access to care and, in some cases, the continued viability of providers.

Another matter that raises concern is the new cost-sharing requirements included in section 44142. While these requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost-sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other necessities, such as food and rent.[15] This is especially the case for individuals with chronic conditions who may require

[15] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

more frequent medical care and thus be charged more copayments. As physicians, we fear that the proposed cost-sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

Artificial Intelligence

The AMA has serious concerns about the inclusion of provisions in section 43201 that would prohibit state-level regulation of AI without additional federal action to create guardrails around the design, development, and deployment of AI. This lack of clear and consistent legislative and regulatory requirements is especially notable as applied to health care AI, including any AI that may be used in federal programs and may impact patient data privacy and patient access to care.

The AMA shares Congress' concerns that a patchwork of state legislation regulating AI would be problematic and confusing for developers, physicians, and patients alike. However, to ensure the safety and protection of our patients, additional federal action to ensure quality, performance, and transparency of AI must be in place. Without additional consumer protections, clear guidelines to assure AI quality, strong consumer data privacy protections, and further action to limit bias within AI systems, Americans will undoubtedly suffer harm. In the absence of any federal action to further these critical protections, states have taken action to fill critical gaps by mandating transparency and stepping up efforts to ensure their residents are covered by strong consumer protection laws that serve to limit unintended consequences from poorly performing AI systems.

In the health care space specifically, use of unregulated AI by federal departments and agencies could ultimately result in inappropriate dissemination and use of protected personal health information and denials of critical health care by federal payers—issues we have already seen come to fruition that have caused real harm to real patients. Stakeholders across industry, physicians, and patient organizations have consistently agreed that additional federal action to create clear and consistent guardrails that seek to ensure patient safety and data privacy are a critical need that remains unaddressed.

While the AMA remains a strong supporter of developing innovative AI tools that reduce physician burden and improve health outcomes for our patients, we also recognize the distinct and serious risks that health care AI poses to patient safety. These risks must be mitigated to the greatest extent possible. This legislation, as currently drafted, may fall short of achieving that goal. It sets a precedent for AI regulation that lacks sufficient clarity, contributes to ongoing confusion, and may fail to provide adequate assurances of performance and safety. We urge a reconsideration of this approach and encourage close collaboration with stakeholders to ensure the right balance between enabling innovation and upholding our shared responsibility to do no harm.

The AMA has significant concerns about section 112204, under which a total of $25 million will be transferred from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare & Medicaid Services to enter into contracts with AI tool vendors to help identify and reduce improper payments made under Medicare Parts A and B. While supportive of rooting out improper payments, delegating Medicare integrity functions to opaque, black-box algorithms would strip physicians of due-process visibility, invite biased or erroneous claw-backs, and erode clinical autonomy. The legislation is also silent regarding any appeals processes available to physicians or physician practices subjected to errors committed by the AI technology. The AMA is

concerned about the precedent of using AI technology for this purpose and the lack of statutory protections for physicians. Congress should instead require transparent, evidence-based audit standards with meaningful physician oversight and appeal rights before allowing any AI-driven payment policing.

ACA Marketplace

The AMA believes there are opportunities to enhance program integrity and protect taxpayer dollars with regard to the ACA Exchanges. We are concerned, however, that several provisions within sections 44201, 112201,112202, and 112203 codifying provisions of the proposed ACA "Marketplace Integrity and Affordability Rule"[16] will effectively reduce marketplace coverage for middle and low-income Americans. The Trump administration previously estimated that the various reforms included in this package will cumulatively reduce projected enrollment by up to two million individuals, and result in $11-14 billion in fewer advanced premium tax credits (APTC) available to help Americans afford their health insurance every year.[17] We are also concerned by the cumulative effect of these policies happening at once, shortening the enrollment window at the same time income verification processes and timelines are being ramped up, for example. These estimates also do not account for the scheduled expiration of enhanced tax credits at the end of 2025, which would result in an additional $26.1 billion reduction in 2026 alone.[18]

The AMA has significant concerns with provisions in section 44201 that would permanently limit the annual ACA marketplace open enrollment period to 45 days, rather than the previous 75-day timeline. A primary reason for the longer open enrollment period is to give consumers more time to make plan decisions, particularly when their subsidy has changed compared to the previous year. Individuals that are automatically reenrolled may not be aware of subsidy changes or impacts on their premiums until January, so this extended timeframe provides a valuable opportunity for consumers to make more informed decisions about switching plans and should be maintained to prevent coverage disruptions. Further, by shortening the standard annual enrollment period, the Agency is likely deterring healthy individuals from enrolling, which runs counter to the goal of stabilizing the risk pool.

The AMA is also concerned about the potential impacts of sections 44201 and 112202 as they relate to special enrollment periods based on income. We are concerned that the language in the bill could be interpreted to disallow special enrollment periods that are triggered by a change to an individual's income, such as the special enrollment period for individuals who become newly eligible for premium tax credits following a change in income. While the AMA appreciates the need to address potential adverse selection concerns associated with continuous special enrollment periods that allow an individual to enroll in any month provided that their income is below a certain threshold, we also believe it is essential that individuals retain the ability to enroll in a health plan if they experience a change in circumstances, including a change in income, that impacts their health insurance coverage or their eligibility for premium tax credits or cost-sharing reductions. AMA policy would oppose the limitations placed on special enrollment periods by sections 44201 and 112202 if they would prohibit any special enrollment period that allows individuals to enroll in, or change, health plans following a change to their income or coverage status.

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[16] https://www.cms.gov/files/document/MarketplacePIRule2025.pdf.
[17] https://www.healthaffairs.org/content/forefront/house-republican-budget-reconciliation-legislation-unpacking-coverage-provisions.
[18] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits.

If carefully designed, reasonable income verification measures have the potential to strengthen program integrity and ensure enrollees meet income-based and other eligibility requirements. However, we are strongly concerned that provisions within sections 44201 and 112201 may be both burdensome on individual enrollees and difficult for states to administer and may ultimately negatively impact enrollment of eligible individuals, particularly healthy individuals, in marketplace plans, thus also negatively impacting risk pools. For example, automatic enrollment with verification from federal data sources is an effective way to protect the integrity of eligibility requirements and promote coverage for eligible individuals while reducing enrollment burden, yet this would be eliminated under section 112201. Many states already have robust verification processes in place. Adding additional verification criteria and moving up the timeline to require verification prior to enrollment may lead to coverage disruptions, interfering with enrollees' abilities to see their physicians. The AMA also strongly supports flexibility for state exchanges to design their own pre-enrollment verification processes, which these provisions would interfere with.

In sections 44201 and 112203, which bar premium tax credits for individuals that fail to reconcile their previous tax returns, the AMA urges a grace period for enrollees to retroactively reconcile and apply for coverage and have their coverage be retroactively effective to the beginning of the coverage year. This grace period would balance the need to ensure income is verified while averting coverage disruptions for eligible enrollees. Failure to reconcile income status likely reflects a lack of understanding of the need to file taxes based solely on the receipt of APTC, reiterating the strong need to provide educational resources and enrollment support, including through care navigators, particularly during the initial transition period.

Section 44201 would allow issuers to redirect premium payments for the current payment year to instead repay past-due premiums from any previous plan year before coverage can be effectuated for a new benefit year. We have several concerns with this policy. Typically, once insurance premiums go unpaid for a certain period of time, coverage is terminated, and any outstanding claims made during the non-payment window may not be covered. Once coverage is terminated, the enrollee would be responsible for paying for his or her own medical bills moving forward. Therefore, if enrollees are required to pay for any outstanding premiums for any plan year, they are likely paying insurance companies for coverage from which they will not actually benefit. There are also several unanswered questions about how this policy will work logistically, including how services in previous plan years during which coverage was interrupted would be treated, as well as how incomplete payments for premiums would impact coverage for services moving forward. The fact that this policy would extend to unpaid premiums during any period of time in the distant past adds further complication and concern. At a minimum, the lookback period should be limited to 12 months as it was during a prior Trump administration rule and issuers should be required to disclose this policy to enrollees prior to making any payments for new policy premiums. Not disclosing how their money will be spent creates a potentially serious breach of contractual obligations to enrollees.

Section 112203 would remove the current cap on paying back excess advance premium tax credits received during the coverage year based on an enrollee's income. Moving forward, enrollees would owe the full past due amount, regardless of income. The AMA is concerned that this change might be particularly difficult for low-income enrollees to comply with and may result in additional coverage losses.

The AMA is concerned by provisions in section 44201 to widen required de minimis ranges and loosen restrictions on silver-level plans, which would negatively impact patients' ability to afford their coverage

and access health care services. Under the new growth rate methodology, the growth rate for 2026 would be approximately 7.2 percentage points higher than under the previous methodology, which would have several important implications for enrollee cost-sharing, including higher maximum annual cost-sharing limits, higher required contributions (and therefore decreased APTCs), and higher employer shared responsibility payment amounts. Higher out-of-pocket expenses disproportionately impact those with more complex health needs, including those with chronic disease. Broader ranges also confuse enrollees and make it more difficult for enrollees to compare coverage options within the same metal tier levels. Regarding easing silver level plan restrictions, we are concerned about the negative impact on APTCs, which are calculated using the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee's income. If these provisions are enacted, it will be incumbent on the U.S. Department of Health and Human Services to provide clear information to enrollees about the differences in out-of-pocket costs across plan options and to closely monitor plan premiums to ensure that these proposals are indeed correlating to lower premiums that offset the higher out of pocket costs. If not, patients are simply paying more for the same coverage.

Finally, the AMA is concerned by provisions in 44201 and 112102 that would eliminate marketplace eligibility for lawfully present immigrants including deferred action for childhood arrivals (DACA) recipients, and in the case of section 112102, asylum seekers, and green card holders. The AMA appreciates the need to protect taxpayer dollars. With this in mind, we believe there is an economic argument to be made to maintain ACA coverage and subsidies for immigrants who are in the U.S. legally, as these groups often have minimal alternative health insurance options and would otherwise be uninsured and it is well-established that expanding access to coverage improves population health and is likely to result in reduced costs for the American taxpayer since individuals without insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, often resulting in higher health care costs down the road. Legal immigrants such as green card holders and DACA recipients also play a critical role in local economies. For example,[19] more than 200,000 DACA recipients serve as frontline workers and studies show that individuals with health coverage are likely to miss fewer days of work.[20] Allowing legal immigrants to enroll in exchange coverage would provide stability for these individuals to seek out lawful education and employment opportunities. Furthermore, many of these classes of individuals including DACA recipients are relatively young and healthy,[21] and thus would have a positive impact on ACA risk pools. Therefore, the AMA opposes the proposal to restrict the definition of "lawfully present" to exclude immigrants who are in this country legally.

Student Loans

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. As such, we greatly appreciate the provision in section 30022 that would defer the accrual of student loan interest during the first four years of residency in a somewhat similar manner to the Resident Education Deferred Interest Act (H.R. 2028/S. 942)[22] and believe this provision should be extended to cover the entire residency period of a physician. However, we are extremely concerned about the negative

[19] https://cmsny.org/daca-essential-workers-covid.
[20] https://pmc.ncbi.nlm.nih.gov/articles/PMC2690190.
[21] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[22] https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfra.zip/2025-4-2-Letter-to-Babin-and-Houlahan-re-HR-2028-REDI-Act-v3.pdf.

ramifications of the overall implementation of this bill and ask that at a minimum, carveouts are provided for medical school education to ensure that we can continue to educate our next generation of physicians.

Medical education remains the most expensive post-secondary education in the United States with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt.[23] This is in part due to the fact that the median cost of graduating from a public in-state medical school is $286,454, while the cost of graduating from a private institution is $390,848.[24] As a result, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[25]

Unfortunately, section 30002 would base the amount of student loans offered on the median cost of attendance for students enrolled in the same program of study nationally. And section 30011 would eliminate subsidized loans and Federal Direct Graduate (GRAD) PLUS loans, limit parents' ability to borrow loans on behalf of their children, and cap the amount of Federal Direct Unsubsidized loans that a student can borrow for professional school to $150,000 not including any amount borrowed to help fund an undergraduate degree.

Currently, Direct Unsubsidized Loans and GRAD PLUS loans are the most common loan types taken out by medical students.[26] Therefore, the combined effect of the elimination of GRAD PLUS loans along with a borrowing cap for Direct Unsubsidized Loans that is $62,000 below the mean amount needed to graduate from medical school will severely limit the number of individuals that can afford a medical degree and likely exacerbate the looming shortage of 86,000 physicians.[27] Moreover, limiting the amount of Direct Unsubsidized Loans that an individual can take based on the median cost of attending medical school will likely require students, especially those from low income backgrounds, to scramble to find multiple funding streams to support their medical education since a significant portion of medical schools will cost more to attend than the national median.

We appreciate the importance of working to create an affordable and sustainable higher education system. However, we worry that the bill, as currently drafted, would make medical school unaffordable for most students, even if they are the most qualified candidates applying. As such, we urge you to maintain subsidized and GRAD Plus loans, allow parents to have better borrowing terms to help fund their children's higher education, and not cap the amount that an individual can borrow to pay for medical school.

Section 30024 would make it so that time spent in residency would not count as a public service job, thereby making residents ineligible for the Public Service Loan Forgiveness (PSLF) program. The PSLF program has increasingly gained popularity since its creation, and in 2024 over 88 percent of medical student graduates with student debt noted in their graduation questionnaire that they intended to participate in the PSLF program.[28] Additionally, studies have shown that more future primary care physicians intend to use PSLF than programs that were historically designed to promote primary care, a

[23] https://store.aamc.org/downloadable/download/sample/sample_id/633/.
[24] *Id.*
[25] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[26] https://students-residents.aamc.org/media/9941/download.
[27] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.
[28] https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq.

stated bipartisan concern of many members of Congress.[29] These studies show that the PSLF program has the ability to incentivize physicians to work for qualifying employers, which ultimately equates to more physicians practicing for 10 or more years in underserved communities. However, if time as a resident does not count towards loan forgiveness, significantly fewer physicians will participate in this program and in turn access to much needed medical care for patients in rural and underserved communities will be diminished.

Moreover, non-physician practitioners (NPPs), including nurse practitioners and physician assistants, are currently able to count their training time toward loan forgiveness under PSLF.[30] Proposing to exclude physicians from the same eligibility raises concerns about fairness especially given that physicians often enter residency with significantly more education and training than NPPs and, as they progress through their residency, ultimately take on larger workloads and more complicated tasks than their NPP counterparts. Instead, all resident physicians should have access to PSLF during their training years since regardless of whether they are working in a public, private, or nonprofit setting, they are working for low wages to better public health.

Section 30021 would end current repayment plans and replace them with a standard plan and a Repayment Assistance Plan. We applaud the provisions under the Repayment Assistance Plan that would allow those borrowers that are making full- and on-time payments to avoid interest accrual and reduce their principal loan balance by $50 or less for each qualifying payment that is made. However, since this section would do away with the current income driven repayment (IDR) plans, it could cause significant hardship for medical students since over 77 percent of physicians were participating in IDR plans in 2020.[31]

Moreover, under the Repayment Assistance Plan a borrower would have to remain in repayment for 30 years, instead of 25 years, before they could receive forgiveness, and repayment amounts would be based on the borrower's adjusted gross income maxing out at 10 percent for individuals that make more than $100,000 per year. Since year one residents earn a mean salary of about $66,700, they would be paying six percent of their adjusted gross income just to student loans, which is a significant amount for anyone in that salary range.[32] Even those physicians who do eventually go on to earn $100,000 or more will be paying 10 percent of their adjusted gross income for 30 years or until they pay off their balance. This is a significant payment and would likely place substantial stress on, and impede, residents and young physicians from meeting important financial goals like saving for retirement, buying a house, marrying, and more.[33] Furthermore, research finds that students with larger student loan balances, such as those with medical degrees, tend to default less frequently,[34] and the Congressional Budget Office found that only about five percent of individuals who financed a graduate degree (including professional degrees) using federal student loans were in default after six years.[35] Given the high success rate of student loan

[29] https://pubmed.ncbi.nlm.nih.gov/27295187/.
[30] https://www.aapa.org/news-central/2024/12/how-physician-associates-can-qualify-for-student-loan-forgiveness/#:~:text=Public%20Service%20Loan%20Forgiveness%20for%20PAs&text=For%20example%2C%20a%20full%2Dtime,student%20loan%20debt%20management%20strategy.
[31] https://www.degruyterbrill.com/document/doi/10.7556/jaoa.2020.058/html.
[32] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits.
[33] https://www.tandfonline.com/doi/full/10.3402/meo.v19.25603.
[34] https://upcea.edu/wp-content/uploads/2018/03/Exploring-the-Determinants-of-Student-Loan-Default-Rates.pdf#:~:text=2%20As%20student%20loan%20debt,at%20managing%20financial%20risk%2C%20for.
[35] https://www.cbo.gov/system/files/2024-09/58963-student-loan.pdf.

repayment for physicians, we would urge you to continue to allow physicians to access the current repayment plans along with the new repayment plans so that they can choose a plan that will be best suited for them.

Physicians are the backbone of the entire medical system and central to one of the most important federally promised benefits, Medicare. Physicians serve as the gatekeepers of Medicare not only by determining medical necessity and authorizing care, but also by safeguarding the system against fraud, waste, and abuse. By law, Medicare only reimburses for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury" which requires physician certification or documentation.[36] This requirement is even more explicit in key areas of the Medicare statute, such as home health care[37] and hospice services,[38] both of which condition coverage based on physician certification. Therefore, without a robust physician workforce, Medicare could not meet its statutory obligation to provide appropriate, medically necessary care to its beneficiaries, and beyond that medical care cannot be provided to our country at large without an adequate supply of physicians. Unfortunately, this bill may deter individuals from applying to medical school, make medical school unaffordable for all but the wealthiest, make student loan repayment harder for some, and deter physicians from serving in health professional shortage areas. As such, we ask that carveouts be provided for medical school education in recognition of the unique role that physicians play in society and in alignment with the heavy educational burden that they undertake to care for those most in need.

Conclusion

The AMA appreciates the House's careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

cc: The Honorable Brett Guthrie
The Honorable Frank Pallone
The Honorable Jason Smith
The Honorable Richie Neal
The Honorable Tim Walberg
The Honorable Bobby Scott
The Honorable Jodey Arrington
The Honorable Brendan Boyle
The Honorable Virginia Foxx
The Honorable Jim McGovern

[36] 42 U.S.C. § 1395y(a)(1)(A) https://www.law.cornell.edu/uscode/text/42/1395y.
[37] 42 U.S.C. § 1395f(a)(2)(C) https://www.law.cornell.edu/uscode/text/42/1395f.
[38] 42 U.S.C. § 1395f(a)(7) https://www.law.cornell.edu/uscode/text/42/1395f.

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June 20, 2025

The Honorable John Thune
U.S. Senate
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Schumer
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

Dear Majority Leader Thune and Leader Schumer:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our comments on numerous parts of H.R. 1, the "One Big Beautiful Bill Act," the reconciliation legislation passed by the House of Representatives on May 22, 2025, and now under consideration in the Senate. As the Senate contemplates changes to the House-passed bill, my colleagues and I would like to offer our perspective. While H.R. 1 touches on many areas of interest to the AMA, this letter will focus on the subjects we believe are most important to the physicians, medical students, and patients that we represent: Medicaid and the Children's Health Insurance Program (CHIP), access to health insurance coverage through the Affordable Care Act (ACA) marketplaces, federal support of medical student loans, artificial intelligence (AI), and Medicare physician payment reform.

Medicaid and CHIP

The AMA would like to share our views on proposed changes to the Medicaid and CHIP programs included in H.R. 1. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be

[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).

[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, preserving patient access to care under Medicaid is a top priority of the AMA, and the AMA strongly supports policies that maintain and expand coverage, access, federal funding, and eligibility criteria under Medicaid and CHIP.

Like any large health insurance program, Medicaid and CHIP lose money to waste, fraud, and abuse.[4] The AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However, changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that Medicaid reforms should avoid jeopardizing patient access to health care. After reviewing the changes to the Medicaid and CHIP programs proposed by both the House of Representatives and the Senate, we note that they would create new administrative requirements for patients to enroll in, and maintain coverage under, these programs, and would shift billions of dollars in program costs to the states. We fear these changes would lead to unintended consequences that could affect patients who are eligible for Medicaid and CHIP benefits, rural and underserved communities, and the providers who serve them.

Many of the changes included in both the House and Senate provisions of H.R. 1 relate to the administrative processes involved in determining eligibility for benefits under Medicaid and CHIP. The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] While there are many new administrative requirements in H.R. 1 that could result in the wrongful denial or loss of coverage under Medicaid or CHIP for eligible patients, of particular concern to the AMA are the sections that would: impose community engagement requirements as a condition of coverage; terminate regulations that are intended to streamline eligibility determinations for Medicaid, CHIP, and the Medicare Savings Program (which is administered by state Medicaid programs); increase the frequency of eligibility redeterminations for Medicaid expansion enrollees; and shorten retroactive coverage periods.

Several of the new administrative provisions are designed to apply either exclusively or with greater force to the Medicaid expansion group. Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[6] and has filled a gap in the health

[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.
[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.
[6] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[7]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in health care coverage, access, utilization, and mortality.[8] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[9] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[10] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[11]

With respect to the community engagement requirements (established under Section 44141 of H.R. 1 as passed by the House of Representatives and under Section 71107 of the language released by the Senate Finance Committee on June 16, 2025), the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and that they have not consistently achieved improved employment outcomes.[12] It should be noted that over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for an exemption from the requirement, such as being the parent of a dependent child.[13] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[14] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact

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[7] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.
[8] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.
[9] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.
[10] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.
[11] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.
[12] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.
[13] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.
[14] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

Both the House and Senate versions of H.R. 1 would require states to redetermine the eligibility of Medicaid expansion enrollees every six months (as opposed to every 12 months under current law). This doubles both the administrative burdens expansion enrollees face when reenrolling in Medicaid and the opportunities for an eligible patient to lose coverage due to an administrative error. As physicians, we prize continuity of care for our patients, and the AMA has policy supporting 12 months of continuous coverage across Medicaid and CHIP. Therefore, we strongly recommend that the Senate reconsider including this policy in its version of H.R. 1.

Another change that could impact timely access to care for some patients is the modification to retroactive coverage requirements (contained in Section 44122 of the House-passed version and Section 71114 of the Senate Finance Committee language). Under current law, states are required to provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program if the patient would have been eligible during the retroactive period. The proposed change would reduce this requirement to one month of retroactive coverage (in the Senate Finance Committee's language new enrollees who are not in the Medicaid expansion category will receive two months of retroactive coverage). To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

In addition to the provisions that establish new administrative requirements, the House and Senate versions of H.R. 1 include policies that shift a substantial portion of total Medicaid costs to the states. Chief among these are the policies that limit states' ability to finance the state share of Medicaid spending using revenue from health care provider taxes. Provider tax arrangements are a legitimate mechanism that states have used to finance their Medicaid programs since the mid-1980s and are governed by federal statute and regulations.[15] These arrangements are widely used (49 states and the District of Columbia use provider taxes to finance their Medicaid programs in 2025)[16] and accounted for as much as 17 percent of the total state share of Medicaid spending in 2024.[17] While Congress has made adjustments to the rules governing provider tax arrangements in the past, the changes currently under consideration are much more drastic. The House-passed version of H.R. 1 would freeze existing provider taxes at current levels, prohibit new provider taxes entirely, and effectively terminate certain existing provider tax arrangements. The Senate Finance Committee's language goes even further and, in addition to all of the policies included in the House language, would lower a safe harbor threshold for permissible provider taxes from six percent of the net patient service revenues received by the taxpayer to 3.5 percent (for expansion states only). Taken together, these changes are expected to reduce the federal share of Medicaid spending by well over $100 billion,[18] leaving states with difficult decisions on how to make up the difference. AMA policy supports the use of provider taxes as a means of financing Medicaid, and we are concerned that excessive restrictions on this source of funding, which states have

[15] https://www.congress.gov/crs-product/RS22843.
[16] *Id*.
[17] https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing-1.pdf.
[18] https://www.cbo.gov/publication/61461.

relied upon for decades, will force states to reduce Medicaid benefits and provider reimbursement, threatening patient access to care and the continued financial viability of providers, particularly in rural and low-income areas. At the very least, the AMA would urge the Senate to revise its language to omit the change to the safe harbor threshold, include clarifying language to ensure that states are able to modify existing provider tax arrangements to comply with new requirements, and provide for a five-year transition period to allow states to make alternative plans for financing their programs.

Finally, another matter that raises concern is the new cost-sharing requirements included in Section 44142 of the House-passed version of H.R. 1 and Section 71125 of the Senate Finance Committee's language. While these requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost-sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other necessities, such as food and rent.[19] This is especially the case for individuals with chronic conditions who may require more frequent medical care and thus be charged more copayments. As physicians, we fear that the proposed cost-sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

ACA Marketplace

The AMA believes there are opportunities to enhance program integrity and protect taxpayer dollars with regard to the ACA Exchanges. However, while the AMA commends the Senate Health, Education, Labor and Pensions Committee for omitting from its language provisions that would codify the proposed ACA "Marketplace Integrity and Affordability Rule," we remain concerned that several provisions included in both the House and Senate versions of H.R. 1 will effectively reduce marketplace coverage for middle and low-income Americans. Furthermore, neither the House nor the Senate's versions of H.R. 1 address the scheduled expiration of enhanced tax credits at the end of 2025, which would result in an additional $26.1 billion reduction in 2026 alone,[20] and could lead to an additional 4.1 million uninsured people in 2034.[21]

Of particular concern to the AMA is Section 71303 of the Senate Finance Committee language, which effectively ends automatic reenrollment in ACA marketplace plans for individuals receiving premium tax credits. If carefully designed, reasonable income verification measures have the potential to strengthen program integrity and ensure enrollees meet income-based and other eligibility requirements. However, we are strongly concerned that provisions within Section 71303 may be both burdensome on individual enrollees and difficult for states to administer and may ultimately negatively impact enrollment of eligible individuals, particularly healthy

[19] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.
[20] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits.
[21] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.

individuals, in marketplace plans, thus also negatively impacting risk pools. For example, automatic enrollment with verification from federal data sources is an effective way to protect the integrity of eligibility requirements and promote coverage for eligible individuals while reducing enrollment burden, yet this would be eliminated under Section 71303. Many states already have robust verification processes in place. Adding additional verification criteria and moving up the timeline to require verification prior to enrollment may lead to coverage disruptions, interfering with enrollees' abilities to see their physicians. The AMA also strongly supports flexibility for state exchanges to design their own pre-enrollment verification processes, which Section 71303 would interfere with.

The AMA is also concerned about the potential impacts of Section 71304 of the Senate Finance Committee's language as it relates to special enrollment periods based on income. We are concerned that Section 71304 could be interpreted to disallow premium tax credits or cost-sharing reductions for patients who enroll during special enrollment periods that are triggered by a change in income, such as the special enrollment period for individuals who become newly eligible for premium tax credits following a change in income. While the AMA appreciates the need to address potential adverse selection concerns associated with continuous special enrollment periods that allow an individual to enroll (and receive premium tax credits and cost-sharing reductions, if eligible) in any month provided that their income is below a certain threshold, we also believe it is essential that individuals retain the ability to enroll in a health plan if they experience a change in circumstances, including a change in income, that impacts their health insurance coverage or their eligibility for premium tax credits or cost-sharing reductions. AMA policy would oppose the limitations placed on special enrollment periods by Section 71304 if they would prevent patients from receiving premium tax credits or cost-sharing reductions simply because they enroll in, or change, health plans during a special enrollment period triggered by a change to their income or coverage status. The AMA urges the Senate to add language to Section 71304 clarifying that patients would remain eligible for premium tax credits and cost-sharing reductions under these circumstances.

Section 71305 of the Senate Finance Committee language would remove the current cap on paying back excess advance premium tax credits received during the coverage year based on an enrollee's income. Moving forward, enrollees would owe the full past due amount, regardless of income. The AMA is concerned that this change might be particularly difficult for low-income enrollees to comply with and may result in additional coverage losses. While the AMA appreciates that the Senate refined the House's language by adding a narrow exception for certain low-income individuals who receive excess tax credits despite acting in good faith, we believe further safeguards are necessary to ensure that low-income patients are not harmed, and would urge the Senate to broaden this exception and apply the current law repayment cap to any individual with income below 400 percent of the poverty line who acts in good faith.

Finally, the AMA is concerned by provisions in Section 71302 of the Senate Finance Committee language that would eliminate premium tax credit eligibility for many categories of lawfully present immigrants, including refugees, asylees, deferred action for childhood arrivals (DACA) recipients, and individuals with Temporary Protected Status. The AMA appreciates the need to protect taxpayer dollars. With this in mind, we believe there is an economic argument to be made to maintain ACA subsidies for all immigrants who are in the United States legally, as these groups often have minimal alternative health insurance options and would otherwise be uninsured. It is well-established that expanding access to coverage improves population health

and is likely to result in reduced costs for the American taxpayer since individuals without insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, often resulting in higher health care costs down the road. Legal immigrants such as DACA recipients also play a critical role in local economies. More than 200,000 DACA recipients serve as frontline workers for example,[22] and studies show that individuals with health coverage are likely to miss fewer days of work.[23] Allowing legal immigrants to enroll in exchange coverage would provide stability for these individuals to seek out lawful education and employment opportunities. Furthermore, many of these classes of individuals including DACA recipients are relatively young and healthy,[24] and thus would have a positive impact on ACA risk pools. Therefore, the AMA opposes the proposal to restrict eligibility for premium tax credits for immigrants who are in this country legally.

Student Loans

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. As a result, we are extremely concerned about the negative ramifications of the overall implementation of this bill and ask that at a minimum, carve outs are provided for medical school education to ensure that we can continue to educate our next generation of physicians.

Medical education remains the most expensive post-secondary education in the United States with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt.[25] This is in part due to the fact that the median cost of graduating from a public in-state medical school is $286,454, while the cost of graduating from a private institution is $390,848.[26] As a result, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[27]

Unfortunately, Section 81001 would eliminate the ability for medical students to receive subsidized loans and Federal Direct Parent Loan for Undergraduate Students (PLUS) Loans, limit parents' ability to borrow loans on behalf of their children, and cap the amount of Federal Direct Unsubsidized Stafford Loans that a student can borrow for professional school to $200,000, including any amount borrowed for graduate school, but not including any amount borrowed to help fund an undergraduate degree.

Currently, Direct Unsubsidized Loans and Federal Direct PLUS Loans are the most common loan types taken out by medical students.[28] In general Federal Direct PLUS Loans are heavily utilized by medical students because they currently allow students to borrow up to the cost of attendance, have a fixed interest rate for the life of the loan, allow for benefits such as residency forbearance

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[22] https://cmsny.org/daca-essential-workers-covid.
[23] https://pmc.ncbi.nlm.nih.gov/articles/PMC2690190.
[24] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[25] https://store.aamc.org/downloadable/download/sample/sample_id/633/.
[26] *Id*.
[27] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[28] https://students-residents.aamc.org/media/9941/download.

and deferment, and have income-driven repayment options.[29] Though we do appreciate the inclusion in Section 70119 of the discharge of all student loans upon death or disability, the combined effect of the elimination of Federal Direct PLUS Loans along with a borrowing cap for Direct Unsubsidized Loans that is below the mean amount needed to graduate from medical school will severely limit the number of individuals that can afford a medical degree and likely exacerbate the looming shortage of 86,000 physicians.[30] Moreover, limiting the amount of Direct Unsubsidized Loans that an individual can take will likely require students, especially those from low income backgrounds, to scramble to find multiple funding streams to support their medical education.

We appreciate the importance of working to create an affordable and sustainable higher education system. However, we worry that the bill, as currently drafted, would make medical school unaffordable for most students, even if they are the most qualified candidates applying. As such, we urge you to maintain subsidized and Federal Direct PLUS Loans, allow parents to have better borrowing terms to help fund their children's higher education, and not cap the amount that an individual can borrow to pay for medical school.

Section 82004 would make it so that time spent in residency would not count as a public service job, thereby making residents ineligible for the Public Service Loan Forgiveness (PSLF) program. The PSLF program has increasingly gained popularity since its creation, and in 2024 over 88 percent of medical student graduates with student debt noted in their graduation questionnaire that they intended to participate in the PSLF program.[31] Additionally, studies have shown that more future primary care physicians intend to use PSLF than programs that were historically designed to promote primary care, such as the National Health Service Corps.[32] These studies show that the PSLF program has the ability to incentivize physicians to work for qualifying employers, which ultimately equates to more physicians practicing for 10 or more years in underserved communities. However, if time as a resident does not count towards loan forgiveness, significantly fewer physicians will participate in this program and in turn access to much needed medical care for patients will be diminished.

Moreover, non-physician practitioners (NPPs), including nurse practitioners and physician assistants, are currently able to count their training time toward loan forgiveness under PSLF.[33] Proposing to exclude physicians from the same eligibility raises concerns about fairness especially given that physicians often enter residency with significantly more education and training than NPPs and, as they progress through their residency, ultimately take on larger workloads and more complicated tasks than their NPP counterparts. Instead, all resident physicians should have access to PSLF during their training years since regardless of whether they are working in a public, private, or nonprofit setting, they are working for low wages to better public health.

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[29] https://www.aamc.org/media/82881/download?attachment.
[30] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.
[31] https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq.
[32] https://pubmed.ncbi.nlm.nih.gov/27295187/.
[33] https://www.aapa.org/news-central/2024/12/how-physician-associates-can-qualify-for-student-loan-forgiveness/#:~:text=Public%20Service%20Loan%20Forgiveness%20for%20PAs&text=For%20example%2C%20a%20full%2Dtime,student%20loan%20debt%20management%20strategy.

Section 82001 would end current repayment plans and replace them with a standard plan and a Repayment Assistance Plan. We applaud the provisions under the Repayment Assistance Plan that would allow those borrowers that are making full- and on-time payments to avoid interest accrual and reduce their principal loan balance by $50 or less for each qualifying payment that is made. However, since this section would do away with the current income driven repayment (IDR) plans, it could cause significant hardship for medical students since over 77 percent of physicians were participating in IDR plans in 2020.[34]

Moreover, under the Repayment Assistance Plan a borrower would have to remain in repayment for 30 years, instead of 25 years, before they could receive forgiveness, and repayment amounts would be based on the borrower's adjusted gross income maxing out at 10 percent for individuals that make more than $100,000 per year. Since year one residents have a median stipend of about $65,000, they would be paying six percent of their adjusted gross income just to student loans, which is a significant amount for anyone in that salary range.[35] Even those physicians who do eventually go on to earn $100,000 or more will be paying 10 percent of their adjusted gross income for 30 years or until they pay off their balance. This is a significant payment and would likely place substantial stress on, and impede, residents and young physicians from meeting important financial goals like saving for retirement, buying a house, marrying, and more.[36]

Furthermore, research has found that students with larger student loan balances, such as those with medical degrees, tend to default less frequently,[37] and the Congressional Budget Office found that only about five percent of individuals who financed a graduate degree (including professional degrees) using federal student loans were in default after six years.[38] This is in part due to the fact that the earning potential of physicians provides the financial means to effectively manage and repay their student loan obligations and results in default rates from medial school graduates being exceedingly low.[39] Given the high success rate of student loan repayment for physicians, and the resulting financial benefit to the government from the higher interest rates repaid, we would urge you to continue to allow physicians to access the current repayment plans along with the new repayment plans so that they can choose a plan that will be best suited for them.

Additionally, the AMA encourages the inclusion of Section 30022 of H. Con Res. 14 in the Senate text. Section 30022 would defer the accrual of student loan interest during the first four years of residency in a somewhat similar manner to the Resident Education Deferred Interest Act (REDI)(H.R. 2028/S. 942)[40] and we believe this provision should be included and extended to

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[34] https://www.degruyterbrill.com/document/doi/10.7556/jaoa.2020.058/html.
[35] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits.
[36] https://www.tandfonline.com/doi/full/10.3402/meo.v19.25603.
[37] https://upcea.edu/wp-content/uploads/2018/03/Exploring-the-Determinants-of-Student-Loan-Default-Rates.pdf#:~:text=2%20As%20student%20loan%20debt,at%20managing%20financial%20risk%2C%20for.
[38] https://www.cbo.gov/system/files/2024-09/58963-student-loan.pdf.
[39] https://www.aamc.org/media/11461/download.
[40] https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfra.zip/2025-4-2-Letter-to-Rosen-and-Boozman-re-S-942-REDI-Act-v3.pdf.

cover the entire residency period of a physician. Section 30022 would be especially beneficial for physicians that either cannot afford to pay six percent of their income during residency or choose to utilize residency forbearance during their training years.

Physicians are the backbone of the entire medical system and central to one of the most important federally promised benefits, Medicare. Physicians serve as the gatekeepers of Medicare not only by determining medical necessity and authorizing care, but also by safeguarding the system against fraud, waste, and abuse. By law, Medicare only reimburses for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury" which requires physician certification or documentation.[41] This requirement is even more explicit in key areas of the Medicare statute, such as home health care[42] and hospice services,[43] both of which condition coverage based on physician certification. Therefore, without a robust physician workforce, Medicare could not meet its statutory obligation to provide appropriate, medically necessary care to its beneficiaries, and beyond that medical care cannot be provided to our country at large without an adequate supply of physicians. Unfortunately, this bill may deter individuals from applying to medical school, make medical school unaffordable for all but the wealthiest, make student loan repayment harder for some, and deter physicians from serving in health professional shortage areas. As such, we ask that carveouts be provided for medical school education in recognition of the unique role that physicians play in society and in alignment with the heavy educational burden that they undertake to care for those most in need.

Artificial Intelligence

The AMA has serious concerns about the inclusion of provisions in Section 0012 of the Senate Committee on Commerce, Science, and Transportation language that would prohibit state-level regulation of AI without additional federal action to create guardrails around the design, development, and deployment of AI. This lack of clear and consistent legislative and regulatory requirements is especially notable as applied to health care AI, including any AI that may be used in federal programs and may impact patient data privacy and patient access to care.

The AMA shares Congress' concerns that a patchwork of state legislation regulating AI would be problematic and confusing for developers, physicians, and patients alike. However, to ensure the safety and protection of our patients, additional federal action to ensure quality, performance, and transparency of AI must be in place. Without additional consumer protections, clear guidelines to assure AI quality, strong consumer data privacy protections, and further action to limit bias within AI systems, Americans will undoubtedly suffer harm. In the absence of any federal action to further these critical protections, states have taken action to fill critical gaps by mandating transparency and stepping up efforts to ensure their residents are covered by strong consumer protection laws that serve to limit unintended consequences from poorly performing AI systems.

In the health care space specifically, use of unregulated AI by federal departments and agencies could ultimately result in inappropriate dissemination and use of protected personal health information and denials of critical health care by federal payers—issues we have already seen come to fruition that have caused real harm to real patients. Stakeholders across industry,

[41] 42 U.S.C. § 1395y(a)(1)(A) https://www.law.cornell.edu/uscode/text/42/1395y.
[42] 42 U.S.C. § 1395f(a)(2)(C) https://www.law.cornell.edu/uscode/text/42/1395f.
[43] 42 U.S.C. § 1395f(a)(7) https://www.law.cornell.edu/uscode/text/42/1395f.

physicians, and patient organizations have consistently agreed that additional federal action to create clear and consistent guardrails that seek to ensure patient safety and data privacy are a critical need that remains unaddressed.

While the AMA remains a strong supporter of developing innovative AI tools that reduce physicians' burden and improve health outcomes for our patients, we also recognize the distinct and serious risks that health care AI poses to patient safety. These risks must be mitigated to the greatest extent possible. This legislation, as currently drafted, may fall short of achieving that goal. It sets a precedent for AI regulation that lacks sufficient clarity, contributes to ongoing confusion, and may fail to provide adequate assurances of performance and safety. We urge a reconsideration of this approach and encourage close collaboration with stakeholders to ensure the right balance between enabling innovation and upholding our shared responsibility to do no harm.

The AMA has significant concerns about Section 112204 of the House-passed language, under which a total of $25 million will be transferred from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare & Medicaid Services to enter into contracts with AI tool vendors to help identify and reduce improper payments made under Medicare Parts A and B. While supportive of rooting out improper payments, delegating Medicare integrity functions to opaque, black-box algorithms would strip physicians of due-process visibility, invite biased or erroneous claw-backs, and erode clinical autonomy. The legislation is also silent regarding any appeal processes available to physicians or physician practices subjected to errors committed by the AI technology. The AMA is concerned about the precedent of using AI technology for this purpose and the lack of statutory protections for physicians. Congress should instead require transparent, evidence-based audit standards with meaningful physician oversight and appeal rights before allowing any AI-driven payment policing. The AMA urges the Senate to continue to omit this provision in its version of H.R. 1.

Medicare

The AMA is disappointed and has serious concerns that the Senate Finance Committee omitted Section 44304 of the House-passed bill which has provisions that would permanently link annual physician fee schedule updates to the Medicare Economic Index (MEI). Physicians are already dealing with a 2.83 percent cut to Medicare payment in 2025 and, since 2001, payment updates have fallen behind practice cost inflation by 33 percent. Each short-term fix enacted since 2021 has expired with a steep cliff, as payment updates reverted to reduced payment rates as if there had been no legislative provision at all. Removing Section 44304 leaves that destructive cycle in place.

Section 44304 provides the first permanent payment adjustment built into baseline Medicare rates since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. It follows the Medicare Payment Advisory Commission's recommendation to tie Medicare payment updates to the MEI. The provision sets the 2026 payment update at 75 percent of the MEI, an estimated 2.25 percent higher than any annual update granted under MACRA. Because the increase becomes part of the baseline rather than a temporary patch, the AMA calculates that cumulative physician payment growth from 2025 through 2035 would reach 4.3 percent, compared to only 2.5 percent under current law. That difference is important especially for small

community practices that already operate on thin margins and serve large numbers of Medicare patients in rural and underserved areas.

Additionally, under current law, ongoing budget-neutrality adjustments have continuously reduced the Medicare conversion factor year after year, making private practice unsustainable for many physicians. In 2001, 61 percent of physicians owned their practices; by 2016 fewer than half did, and since 2018 most physicians have been employees. Restoring Section 44304 would help stop that trend, support participation in value-based care models, and stabilize access for seniors who depend on local physicians for routine and complex treatment.

Section 44304 also lays a foundation for comprehensive physician payment reform in the 119th Congress. Regular, adequate updates are important to practice stability and patient access, especially in most rural communities, where medical practices treat four times as many Medicare patients as their metropolitan counterparts. By linking updates to the MEI and embedding them in the fee schedule, Congress would give physicians and patients a stronger, more predictable Medicare program.

The Senate still has time to correct its course. Reinstating Section 44304 before the reconciliation bill advances would shore up practice sustainability, protect patient access, and end the cycle of temporary fixes and payment cliffs. Physicians and their patients cannot afford yet another year of instability caused by the erosion in Medicare payments.

Conclusion

The AMA appreciates the Senate's careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

AMA
AMERICAN MEDICAL ASSOCIATION

John Whyte, MD, MPH
CEO, EXECUTIVE VICE PRESIDENT

john.whyte@ama-assn.org

July 11, 2025

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole Proposed Rule [RIN 0938–AV58]

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to respond to the proposed rule, titled "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole" [RIN 0938–AV58]. In the rule, CMS would establish new criteria to limit certain forms of Medicaid provider taxes that impose higher tax rates on Medicaid providers by ensuring rates imposed on any taxpayer or tax rate group are not higher than another within the same permissible class, either outright or via a lower volume or percentage of Medicaid taxable units. CMS estimates that seven states would be impacted. The rule would also prevent additional states from creating similar taxes in the future. The rule would be effective immediately for states that implemented such taxes in the last two years. Other states would have two years to come into compliance.

The AMA supports the use of provider taxes and opposes federal proposals that would restrict or eliminate states' ability to assess provider taxes on hospitals, nursing homes, and managed care organizations to protect patient access to care. Provider taxes are a legitimate financing mechanism used by states in partnership with the federal government to fund essential health services and have kept rural hospitals, maternity wards, nursing homes, and physician practices open in rural and underserved areas across this country. If these provider tax reforms are enacted, it will create significant gaps in state budgets, forcing states to raise taxes or reduce benefits, coverage, or provider payments, or a combination thereof, leading to real impacts on Medicaid enrollees and communities across the country. Emergency department overcrowding will be exacerbated. As the uncompensated care burdens grow from patients losing coverage, many rural hospitals, nursing homes, and community physician practices could be forced to close, leaving entire vulnerable communities without access to critical health care services. Given hospitals and health systems are often among the largest employers in local communities, particularly rural areas, closures could incite broader economic instability.

Provider taxes are often used by states to increase payment rates to physicians and other health care professionals. Far too often, Medicaid payment rates lag behind private insurance and Medicare. While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot remain economically viable if they lose money on the care they provide. Without adequate payment rates, participating physicians will remain sparse in many areas of the country, and without an adequate supply of participating physicians, Medicaid patients may have coverage but not real

access to care. Too often beneficiaries must wait for unreasonable periods of time to receive the needed care, travel long distances to find Medicaid participating physicians, or go without care altogether. Lack of access to participating physicians puts beneficiaries at risk of harm or even death. Numerous studies have found adequate provider payment rates result in higher acceptance rates of Medicaid patients, greater access to and use of primary care, better patient outcomes, and significantly reduced health disparities.[1]

The AMA is deeply concerned that, according to CMS estimates, the changes proposed in this rule will amount to an estimated $33.2 billion reduction in federal Medicaid spending from 2026 through 2030. Several assumptions made in the rule, such as assuming all states will expand existing taxes to all payers, make this likely an underestimation. Furthermore, while a handful of states may be impacted now, the moratorium would prevent additional states from adopting similar taxes in the future, broadening the impact and severely hamstringing states' abilities to expand Medicaid services or respond to health crises or increases in Medicaid enrollment during economic downturns. The funding cuts that will result from this proposed rule will disproportionately impact the traditional Medicaid population of children, veterans, seniors, people with disabilities, and pregnant women.

Importantly, this proposed rule comes on the heels of more than $860 billion in reduced federal Medicaid spending over the next decade as a result of the One Big Beautiful Bill Act (OBBBA) according to the most recent estimate by the nonpartisan Congressional Budget Office, doubling down on the economic pressure states will face. Furthermore, the OBBBA also includes provisions related to provider taxes that overlap in key ways with the proposals in this rule. In particular, section 71117 of the OBBBA imposes limitations on provider taxes that are substantially similar to the limitations in the proposed rule, though there are important differences between the new law and the proposed rule (including whether affected states will be given a transition period to bring their taxes into compliance with new requirements, and how long such transition period will be). **Given these recent developments, the AMA calls on CMS to reevaluate this proposed rule in light of the changes in this legislation and reconsider whether this rule is still necessary.**

The rule asserts that the proposed changes are necessary in part because Medicaid dollars are not being spent judiciously. The AMA fundamentally disagrees with this premise. Administrative costs for Medicaid plans account for just 3.9 percent of total Medicaid spending in 2023, making it the most cost-efficient health insurance program in the country. [2] States are required to develop capitation rates that meet a medical loss ratio (MLR) target of at least 85 percent.[3] In 2023, the average MLR across states was 87 percent.[4] Rates of incomplete documentation or other errors in Medicaid payment and eligibility data have also declined by over 75 percent from 2019 to 2024 thanks to enhanced state Medicaid transparency efforts in recent years. Such errors now amount to no more than six percent of Medicaid payment and eligibility records. The vast majority of these errors (~80 percent) reflect insufficient documentation or technical errors, not necessarily improper payments.[5]

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[1] Alexander, Diane and Schnell, Molly. *"The Impacts of Physician Payments on Patient Access, Use, and Health."*American Economic Journal: Applied Economics. July 2024.
[2] Machledt, David. "Medicaid is Even Leaner as Accountability Improves." National Health Law Program. February 25, 2025. https://healthlaw.org/medicaid-is-even-leaner-as-accountability-improves/.
[3] "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." Final rule. CMS. May 6, 2016. https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[4] Cox, Cynthia et al. "Health Insurer Financial Performance in 2023." Kaiser Family Foundation. July 2, 2023. https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/.
[5] Machledt, David. "Medicaid is Even Leaner as Accountability Improves." National Health Law Program. February 25, 2025. https://healthlaw.org/medicaid-is-even-leaner-as-accountability-improves/.

We also disagree with the assertion that state Medicaid funds, including those raised by provider taxes, are spent without accountability for quality or patient outcomes or without commensurate benefit to the Medicaid program or its beneficiaries. States deploy a variety of quality and outcome provisions, particularly those that use managed care contracts, which cover 75 percent of the nation's Medicaid enrollees. Forty-three of 51 states had at least one delivery and payment reform initiative designed to address Medicaid cost and quality in place as of July 2021 and half (25) had multiple initiatives in place. Thirty-eight of 47 states reported using at least one specified financial incentive to promote quality of care.[6] Under 2016 and 2020 regulations, states are also required to implement the CMS-developed quality rating system (QRS) or a state alternative QRS under which it must collect data and issue annual quality ratings for each of its managed care organizations and prepaid health plans.[7] 2016 and 2020 federal rules also stipulate additional transparency around financial and quality data for state Medicaid programs. As part of these efforts, CMS began publicly posting the Managed Care Program Annual Report and the MLR Summary Reports on Medicaid.gov in 2024.[8]

CMS expresses concern that certain states are using Medicaid provider tax revenue to fill state budget shortfalls rather than reinvesting the revenue in their Medicaid programs. On this point, **the AMA agrees that provider tax revenue should be used to directly support Medicaid patients' access to care.** Fortunately, many state tax policies already align with this view, and, in many cases, state medical associations have led the charge in ensuring such guardrails are in place. For example, in California, a provider coalition brought a successful ballot initiative (Proposition 35) in November 2024 championed by the California Medical Association, so state law now requires these funds be dedicated to supporting increasing access to care for the millions of seniors, children, low-income families and people with disabilities who rely on Medicaid in the state.[9] Similarly, a recently enacted law in Minnesota requires that revenue from a new assessment on managed care organizations be used to improve access to mental and behavioral health services.[9] Another recently enacted law in Nebraska stipulates that revenue from a provider tax go into a "Medicaid Access and Quality Fund" to be used to enhance rates paid to nonhospital providers of physical health services.[10] **Rather than broadly disallowing certain provider taxes altogether, the agency should instead put guardrails in place to ensure Medicaid tax revenue is used responsibly to improve the program and increase access to care, as many states have already done.**

We are also concerned with the lack of transparency and clarity regarding definitions in the proposed rule. CMS notes several times in the rule that seven states would be impacted by the proposed changes but does not identify these seven states. It is also not clear how CMS intends to define Medicaid providers and Medicaid taxable units versus non-Medicaid providers and non-taxable units, and CMS appears to retain a large degree of autonomy and discretion in doing so. CMS provides illustrative examples in the rule but does not provide a specific threshold or definition. Without clearly defined terms, we are concerned that states will have difficulty determining whether or not they comply with the rule and the agency could significantly expand the scope of this rule in the future without public notice of comment and rulemaking. **We urge CMS to more clearly define these core concepts, including what constitutes**

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[6] Elizabeth Hinton, Lina Stolyar, Madeline Guth, and Mike Nardone. State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid. Kaiser Family Foundation. January 12, 2022. https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/.

[7] Medicaid and CHIP Managed Care Final Rules. https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules.

[8] Elizabeth Hinton and Jada Raphael. 10 Things to Know About Medicaid Managed Care. Kaiser Family Foundation. February 27, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care.

[9] Minnesota House File 2, 94th Legislature, 2025 1st Special Session. Enacted June 14, 2025.

[10] Nebraska Legislative Bill 527, The Medicaid Access and Quality Act, 109th Legislature, Enacted April 7, 2025.

a Medicaid provider and taxable unit, and to invite stakeholder comment on these important concepts before finalizing this rule.

Lastly, the AMA appreciates that a transition period has been proposed for states with provider taxes that were approved at least two years prior. However, we disagree with the CMS view that states who received approval within the last two years received advance notice that there may be future rulemaking in this area and therefore should not be eligible for a transition period. Provider tax reforms have been floated for decades; a general warning with no specified rulemaking or timeframe does not constitute sufficient notice and does not allow states to plan for significant budgetary changes. Many states will have to amend their tax and revenue statutes via the legislative process, but most state legislatures convene briefly once each year and four convene only on a biennial basis. A transition period should be offered to all states regardless of when their tax was approved. Furthermore, the two-year period provides inadequate advance notice to the health care professionals and institutions that care for Medicaid patients who are likely to receive reduced payment rates following the states' loss of federal funding. Moreover, section 71117 of the recently enacted OBBBA provides for a transition period of up to three fiscal years and does not distinguish between states based on the approval date of their waiver, creating further confusion. **We urge CMS to set a minimum implementation timeframe of three years regardless of when a state's tax was approved by CMS.** The AMA would also strongly oppose any alternative transition period shorter than two years.

Medicaid has a long, proven track record of providing much-needed care for the 80 million vulnerable Americans it serves. The AMA and physicians nationwide urge CMS to reject the harmful cuts to federal Medicaid financing that would result from this proposed rule, which will destabilize state health systems, reduce access to care, and worsen physician shortages. Instead, we urge you to reconsider this rule in its entirety due to the Medicaid provider tax reform provisions included in the recently enacted OBBBA and to consider more targeted provisions that would address the root concerns raised by CMS in the rule, such as guardrails to ensure revenue generated by Medicaid provider taxes are used solely for the improvement of state Medicaid programs.

Thank you for your support of physicians and the patients we serve. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,

John Whyte, MD, MPH

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-25)

Introduced by: American Association of Clinical Urologists, Utah Medical Association

Subject: Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)

Referred to: Reference Committee B

Whereas, on March 27, 2025, the Utah State Legislature passed H.B. 503 which addressed medical malpractice tort reform. The bill was sponsored by Representative Katy Hall and Senator Scott D. Sandall, and was signed into law by Governor Spencer J. Cox on March 27, 2025; and

Whereas, this bill:

- defines terms;

- with respect to a medical malpractice action:
  - repeals requirements related to affidavits of merit;
  - prohibits prejudicing a defendant in an adjudication of a claimant's claims;
  - prohibits pursuing or collecting on a judgment against a health care provider's personal income or assets, with exceptions;
  - grants access to the court's Xchange database to the Division of Professional Licensing(division);
  - establishes data collection and reporting requirements for the division;
  - amends procedure pertaining to prelitigation review panels and panel reviews; and
  - makes a prelitigation review panel's recommendations or findings advisory; and

- makes technical changes; and

Whereas, specific highlights of the Utah bill provide that:

- A plaintiff may not pursue, collect, or execute on a judgment against an individual health care provider's personal income or assets, unless the court finds that:
  a. the provider's conduct was willful and malicious or intentionally fraudulent; or
  b. the defendant provider failed to maintain an insurance policy with a policy limit of at least $1,000,000.
- Prior to any award of damages to a plaintiff, a plaintiff may not make allegations that the court finds:
  a. are irrelevant to the adjudication of the claims at issue;
  b. are made primarily to coerce or induce settlement in an individual defendant provider; and
  c. pertain to a provider's personal income or assets.
- The court may award attorney fees and costs to a respondent provider if:
  a. (i) a prelitigation review panel renders an opinion under Subsection 78B-3-418(2)(a) that a claimant's claim or cause of action has no merit; or
  (ii) the court finds that the claimant did not receive a certificate of compliance because the plaintiff failed to reasonably cooperate in the scheduling of the

prelitigation panel review under Subsection 78B-3-416(4)(f);

b. the claimant proceeds to litigate the malpractice action against a health care provider without obtaining an affidavit of merit under Section 78B-3-423; and

c. the court finds that the claimant did not substantially prevail; and

• A claimant in a malpractice action against a health care provider, or the claimant's attorney, is liable to any respondent for the reasonable attorney fees and costs incurred by the respondent, or by the respondent's insurer, in connection with any filing, submission, panel review, arbitration, or judicial proceeding under this part for which a claimant files or submits an affidavit containing an allegation that the court or arbitrator finds that the claimant knew, or should have known, to be baseless or false at the time the affidavit was signed, filed, or submitted; and

Whereas, the full text of the bill is included in the references; therefore be it

RESOLVED, that our American Medical Association develop model state legislation incorporating medical malpractice tort reform based on Utah H.B. 503 enacted into law March 27, 2025. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/2/25

REFERENCES

1. https://le.utah.gov/~2025/bills/static/HB0503.html
2. https://le.utah.gov/Session/2025/bills/enrolled/HB0503.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-25)

Introduced by: Michigan

Subject: Deepfake Technology and Harm to Physicians and Patients

Referred to: Reference Committee B

Whereas, deepfake technology represents a significant threat as a form of synthetic media generated by artificial intelligence that fabricates images, videos, and audio content to depict false events or actions; and

Whereas, advancements in generative deepfake technology have reached a point where distinguishing between real and fake content is increasingly difficult, especially when an individual's image, voice, and likeness are mixed with another person's; and

Whereas, deepfake technology can and is being utilized for malicious purposes, such as identity theft, legal manipulation, blackmail, the creation of non-consensual sexual content, child pornography, the dissemination of misinformation, and other forms of fraud; and

Whereas, physicians who utilize social media for patient engagement face heightened risks of reputational damage resulting from deepfake content; and

Whereas, deepfake "doctors" are garnering millions of views on social media, endorsing products from weight-loss supplements to unproven medical treatments and devices purely for financial gain, thereby jeopardizing patient safety and exposing them to serious harm; and

Whereas, the foundation of the patient-physician relationship - built on accurate information, trust, professionalism, and authenticity - is under direct threat due to deepfake content, which misleads patients and undermines their confidence in medical practice; and

Whereas, the proliferation of deepfakes has become alarmingly common, posing substantial threats to politics, national security, and critical sectors such as finance and business, by misrepresenting politicians, celebrities, and industry leaders in ways that provoke anger or fear; and

Whereas, aggressive measures must be taken to raise awareness and implement protective safeguards against deepfake content, which carries potentially devastating mental health implications for both patients and physicians; therefore be it

RESOLVED, that our American Medical Association recognize that while there are documented advantages of deepfake technology for medical education, training, and patient engagement, there currently exists a significant regulatory void, and such lack of oversight can result in harmful consequences, including the manipulation of patients, the spread of misinformation, and the potential for injury or death (New HOD Policy); and be it further

RESOLVED, that our AMA support relevant organizations including healthcare professionals, technology developers, government regulators, social media platforms, and the public, to

formulate comprehensive federal legislation and regulations regarding deepfake technology to uphold the integrity of the medical profession against malpractice, increase awareness of the risks associated with deepfake content, and safeguard patient well-being across all communities. (Directive to Take Action)

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

Received: 9/3/25

REFERENCES

1. Unmasking deepfakes: A systematic review of deepfake detection and generation techniques using artificial intelligence - ScienceDirect
2. Deep Fakes in Healthcare: How Deep Learning Can Help to Detect Forgeries – ScienceDirect
3. https://pmc.ncbi.nlm.nih.gov/articles/PMC11503397/
4. https://www.forbes.com/sites/shashankagarwal/2024/05/30/deepfakes-in-healthcare-addressing-dangers-and-reducing-risks/
5. Revenge Pornography: Mental Health Implications and Related Legislation | Journal of the American Academy of Psychiatry and the Law
6. Montréal Declaration on Responsible AI
7. The US has plans to tackle AI-generated deepfakes | World Economic Forum
8. www3.weforum.org/docs/WEF_The_Global_Risks_Report_2024.pdf
9. FTC Proposes New Protections to Combat AI Impersonation of Individuals | Federal Trade Commission
10. Hearing Wrap Up: Action Needed to Combat Proliferation of Harmful Deepfakes - United States House Committee on Oversight and Accountability
11. Deepfakes and doctors: How people are being fooled by social media scams | The BMJ
12. Deepfakes: The Unsung Hero of Healthcare Innovation?

RELEVANT AMA POLICY

Medical and Public Health Misinformation Online D-440.915

1. Our American Medical Association encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information.
2. Our AMA encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms.
3. Our AMA will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts.
4. Our AMA will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935

1. Our American Medical Association will study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24.
2. Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.
3. Our AMA will encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs.
4. Our AMA will support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented

intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

Assessing the Intersection Between AI and Health Care H-480.931

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-25)

Introduced by: Academic Physicians Section

Subject: Restore and Enhance Federal Loan Programs for Medical Education

Referred to: Reference Committee B

Whereas, physician workforce projections indicate that the United States will face an increasing shortage of physicians[1]; and

Whereas, the cost of medical education is significant, and most medical students finance their medical education through debt[2]; and

Whereas, the Federal Loan program Grad PLUS loans provided significant benefits for medical education in comparison to private debt, such as the option to borrow up the cost of attendance, mandatory residency forbearance, and Income Driven Repayment[3]; and

Whereas, physician workforce gaps are especially prominent in primary care, rural practice, and practice in underserved areas[4]; and

Whereas, the Public Service Loan Forgiveness program supports the ability of students interested in primary care, rural practice, or practice with underserved populations to finance medical education with less debt load[5]; and

Whereas, recent legislation eliminated Grad PLUS loans and reduced the impact of Public Service Loan Forgiveness indirectly through decreased access to Public Service Loan Forgiveness with the elimination of Grad PLUS[6]; and

Whereas, the impact of recent legislation on medical student education will have a negative impact on the physician workforce through the creation of financial barriers that decrease access to medical education for many qualified applicants and reduce medical student access to future careers in primary care, rural medicine, or medical care for the underserved; therefore be it

RESOLVED, that our American Medical Association advocates for the restoration of the Grad PLUS program with loan limits established to support the cost of attendance of medical education programs. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/19/25

REFERENCES
1. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf
2. https://store.aamc.org/downloadable/download/sample/sample_id/368/https://www.aamc.org/media/82881/download; https://store.aamc.org/downloadable/download/sample/sample_id/633/
3. https://www.aamc.org/media/82881/download
4. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf, https://www.jec.senate.gov/public/index.cfm/democrats/2024/1/addressing-rural-health-worker-shortages-will-improve-population-health-and-create-job-opportunities, https://data.hrsa.gov/topics//health-workforce/shortage-areas
5. Marcu M. I., Kellerman A. L., Hunter C., Curtis J., Rice C., and Wilensky, G. R (2017). "Borrow or Serve? An Economic Analysis of Options for Financing a Medical School Education". Academic Medicine 92 (7): 966-975. https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/reconciliation-grad-loan-fact-sheet-6-30-25.pdf
6. https://www.congress.gov/bill/119th-congress/house-bill/1. https://www.americanbar.org/advocacy/governmental_legislative_work/publications/washingtonletter/june-25-wl/student-loan-updates-0625wl/

RELEVANT AMA POLICY

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

1. It is AMA policy that:

A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty. [CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmed: Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: CME Rep. 15, A-10 Reaffirmation A-11 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13 Appended: CME 05, A-16 Appended: Res. 319, A-16 Reaffirmation A-16 Reaffirmed: Res. 310, A-24]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and
    b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
    d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
    e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
    f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
    g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
    h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
    i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
    g. Adding the ability to refinance Federal Consolidation Loans.
    h. Eliminating the cap on the student loan interest deduction.
    i. Increasing the income limits for taking the interest deduction.
    j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
    k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.

l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
    a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
    b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
    c. share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
    f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,
    g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
    h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
    i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
    j. Monitor the denial rates for physician applicants to the PSLF.
    k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
    l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
    m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism. [CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19 Appended: Res. 316, A-19 Appended: Res. 226, A-21 Reaffirmed in lieu of: Res. 311, A-21 Modified: CME Rep. 4, I-21 Reaffirmation: A-22 Appended: CME Rep. 02, A-23 Appended: Res. 311, A-23 Reaffirmed: Res. 314, A-24 Reaffirmed: Res. 215, I-24 Reaffirmed: BOT Rep. 07, I-24]

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Our AMA will:

a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and

b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.

5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. [CME Rep. C, I-90 Reaffirmation A-00 Reaffirmation A-01 Reaffirmation I-01 Reaffirmed: CME Rep. 1, I-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 956, I-18 Appended: Res. 318, A-19 Modified: CME Rep. 3, I-21 Reaffirmation: I-22 Reaffirmed: BOT Rep. 11, A-23 Reaffirmed: Res. 215, I-24 Reaffirmed: BOT Rep. 07, I-24]

H-200.949 Principles of and Actions to Address Primary Care Workforce
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice. [CME Rep. 04, I-18 Reaffirmed: CMS Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-25)

Introduced by: Organized Medical Staff Section

Subject: Addressing Anti-Physician Contractual Provisions

Referred to: Reference Committee B

Whereas, over three-quarters of physicians are under employment contracts with hospitals, hospital systems, and other corporate entities[1]; and

Whereas, our AMA has opposed anti-physician labor practices such as restrictive non-compete clauses on the grounds that they limit the career advancement of young physicians and unduly restrict competition[2]; and

Whereas, "tail insurance" must be secured to ensure continued liability coverage when a physician unenrolls from a claims-made malpractice policy, as such policies do not cover any claims made after unenrollment[3]; and

Whereas, physician contracts typically do not specify which party is responsible for paying for tail insurance with that responsibility frequently falling to physicians[4-6]; and

Whereas, tail insurance, similar to non-compete clauses, can be used as leverage to prevent physicians from leaving a practice and thereby limit the career advancement of young physicians and restrict competition[7-10]; and

Whereas, indemnification clauses are a feature of many physician contracts which render the physician financially liable for all damages incurred by an employer as part of a malpractice lawsuit, even when another practitioner or the employer were negligent[11]; and

Whereas, the financial damages created by indemnification clauses are frequently not covered by malpractice policies, leaving physicians personally liable for these damages[12]; and

Whereas, indemnification clauses have become a routine part of physician contracts over the last 20 years[11,12]; and

Whereas, the American College of Emergency Physicians has identified such clauses as "not appropriate in medical contracts" as they "unnecessarily complicate medical malpractice litigation and may result in additional liability," and has advised physicians to decline contracts containing such clauses[13]; and

Whereas, legal experts and practice groups routinely advise physicians to challenge or eliminate indemnification clauses in their contracts[14-16]; therefore be it

RESOLVED, that our American Medical Association develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts (Directive to Take Action); and be it further

RESOLVED, that our AMA will actively work to increase the education and awareness of physicians on the implications of accepting employment contracts which require physicians to (i) pay for tail insurance, or (ii) indemnify their employers. (Directive to Take Action)

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

Received: 9/22/25

REFERENCES

1. Physicians Advocacy Institute, Avalere Health. Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023. Physicians Advocacy Institute; 2024. Accessed April 6, 2025. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023
2. Robeznieks A. AMA backs effort to ban many physician noncompete provisions. American Medical Association. June 13, 2023. Accessed March 9, 2025. https://www.ama-assn.org/medical-residents/transition-resident-attending/ama-backs-effort-ban-many-physician-noncompete.
3. Malpractice Insurance: What You Need to Know. J Oncol Pract. 2007;3(5):274-277. doi:10.1200/JOP.0756501
4. Guglielmo WJ. Tail insurance: watch out for the gotcha!. *Med Econ*. 2008;85(4):35-39.
5. Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row. American Medical Association. 2023. Accessed March 9, 2025. https://www.ama-assn.org/system/files/prp-mlm-premiums-2022.pdf.
6. Physician contracting: Job duties and liability insurance. American Medical Association. February 11, 2025. Accessed March 9, 2025. https://www.ama-assn.org/medical-residents/transition-resident-attending/physician-contracting-job-duties-and-liability.
7. Moawad H. Medical malpractice tail coverage know-how for doctors. MedicalEconomics. November 12, 2020. Accessed March 9, 2025. https://www.medicaleconomics.com/view/medical-malpractice-tail-coverage-know-how-doctors.
8. Malpractice insurance. American College of Physicians. Accessed March 9, 2025. https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/malpractice-insurance.
9. Career Development in Academic Medicine. American Professors of Gynecology and Obstetrics. 2012. Accessed March 9, 2025. http://tools.apgo.org/binary/CareerBook_3rd%20Ed.pdf.
10. Salib S, Moreno A. Good-Bye and Good Luck: Teaching Residents the Business of Medicine After Residency. J Grad Med Educ. 2015;7(3):338-340. doi:10.4300/JGME-D-14-00720.1
11. Indemnification clauses in emergency medicine contracts. American College of Emergency Physicians. April 2016. Accessed March 9, 2025. https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/indemnification-clauses-in-emergency-medicine-contracts---information-paper.pdf.
12. Weiss L. Read Your Contract: It's Dangerous! Common Sense: Voice of the American Academy of Emergency Medicine. 2019. https://issuu.com/aaeminfo/docs/26-3_mayjun_2019.
13. Sellinger T. Breaking down indemnification clauses. Physician's Weekly. January 23, 2025. Accessed March 9, 2025. https://www.physiciansweekly.com/qa-breaking-down-indemnification-clauses/.

RELEVANT AMA POLICY

Insurer Accountability When Prior Authorization Harms Patients D-320.974

1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

Citation: Res. 711, A-24

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.
    f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.
    g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: Issued: BOT Rep. M, I-90; Reaffirmed: Res. 716, A-95; Reaffirmed: CMS Rep. 4, A-95; Reaffirmed: I-96; Reaffirmed: Rules and Cred. Cmt, I-97; Reaffirmed: CMS Rep. 13; I-98; Reaffirmed: I-98; Reaffirmed:A-99; Reaffirmation: I-99; Reaffirmed: A-00; Reaffirmed in lieu of: Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed; CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

Promoting Accountability in Prior Authorization D-285.960

1. Our American Medical Association will advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.
2. Our AMA will advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.
3. Our AMA will advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.
4. Our AMA will continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.
5. Our AMA will advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations.
6. Our AMA will advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care

Referred to: Reference Committee B

Whereas, the American Medical Association mission is to promote the art and science of medicine and the betterment of public health, and core advocacy positions include access to health care and physician well-being & burnout; and

Whereas, over the past 20+ years, reimbursement rates have declined significantly in real-dollar items (led by Medicare at 30 percent—more in inflation-adjusted terms—but more often than not leading other insurance organizational policy in parallel), while practice overhead (rent, staff, EHR compliance, and malpractice insurance) has risen sharply. Physicians are no expected to provide increasingly complex care while bearing financial risk, without the ability to charge fair value or relieve financial burden for struggling patients; and

Whereas, efforts to redress this disparity by advocacy to improve third party fee schedules, particularly Medicare, have so far been unproductive of relief; and

Whereas, balance billing refers to a physician's ability to charge a patient for the difference between the provider's fee and what the insurer reimburses. This was historically permitted in Massachusetts until reforms during the Dukakis administration in the 1980s prohibited balance billing, even for non-participating physicians treating Medicare patients. Massachusetts General Laws and Board of Registration regulations further prohibit charging beyond allowable amounts for many insured patients, irrespective of network participation; and

Whereas, thirty-three states have some form of prohibition on balance billing and subsequently the federal No Surprises Act was enacted in 2020 that protects patients from receiving unexpected, high out-of-network medical bills for certain emergency and non-emergency services. The law limits balance billing by out-of-network providers at in-network facilities and prevents out-of-network providers from balancing billing for certain services, such as air ambulance services (but not land ambulance services). Patients are generally responsible only for their in-network cost-sharing amounts, such as copayments and deductibles; and

Whereas, at the same time, federal regulations and payer contracts—largely through anti-kickback statutes and insurer agreements—restrict a physician's ability to waive or forgive co-pays and deductibles, even in cases of demonstrated financial hardship; and

Whereas, the prohibition of balance billing and mandated collection of co-pays, even from indigent or financially stressed patients, places independent physicians in an untenable position—both economically and ethically; and

Whereas, hospitals, by contrast, can negotiate higher rates, apply facility fees, and benefit from vertical integration and government subsidies. Independent practitioners are increasingly forced

to sell their practices, retire early, or reduce services. Patient, in turn, face reduced access, fewer choices, and more corporatized care; and

Whereas, private/independent physician practices need both the freedom to set fair, transparent fees and the discretion to relieve patients of financial hardship when appropriate. Restoring regulated balance billing for outpatient, non-emergency care—combined with lifting restrictions on copay forgiveness in cases of financial hardship—would provide physicians with essential flexibility and improve practice's financial sustainability while preserving transparency and protecting vulnerable patients; and

Whereas, the AMA has multiple policies addressing the need for, right of, and promotion of advocacy for, balanced billing but has not prioritized that in advocacy, in preference to advocating for fee schedule improvement; and

Whereas, the AMA has policy to monitor the effect of balance billing on rural health and to report back "at every HOD meeting its progress toward completion of all these goals" on balance billing though such reporting is obscure[1,2]; and

Whereas, there are successful models in other professional service industries (e.g., law, dentistry), where clients/patients may opt for higher-cost services if they perceive value, and practitioners may offer charitable relief when warranted, and the AMA acknowledges patient choice as a relevant factor[3]; therefore be it

RESOLVED, that our American Medical Association assign high priority to advocacy to support legislation or regulatory reform to restore private physicians' ability to balance bill patients for non-emergency, outpatient medical services, regardless of insurance network participation status (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose artificial caps on private physician balance billing amounts, especially of less than 100 percent above the insurer's allowed amount, to reflect and offset decades of reimbursement erosion (New HOD Policy); and be it further

RESOLVED, that our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently required under state and federal law (New HOD Policy); and be it further

RESOLVED, that our AMA advocate at the federal level for reform of anti-kickback and payer contracting rules that prohibit physicians from waiving co-pays and deductibles for patients experiencing financial hardship. (Directive to Take Action)

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

Received: 9/22/25

REFERENCES

1. AMA Policy H-465.985 "Medicare Balance Billing"
2. AMA Policy D-380.996 "Balance Billing for All Physicians"
3. AMA Policy H-390.854 "Freedom of Choice"

RELEVANT AMA POLICY

Balance Billing for All Physicians D-380.996
1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.

2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Citation: Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17

Balance Billing H-385.991
Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Citation: Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmed: A-04; Reaffirmed: A-05; Reaffirmed: A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16

Parity in Medicare Reimbursement D-390.969
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing.

Citation: BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: I-08; Modified: BOT Rep. 09, A-18; Reaffirmed in lieu of: Res. 823, I-18

Medicare Balance Billing D-390.986
1. Our American Medical Association advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges
2. Our AMA seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients.
3. Our AMA further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Citation: Res. 713, I-02; Reaffirmed: A-04; Reaffirmed: A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22

Medicare Balance Billing D-390.985
Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Citation: Res. 119, A-03; Reaffirmed: A-04; Reaffirmed: A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Modified: CMS Rep. 01, A-16

Rural Health H-465.989
It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.

Citation: CMS Rep. K, A-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 3, A-15; Reaffirmed: CMS Rep. 01, A-25

Freedom of Choice H-390.854
(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.

Citation: Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmed: A-06; Reaffirmed: CMS Rep. 01, A-16

Reform the Medicare System D-330.924
Our AMA will renew its commitment for total reform of the current Medicare system by making it a high priority on the AMA legislative agenda beginning in 2009 and the AMA's reform efforts will be centered on our long-standing policy of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), and balance billing (D-380.996, H-385.991, D-390.969).

Citation: Res. 834, I-08; Reaffirmed: CMS Rep. 6, A-09; Modified: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-25)

Introduced by: Colorado

Subject: Restore Funding to USAID

Referred to: Reference Committee B

Whereas, In a recent detailed Analysis of the impact of withdrawal of funding from USAID, it is estimated that there will be an increase of 14 Million preventable deaths worldwide in the next 5 years[1]; and

Whereas, the AMA Declaration of Professional Responsibility[2] calls on us, among other things, to:

1. Respect human life and the dignity of every individual.
2. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
3. Educate the public and polity about present and future threats to the health of humanity.
4. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being; and

Whereas, the withdrawal of support for USAID, and its mission to treat global infectious diseases, will likely lead to large numbers of people with partially treated tuberculosis, HIV and other infectious diseases. This in turn will lead to the development of drug resistant disease putting the world population at higher risk; therefore be it

RESOLVED, that our American Medical Association vigorously advocate for restoration of funding to USAID including resumption of aid to Africa (Directive to Take Action); and be it further

RESOLVED, that our AMA make public statements regarding the cost in human life of withdrawal of funding for USAID (Directive to Take Action); and be it further

RESOLVED, that our AMA make public statements regarding the worldwide health risks associated with withdrawal of funding for treatment of infectious diseases such as Tuberculosis, HIV, Ebola, and others. (Directive to Take Action)

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

Received: 9/22/25

REFERENCES

1. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)01186-9/fulltext
2. https://www.ama-assn.org/system/files/2020-03/declaration-professional-responsibility-english.pdf

RELEVANT AMA POLICY

Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID) D-250.986

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-25)

Introduced by: American Academy of Family Physicians

Subject: Support for a Federal Tax Incentive for Volunteer Community Preceptors

Referred to: Reference Committee B

Whereas, community-based preceptors are essential to the clinical education of medical students and residents, especially in primary care and underserved areas, where most health care is delivered; and

Whereas, the United States faces a significant and growing physician shortage, with the Association of American Medical Colleges (AAMC) projecting a shortfall of up to 124,000 physicians by 2034[1]; and

Whereas, to address this shortage, medical schools have expanded class sizes and opened new campuses, increasing the demand for clinical training sites and qualified preceptors[2]; and

Whereas, many community physicians volunteer their time to teach without compensation, yet face increasing clinical demands, administrative burdens, and burnout, which reduce their capacity and willingness to serve as preceptors[3]; and

Whereas, studies show that effective recruitment and retention of community preceptors depend on both intrinsic motivations and external incentives, such as recognition and financial support[3]; and

Whereas, states like Alabama, Colorado, Georgia, Hawaii, Maryland, Missouri, and South Carolina have implemented tax deductions of up to $8,500 for community-based faculty, resulting in improved recruitment and retention of preceptors[4-10]; and

Whereas, a national tax credit or deduction would provide a standardized, equitable incentive across all states, helping to sustain and grow the preceptor workforce critical to medical education; therefore be it

RESOLVED, that our American Medical Association advocate for the establishment of a national tax credit or tax deduction for physicians who serve as community preceptors for medical students and residents, provided these services are rendered without financial compensation from any educational institution. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/23/25

REFERENCES

1. Dall T, Reynolds R, Chakrabarti R, Ruttinger C, Zarek P, Parker O. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: Association of American Medical Colleges; 2024. doi:10.1000/aamc.2024.75231
2. Babalola D, Mobolaji A, Welch B, Stubbs R. The Impact of Fluctuating Preceptors Recruitment and Retention in View of an Increasing Medical School Class Size. *STFM Education Columns*. August 2020. Available from: https://www.stfm.org/publicationsresearch/publications/educationcolumns/2020/august/
3. Minor S, Huffman M, Lewis PR, Kost A, Prunuske J. Community Preceptor Perspectives on Recruitment and Retention: The CoPPRR Study. *Fam Med*. 2019;51(5):389–398. doi: 10.22454/FamMed.2019.937544
4. Alabama Legislature. Senate Bill 186: Preceptor Tax Incentive Act. Montgomery, AL: Alabama State Legislature; 2023. Available from: https://www.legislature.state.al.us/pdf/SearchableInstruments/2023RS/E134CC-1.pdf
5. Colorado General Assembly. House Bill 22-1005: Reauthorization of Preceptor Tax Credit. Denver, CO: State of Colorado; 2022. Available from: https://leg.colorado.gov/sites/default/files/2022a_1005_signed.pdf
6. Georgia General Assembly. House Bill 308: Extension of Preceptor Tax Credit Sunset. Atlanta, GA: State of Georgia; 2023. Available from: https://legiscan.com/GA/text/HB308/2023
7. Hawaii State Legislature. Senate Bill 2298: Preceptor Tax Credit Act. Honolulu, HI: State of Hawaii; 2018. Available from: http://preceptortaxcredit.hawaii.edu/wp-content/uploads/2018/12/Act-43-Preceptor-Tax-Credits-GM1143_.pdf
8. Maryland General Assembly. Senate Bill 0411: Preceptor Tax Credit Legislation. Annapolis, MD: State of Maryland; 2016. Available from: https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0411/?ys=2016rs
9. Missouri Senate. Senate Bill 801: Preceptor Tax Credit Program. Jefferson City, MO: State of Missouri; 2022. Available from: https://www.senate.mo.gov/22info/BTS_Web/Bill.aspx?SessionType=R&BillID=71259836
10. South Carolina Legislature. Senate Bill 314: Preceptor Tax Credit Structure. Columbia, SC: State of South Carolina; 2020. Available from: https://www.scstatehouse.gov/sess123_2019-2020/prever/314_20190508.htm

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-24)

Introduced by: Tennessee

Subject: Centralization of Medicare Provider Data Sources

Referred to: Reference Committee B

Whereas, it is with growing frequency that physicians and providers are responsible for providing personal and practice data to multiple outlets for participation in panels; and

Whereas, this is another redundant administrative task that can be reduced by deployment of technology to centralized and align provider data; and

Whereas, our American Medical Association has current policies addressing the accuracy of provider directories and the timeliness by which plans should update information to aid patients and further protections for patients to report network inadequacies; and

Whereas, our AMA policy can be further improved by addressing the burden placed on physicians for needless administrative data input to populate directories; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Medicare and Medicaid Services (CMS) adopt centralized, standardized, and interoperable provider data repositories for Medicare and Medicare Advantage provider directory purposes, including acceptance of validated data from nationally recognized sources such as the Coalition for Affordable Quality Healthcare (CAQH) or equivalent, and eliminate duplicative attestations by physicians when accurate data has already been submitted through such systems (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to urge CMS to harmonize provider directory requirements across programs and promote automation, data governance standards, and streamlined workflows that improve directory accuracy, reduce administrative burden, and ensure patients have timely access to reliable provider information. (Directive to Take Action)

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

Received: 9/24/25

REFERENCES

1. AMA White Paper: Improving Health Plan Provider Directories - www.ama-assn.org/system/files/improving-health-plan-provider-directories.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians

Referred to: Reference Committee B

Whereas, despite efforts by our AMA to reform Medicare payment, ongoing cuts are planned and many physicians are unable to sustain their private practices and may need to work in multiple settings; and

Whereas, in order to start a private practice or work in certain practice settings, physicians may desire to 'opt out' of Medicare; and

Whereas, current federal Medicare regulations require physicians who opt out of Medicare to do so entirely, without the ability to selectively participate in certain practice settings, as Medicare billing is linked to a physician's NPI number; and

Whereas, this "all-in or all-out" policy prevents physicians who practice in different settings from billing Medicare for services provided in separate roles such as hospice, inpatient care, or locum tenens (outside of emergency care exceptions) without jeopardizing their opt-out status; and

Whereas, this restriction discourages physicians from opening innovative practice models that can improve access, reduce administrative burden, and enhance patient satisfaction; and

Whereas, the inability to partially opt out of Medicare can create physician shortages in high-need areas such as small practices, hospice, rural hospitals, and skilled nursing facilities, where part-time or moonlighting physicians could otherwise fill gaps; and

Whereas, AMA policy supports a physician's right to opt out of Medicare; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation or regulatory changes to allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other practice settings (e.g., private practices, hospice, inpatient hospital care, or other defined roles).
(Directive to Take Action)

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

Received: 9/24/25

REFERENCES

1. Centers for Medicare & Medicaid Services. Manage your enrollment. Opt out of Medicare. Accessed August 14, 2025. https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment#
2. Eskew, P. Opted-Out Moonlighting. Direct Primary Care Frontier. Accessed August 14, 2025. https://www.dpcfrontier.com/opted-out-moonlighting.
3. Shay, D. Opting Out of Medicare: How to Get Out and Stay Out. Fam Pract Manag. 2017;24(6):17-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: PBM Divestiture and Transparency

Referred to: Reference Committee B

Whereas, Pharmacy Benefit Managers (PBMs) are facing increasing scrutiny due to middlemen practices that are seen as harmful to patients, pharmacies, and the overall healthcare system. These include driving up drug costs, prioritizing profits over patient care, and engaging in anticompetitive practices; and

Whereas, PBMs negotiate rebates with drug manufacturers and often don't pass these savings onto consumers, instead marking up prices and pocketing the difference. This practice, known as "spread pricing," leads to higher costs for patients and health plans; and

Whereas, PBMs often prioritize drugs formularies by prioritizing profits over patient health that yield higher rebates, even if they are not the most effective or cost-effective options for patients. This can lead to patients being steered towards more expensive drugs or having access to necessary medications restricted through formularies and prior authorization requirements; and

Whereas, the dominance of a few large PBMs (the "Big 3") raises concerns about anticompetitive behavior. They can favor their own affiliated pharmacies, and infusion centers and manipulate formularies to benefit certain manufacturers, and engage in self-preferencing, which can harm independent pharmacies, and practices not owned by the insurance company and affiliate PBMs and limit patient choice; and

Whereas, ownership of PBMs by insurance companies creates a conflict of interest that rewards profits over patients and can only be solved by divestitures of PBM ownership by insurance companies; and

Whereas, the complex contracts and negotiations between PBMs, manufacturers, and health plans often lack transparency, making it difficult for stakeholders to understand how drug prices are set and how rebates are used. This lack of transparency hinders oversight and allows PBMs to operate with less accountability; and

Whereas, PBMs' practices have been linked to higher costs for taxpayers in government health programs like Medicare Part D, as well as for employers and insurers who pay for prescription drug benefits; and

Whereas, PBMs' actions can restrict patient access to medications, particularly those not on their preferred formularies, and can increase out-of-pocket costs for patients, especially those with chronic conditions; and

Whereas, bills regarding divestment of PBMs were introduced in congress in the 2024 session and are expected to be reintroduced this year; therefore be it

RESOLVED, that our American Medical Association will work with appropriate parties to support and lobby for divestment of Pharmacy Benefit Managers (PBMs) from ownership by insurance companies (Directive to Take Action); and be it further

RESOLVED, that our AMA will work with appropriate parties to support and lobby for divestment of PBMs from owning affiliate pharmacies and infusion centers. (Directive to Take Action)

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

Received: 9/24/25

RELEVANT AMA POLICY

D-120.933 Pharmacy Benefit Managers Impact on Patients
Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patients timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related claw backs and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge. [Citation: Res. 225, A-18; Reaffirmed: CMS Rep. 06, A-24]

H-110.963 Third-Party Pharmacy Benefit Administrators
1. Our American Medical Association recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. [Citation: Res. 820, I-22; Reaffirmed: CMS Rep. 06, A-24]

H-110.981 Public Reporting of PBM Rebates
Our AMA will advocate for: (1) Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and (2) the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation. [Citation: Res. 813, I-19]

D-120.924 Pharmacy Benefit Manager (PBM) Control of Treating Disease States
1. Our American Medical Association will take a strong public stance against allowing payors and pharmacy benefit managers to divert patients to their own care teams for medical care and medication prescribing.
2. Our AMA will take immediate action (which may include legal or policy action) to assess and pursue appropriate measures designed to prevent payors and pharmacy benefit managers from diverting patients to their own care teams for medical care and medication prescribing. [Citation: Res. 234, I-23]

D-110.987 The Impact of Pharmacy Benefit Managers on Patients and Physicians
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;

- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

[Citation: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-25)

Introduced by: Utah

Subject: Access to, and Retention of, Electronic Medical Records

Referred to: Reference Committee B

Whereas, retention of patient records is important for continuing medical care; and

Whereas, codified duration of record retention is not uniform for all health care providers or centers in all states; and

Whereas, third-party web-based electronic medical record platforms are becoming commonplace; and

Whereas, web-based data is saved in various formats that may not be accessible without proprietary software; and

Whereas, transitioning from one electronic medical record (EMR) provider to another creates the potential of patient data loss through the transferring or extracting process; and

Whereas, there is a risk for significant additional cost to the health care provider or system to "re-extract" or access this information; and

Whereas, there is a potential for permanent loss of medical information if an EMR provider deletes the information after contract termination or becomes insolvent; therefore be it

RESOLVED, that our American Medical Association support federal legislation to standardize the duration of all medical record retention and to require that records of discharged patients be compiled, reviewed for completeness, and authenticated within 30 days of discharge (New HOD Policy); and be it further

RESOLVED, that our American Medical Association adopt as its formal policy and also support federal legislation that mandates the following:

a) All EMR vendors must retain patient data electronically to comply with state laws regardless of whether the provider or health-care system contract is still in effect;
b) All EMR vendors must arrange for custodians of all electronic medical files to comply with state law regarding medical record retention in case of insolvency; and
c) All EMR vendors must deliver an individual patient's medical records when requested to lawful recipients in a timely manner, at reasonable or no cost, and in formats that are readily accessible to the general public.

(New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

RELEVANT AMA POLICY

National Health Information Technology D-478.995

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA:
   a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
   b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
   c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
   d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services:
   a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
   b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will:
   a. Seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community-based settings of care delivery.
   b. Work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost-effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

AMA Policy: Electronic Data Interchange Status Report H-315.979

Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

AMA POLICY: Guiding Principles, Collection and Warehousing of Electronic Medical Record Information H-315.974
Our American Medical Association expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

Guiding Principles, Collection and Warehousing of Electronic Medical Record Information H-315.974

Our American Medical Association expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-25)

Introduced by: American Society of Addiction Medicine

Subject: Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder

Referred to: Reference Committee B

Whereas, the opioid overdose crisis remains a significant public health emergency;[1] and

Whereas, provisional data, although encouraging, reflects national drug overdose deaths remain above pre-COVID-19 pandemic levels;[2] and

Whereas, there is a 20-fold increased risk of early death for patients with opioid use disorder (OUD);[3] and

Whereas, opioid agonist treatment, like buprenorphine,[4] is lifesaving for patients suffering from OUD; and

Whereas, buprenorphine for OUD improves treatment retention[5] and criminal justice outcomes;[6] and

Whereas, buprenorphine for OUD reduces intravenous drug use and improves maternal-fetal health outcomes, Hepatitis C treatment, social functioning, and quality of life;[7] and

Whereas, the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder - 2020 Focused Update favors buprenorphine/naloxone (BNX) over buprenorphine mono-product (BUP) outside narrow circumstances like initiation in patients who are physically dependent on methadone or other long-acting opioid products or pregnancy, primarily due to the belief that naloxone in the sublingual formulation is an effective intravenous use deterrent;[8] and

Whereas, ASAM has since acknowledged that the addition of naloxone to buprenorphine may not add any real misuse deterrent utility, indicating the use of BUP outside those narrow clinical exceptions is also appropriate at the prescribers' professional discretion;[9] and

Whereas, diverted buprenorphine products are primarily used for self-treatment;[10] and

Whereas, naloxone may be systemically absorbed at higher doses of BNX, and, though rare, a few case reports describe precipitated opioid withdrawal following oral naloxone use, including one involving a patient switching from BUP to BNX;[11] and

Whereas, BUP, like BNX, is an FDA-approved, evidence-based, and lifesaving treatment for OUD;[12] and

Whereas, although BUP is not considered a first-line sublingual formulation like BNX, there is no specific prohibition against using BUP instead of BNX on a case-by-case basis when deemed

the most suitable treatment option in ASAM guidelines or the Substance Abuse and Mental Health Services Administration (SAMHSA) publications;[8,13] and

Whereas, patient-centered care is a fundamental treatment principle in general and specifically for Addiction Medicine;[14] and

Whereas, revised guidance on medications for OUD from the National Association of Boards of Pharmacy and the National Community Pharmacists Association acknowledges that prescribing BUP instead of BNX for OUD is a reasonable clinical approach for cost consideration or adverse effects from BNX and that BUP prescriptions for OUD should generally not raise red flags;[15] therefore be it

RESOLVED, that our American Medical Association advocate at the state and federal level to remove “red-flag” or “suspicious order” designations suspecting or distinguishing between buprenorphine mono-product and buprenorphine/naloxone that are approved for treatment of OUD (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare, Medicaid, and all commercial health plans and other payers, be required to cover medications to treat opioid use disorder in all formulations without prior authorization, step therapy, fail first requirements, or other inappropriate utilization management. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

REFERENCES

1. Renewal of determination that a public health emergency exists. Renewal of Determination that a Public Health Emergency Exists as a Result of the Continued Consequences of the Opioid Crisis. June 18, 2025. Accessed August 29, 2025. https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-18June2025.aspx#:~:text=%C2%A7%20247d%2C%20do%20hereby%20renew,public%20health%20emergency%20exists%20nationwide.&text=_____-,Robert,Kennedy%20Jr.
2. Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008
3. Schuckit MA. Treatment of Opioid-Use Disorders. N Engl J Med. 2016;375(4):357-368. doi:10.1056/NEJMra1604339
4. Methadone and buprenorphine reduce risk of death after opioid overdose. National Institutes of Health website. https://www.nih.gov/news-events/news-releases/methadone-buprenorphine-reduce-risk-death-after-opioid-overdose#:~:text=A%20National%20Institutes%20of%20Health,reductions%20in%20opioid%20related%20mortality. Published June 19, 2018. Accessed August 29, 2025.
5. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane website. https://www.cochrane.org/CD002207/ADDICTN_buprenorphine-maintenance-versus-placebo-or-methadone-maintenance-for-opioid-dependence. Published February 6, 2014. Accessed August 29, 2025.
6. Evans, EA, Zhu Y, Yoo C, Huang D, Hser Y. Criminal justice outcomes over 5 years after randomization to buprenorphine-naloxone or methadone treatment for opioid use disorder. *Addiction*. 2019 Aug;114(8):1396-1404. doi: 10.1111/add.14620.
7. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. 2, The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541393/
8. American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update*. Rockville, MD: American Society of Addiction Medicine, 2020:40.
9. Public Policy Statement on the Role of Pharmacists in Medications for Addiction Treatment. American Society of Addiction Medicine, Public Policy Statements. July 19, 2024:3 Accessed August 29, 2025. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/final-pps-on-the-role-of-pharmacists-in-medications-for-addiction-treatment_with-amendments.pdf?sfvrsn=d3dac290_1.
10. Cicero TJ, Ellis MS, Chilcoat HD. Understanding the use of diverted buprenorphine. Drug Alcohol Depend. 2018 Dec 1;193:117-123. doi: 10.1016/j.drugalcdep.2018.09.007. Epub 2018 Oct 12. PMID: 30359928.
11. The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARMOUD) Guideline. https://nabp.pharmacy/wp-content/uploads/2025/04/PhARM-OUD-Guidance.pdf. Accessed August 28, 2025.
12. Heidbreder C, Fudala PJ, Greenwald MK. History of the discovery, development, and FDA-approval of buprenorphine medications for the treatment of opioid use disorder. Drug Alcohol Depend Rep. 2023 Jan 10;6:100133. doi: 10.1016/j.dadr.2023.100133. PMID: 36994370; PMCID: PMC10040330.

13. Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, 2018 at 3-53, 3-54 & 3-67. Updated 2021. Accessed August 29, 2025. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
14. American Society of Addiction Medicine Public Policy Statement on Medical Ethics in Addiction Medicine. American Society of Addiction Medicine. April 3, 2024. Accessed August 29, 2025. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/final-pps-on-medical-ethics-in-addiction-medicine.pdf?sfvrsn=dd340991.
15. The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARMOUD) Guideline. https://nabp.pharmacy/wp-content/uploads/2025/04/PhARM-OUD-Guidance.pdf. Accessed August 28, 2025.

RELEVANT AMA POLICY

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972

1. Our American Medical Association's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder
2. 2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.
3. 3. Our AMA supports patients' ability to receive buprenorphine doses that exceed dosage limits listed in FDA-approved labeling when recommended by their prescriber for the treatment of opioid use disorder.
4. 4. Our AMA urges interested parties, including federal agencies, manufacturers, medical organizations, and health plans to review the evidence concerning buprenorphine dosing and revise labels and policies accordingly, in light of increasing mortality related to high-potency synthetic opioids.

Eliminate Fail First Policy in Addiction Treatment H-320.941

Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.

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MERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-25)

Introduced by: International Medical Graduates Section

Subject: Pathways to U. S. Permanent Residency for H-1B Physicians

Referred to: Reference Committee B

Whereas, the United States faces a worsening physician shortage that has been further exacerbated by the COVID-19 pandemic, with critical gaps in primary care, mental health, and specialty services, especially in rural and underserved areas; and

Whereas, International Medical Graduates (IMGs) continue to provide care to millions of patients nationwide, with immigrant physicians now representing nearly one in four practicing physicians in the U.S.; and

Whereas, immigrant physicians do not displace U.S. workers, but instead fill essential workforce gaps, create jobs, and disproportionately serve high-need communities; and

Whereas, the Department of Veterans Affairs continues to face significant physician staffing shortages, with ongoing delays in access to care for Veterans despite increased funding, underscoring the urgency of mobilizing qualified physicians already practicing in the United States; and

Whereas, thousands of physicians, including nearly 15,000 IMGs from India alone, remain stuck in employment-based green card backlogs that may take decades to resolve, leaving them and their families in prolonged uncertainty; and

Whereas, these delays prevent physicians from working at multiple sites, limit career advancement, restrict opportunities to expand practices, and undermine long-term workforce stability in the U.S.; and

Whereas, despite years of recognition of this problem, meaningful progress has not been made, and the current political climate with bipartisan acknowledgment of healthcare workforce shortages and immigration reform needs demand immediate action; therefore be it

RESOLVED**,** that our American Medical Association urgently, aggressively, and continuously collaborate with the Office of the Inspector General, the Department of Veterans Affairs, U.S. Citizenship and Immigration Services, Congress, and the Executive Branch to advocate for establishing an expedited and separate pathway for physicians to obtain permanent residence and U.S. citizenship, enabling them to practice immediately and without restrictions—including within the Veterans Affairs healthcare system—to address the critical and rapidly worsening physician shortages threatening access to care across the United States. (Directive to Take Action)

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

Received: 9/25/25

REFERENCES

Adashi, E.Y., O'Mahony, D.P. & Gruppuso, P.A. The National Physician Shortage: Disconcerting HRSA and AAMC Reports. *J GEN INTERN MED* (2025). https://doi.org/10.1007/s11606-025-09575-7
OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages, FY 2025. VA OIG (Aug 12, 2025). https://www.vaoig.gov/sites/default/files/reports/2025-08/vaoig-25-01135-196-final.pdf

Fewer qualified doctors for hire: Survey. Axios (August 26, 2025) https://www.axios.com/2025/08/26/health-care-workforce-doctor-shortage-survey

RELEVANT AMA POLICY

Permanent Residence Status for Physicians on H1-B Visas D-255.979

Our AMA will work with all relevant stakeholders to: (1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status; and (2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents' green card applications are pending.
Res. 229, A-18 Appended: BOT Rep. 01, I-19

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

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

Citation: Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23;

Conrad 30 - J-1 Visa Waivers D-255.985

1. Our AMA will:
    a. lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program;
    b. advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state;
    c. advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages;
    d. publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program;
    e. advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage;

   f. work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and
   g. continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
   Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11; Modified: BOT Rep. 5, I-12

Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976

Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion. Res. 218, A-22

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

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians. Res. 222, A-25

Expansion of US Veterans' Health Care Choices H-510.983

1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.
9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.
10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.
CMS Rep. 06, A-17 Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-25)

Introduced by: International Medical Graduates Section

Subject: Physician Visa Protection and Pathway to Serve Underserved Communities

Referred to: Reference Committee B

Whereas, international medical graduates (IMGs) represent 25% of the U.S. physician workforce and are essential in addressing physician shortages, particularly in primary care, rural, and underserved areas; and

Whereas, thousands of U.S. trained physicians in the United States rely on H-1B visas at various stages of their careers, including residency and fellowship training, during transitions from J-1 status, and while serving in underserved communities through the Conrad 30 and other J-1 waiver programs; and

Whereas, the President's administration has proposed a rule imposing a $100,000 fee for H-1B visas, which, if applied to physicians, would create an insurmountable barrier to entry and retention of qualified doctors in the U.S.; and

Whereas, physicians are often unintended collateral damage in broader immigration policy changes, despite their essential contributions to U.S. healthcare delivery and their commitment to serving in areas of greatest need; and

Whereas, there is precedent for creating a healthcare-specific visa category, as demonstrated by the H -1C visa program, which was created exclusively for nurses during a severe nursing shortage before being discontinued in 2009; and

Whereas, the National Interest Waiver provision has previously been used as a precedent to recognize physicians serving in rural and underserved areas as eligible for immigration benefits, underscoring the federal government's recognition of their critical role in meeting national health care needs; and

Whereas, restricting or discouraging physicians from obtaining H-1B visas would worsen existing physician shortages, threaten continuity of patient care, and undermine federal and state efforts to expand healthcare access; therefore be it

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from any proposed increases in H-1B visa fees, including the proposed $100,000 charge, <u>through feasible alternatives such as</u> by including them in the National Interest Waiver (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the creation of a dedicated non-immigrant visa pathway specifically for physicians, in recognition of their essential role in U.S. healthcare and to prevent them from being unintended casualties of broader immigration policy changes. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

RELEVANT AMA POLICY

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961
Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians. Res. 222, A-25

Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976
Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion. Res. 218, A-22

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19 Reaffirmed: CME Rep. 4, A-21 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 210, A-23

J-1 Visas and Waivers D-255.993
1. Our American Medical Association shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs.
3. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B waiver visas, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
4. Our AMA supports a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

BOT Rep. 11, I-02 Appended: Res. 324, A-11 Appended: Res. 904, I-11Reaffirmation A-14 Modified: BOT Rep. 09, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-25)

Introduced by: Women Physicians Section

Subject: Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum

Referred to: Reference Committee B

Whereas, Medicaid work requirements were signed into law under H.R.1 - *One Big Beautiful Bill Act* on July 4, 2025; and

Whereas, our American Medical Association has strong policy opposing Medicaid work requirements, citing evidence that such requirements lead to coverage loss due to administrative burdens and eligibility confusion, disproportionately harming low-income and historically marginalized populations; and

Whereas, the implementation of such requirements remains an opportunity for physicians to mitigate harm and ensure protection for high-risk groups, including postpartum individuals; and

Whereas, women constitute over half of adult Medicaid enrollees;[1] and

Whereas, Medicaid is the largest single payer for pregnancy-related services in the United States, financing over 40% of all births;[2] and

Whereas, prior to H.R.1, Georgia was the only state to implement Medicaid work requirements, initially exempting postpartum individuals for only 60 days until the American Rescue Plan Act of 2021 extended postpartum Medicaid coverage in participating states to 12 months;[3] and

Whereas, H.R.1 does not mandate a postpartum exemption beyond the federal minimum of 60 days, despite the recognized medical and mental health needs extending well beyond that timeframe; and

Whereas, the Centers for Disease Control and Prevention (CDC), American College of Obstetricians and Gynecologists (ACOG), and the AMA recognize the first 12 months postpartum as a critical window for maternal health monitoring, with elevated risks for conditions such as postpartum depression, cardiovascular disease, and substance use disorders; and

Whereas, requiring women to meet work or reporting requirements during the postpartum period may exacerbate health inequities, increase maternal morbidity and mortality, disrupt continuity of care, and compound socioeconomic stressors, particularly for low-income women and those without access to childcare or paid leave; therefore be it

RESOLVED, that our American Medical Association supports a clear, mandatory exemption from Medicaid work requirements for all postpartum women up to 12 months postpartum. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

REFERENCES
1. Kaiser Family Foundation. Distribution of Adults Ages 19–64 Enrolled in Medicaid, by Sex. State Health Facts. Published 2023. Accessed July 28, 2025. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-adults-19-64-by-sex/
2. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Mathews TJ. *Births: Final Data for 2019*. Natl Vital Stat Rep. 2021;70(2):1–50. Published March 23, 2021. Accessed July 28, 2025. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf
3. Georgia Department of Community Health. Postpartum Extension Demonstration. Georgia Medicaid. Published online. Accessed July 28, 2025. https://medicaid.georgia.gov/programs/all-programs/postpartum-extension

RELEVANT AMA POLICY

H-290.961 Opposition to Medicaid Work Requirements

Our AMA opposes work requirements as a criterion for Medicaid eligibility [Res. 802, I-17; Reaffirmation: A-18]

D-290.979 Medicaid Expansion

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will:
    a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823.
    b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. [Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Appended: Res. 122, A-22]

D-290.974 Extending Medicaid Coverage for One Year Postpartum

Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. [Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-25)

Introduced by: International Medical Graduates Section

Subject: Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs

Referred to: Reference Committee B

Whereas, our American Medical Association acknowledges the significant contributions of International Medical Students and Graduates and unequivocally supports their participation in the U.S. residency and fellowship programs. According to the 2023-2024 GME Data Resource Book from ACGME, of the 133,776 total active residents in specialty programs, 21.7% (29,058) are international medical school graduates (IMGs)[(1);] and

Whereas, according to the AAMC 2024 U.S. Physician Workforce Data Dashboard, of the 1,010,892 active physicians in the country, 24.7% (249,690) were International Medical Graduates[(2);] and

Whereas, our AMA recognizes that more than twenty million people in the United States reside in areas where foreign-trained physicians comprise at least half of the physician workforce. Furthermore, in these rural and underserved areas, at-risk U.S. citizens depend on visa-sponsored physicians to provide essential primary care and specialty health services[(3)]; and

Whereas, our AMA advocates for the immediate issuance and the resumption of the J-1 visa appointment scheduling to prevent further disruption to International Medical Graduates and the U.S. Healthcare system[(4);] and

Whereas, our AMA collaborates with Educational Commission on Foreign Medical Graduates to reduce the J-1 visa delays for IMGs seeking to enter the United States for postgraduate training and/or medical practice[(5);] and

Whereas, our AMA encourages the timely visa processing for all physicians, including residents and fellows[(4);] and

Whereas, our AMA collaborates with key stakeholder to mitigate delays in visa processing for International Medical Graduates (IMGs) pursuing Graduate Medical Education training programs or medical practice in the United States[(5);] and

Whereas, our AMA will continue to work with relevant authorities to support residency program directors to establish the necessary and effective connection with the State Department and the Department of Homeland Security when needed, to streamline and expedite the necessary procedures for qualified residency or fellowship applicants and, therefore, reduce the uncertainty involved in considering International graduates for residency positions[(5)]; and

Whereas, misinformation about immigration requirements, delayed visa processing times, and increased bureaucratic hurdles can disproportionately impact the recruitment and retention of

International Medical Graduates (IMGs) in residency programs, exacerbating workforce shortages and limiting access to care in underserved areas; and

Whereas, international medical graduates comprise a significant portion of the U.S. residency workforce and are essential in addressing physician shortages, particularly in underserved areas; and

Whereas, the 2025 suspension of J-1 visa appointments created widespread uncertainty and nearly prevented many IMGs from beginning training, leading some residency programs to limit or avoid interviewing IMG applicants; and

Whereas, although J-1 appointments have resumed, the lack of consistent guarantees regarding timely visa processing undermines program directors' confidence in ranking IMGs, thus threatening their participation in the Match; and

Whereas, predictable and timely visa processing is critical to ensuring IMG residents begin training on July 1, thereby avoiding disruptions in workforce planning and patient care; therefore be it

RESOLVED, that our American Medical Association advocate with the U.S. Department of State, Department of Homeland Security, and other relevant agencies to guarantee timely J-1 visa appointments and processing for all IMGs who have matched into U.S. residency programs, ensuring arrival and participation by July 1 (Directive to Take Action); and be it

RESOLVED, that the American Medical Association collaborate with key stakeholders, including Intealth and the Educational Commission for Foreign Medical Graduates (ECFMG), to advocate for the timely issuance and scheduling of J-1 visas for eligible IMGs, while addressing misinformation about immigration policies that may discourage or mislead potential IMGs and residency programs (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant stakeholders to improve processes that reduce visa delays and ensure equitable opportunities for international medical graduates, thereby strengthening the physician workforce (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for contingency protocols at federal agencies to prevent future visa disruptions from jeopardizing IMG participation in the U.S. residency Match (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2026 Annual Meeting on actions taken to secure timely visa processing for IMGs entering U.S. residency programs. (Directive to Take Action)

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

Received: 9/26/25

REFERENCES

1. https://www.acgme.org/about/publications-and-resources/graduate-medical-education-data-resource-book/
2. https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard
3. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-14-AMA-Statement-for-the-Record-re-Immigration.pdf
4. https://policysearch.ama-assn.org/policyfinder/detail/international%20medical%20graduate?uri=%2FAMADoc%2Fdirectives.xml-D-255.969.xml
5. https://policysearch.ama-assn.org/policyfinder/detail/visa%20?uri=%2FAMADoc%2Fdirectives.xml-0-645.xml
6. https://policysearch.ama-assn.org/policyfinder/detail/international%20medical%20graduates?uri=%2FAMADoc%2Fdirectives.xml-D-255.980.xml

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

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

assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.

   c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Visa Complications for IMGs in GME D-255.991

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-25)

Introduced by: New Jersey

Subject: Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)

Referred to: Reference Committee B

Whereas, the average medical school graduate will have $264,519 in student loan, which is 2.25 times greater than the average postgraduate student; and

Whereas, the average medical resident has a monthly net income of $4,400; and

Whereas, the Public Service Loan Forgiveness (PSLF) program offers loan forgiveness to federal student loan borrowers who work for the government, such as a federally qualified health center, or a not-for-profit organization after making 120 consecutive payments; and

Whereas, Income-Driven Repayment (IDR) plans tie monthly loan payment amounts to a percentage of the borrower's discretionary income; and

Whereas, Direct PLUS Loans for Graduate or Professional Students (Grad PLUS Loans) assist borrowers in paying for education-related expenses, such as housing, that are not covered by other financial aid options; and

Whereas, there have been recent federal orders that have paused access to IDR applications, changed the eligibility requirements for PSLF, and put into motion the transfer of federal student loans away from the Department of Education and to the Small Business Administration; therefore be it

RESOLVED, that our American Medical Association advocates for protection of access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans). (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

REFERENCES

1. Hanson, Melanie. Average Medical School Debt. EducationData.org. Updated August 28, 2024. Accessed March 27, 2025. https://educationdata.org/average-medical-school-debt
2. Living on a Resident's Budget. Association of American Medical Colleges. Accessed March 27, 2025. https://students-residents.aamc.org/media/9956/download
3. Office of Federal Student Aid. Public Service Loan Forgiveness (PSLF). Department of Education. Accessed March 27, 2025. https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service
4. Office of Federal Student Aid. Income-Driven Repayment Plans. Department of Education. Accessed March 27, 2025. https://studentaid.gov/manage-loans/repayment/plans/income-driven
5. Office of Federal Student Aid. Direct PLUS Loans for Graduate or Professional Students. Department of Education. Accessed March 27, 2025. https://studentaid.gov/understand-aid/types/loans/plus/grad

6. Office of Communications and Outreach. U.S. Department of Education Opens Revised Income-Driven Repayment Plan and Loan Consolidation Applications for Borrowers. Department of Education. Updated March 26, 2025. Accessed March 27, 2025. https://www.ed.gov/about/news/press-release/us-department-of-education-opens-revised-income-driven-repayment-plan-and-loan-consolidation-applications-borrowers
7. Trump, Donald J. Restoring Public Service Loan Forgiveness. The White House. Updated March 7, 2025. Accessed March 27, 2025. https://www.whitehouse.gov/presidential-actions/2025/03/restoring-public-service-loan-forgiveness/
8. Minsky, Adam S. 40 Million Student Loan Borrowers Hit By Trio Of Trump Orders - Here's Where Things Stand. Forbes. Updated March 25, 2025. Accessed March 27, 2025. https://www.forbes.com/sites/adamminsky/2025/03/25/40-million-student-loan-borrowers-hit-by-trio-of-trump-orders---heres-where-things-stand/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-25)

Introduced by: New York

Subject: Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas

Referred to: Reference Committee B

Whereas, the American Medical Association (AMA) Policy D-160.921[1], originally adopted in 2017 states the following; and

> "Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities."

Whereas, our AMA has a policy on the "Guiding Principles for the Healthcare of Migrants" [2, 3] stating these organizations will:

> "Advocate for the development of adequate policies and/or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the 'Colombo Statement'",
>
> "affirm the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration." and

Whereas, on January 21st, 2025, the Department of Homeland Security Spokesperson on Directives Expanding Law Enforcement and Ending the Abuse of Humanitarian Parole stated[4] that the Acting Department of Homeland Security Secretary issued a directive "to rescind the Biden Administration's guidelines for Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) enforcement actions that thwart law enforcement in or near so-called 'sensitive' areas."; and

Whereas, the policy rescinded, the former Department of Homeland Security (DHS) Memo[5] "Guidelines for Enforcement Actions in or Near Protected Areas" listed as an example of a "protected area" as "a medical or mental healthcare facility, such as a hospital, doctor's office, health clinic, vaccination or testing site, urgent care center, site that serves pregnant individuals, or community health center."; and

Whereas, previous United States Immigrations and Customs Enforcement [6] and Customs and Border Protection [7] memorandums referred to the above healthcare facilities as "sensitive locations" instead of "protected areas", but this language was internally updated to "protected areas" in 2021 [8]; and

Whereas, these changes will allow for ICE Agents to operate in formerly defined "protected areas" in all circumstances; and

Whereas, prior DHS "Guidelines for Enforcement Actions in or Near Protected Areas" listed several exceptions that would allow ICE agents to conduct business in "protected areas", including "national security threat … imminent risk of death, violence or physical harm … hot pursuit of an individual who poses a public safety threat / personally observed border-crosser" and others; and

Whereas, the AMA has a policy on "sensitive locations"; therefore be it

RESOLVED, that our American Medical Association amend policy D-160.921 by addition and deletion as follows:

"Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as ~~sensitive locations~~ protected areas by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as ~~sensitive locations~~ protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as ~~sensitive locations~~ protected areas; and (4) opposes the presence of ICE enforcement at healthcare facilities."

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/26/25

REFERENCES:

1. American Medical Association. Policy D-160.921, Enforcement Actions in Sensitive Locations. Published 2017. Accessed February 4, 2025. https://policysearch.ama-assn.org/policyfinder/detail/Sensitive%20locations?uri=%2FAMADoc%2Fdirectives.xml-D-160.921.xml
2. American Medical Association. Policy H-65.938, Guiding Principles for the Healthcare of Migrants. Published June 2024. Accessed February 4, 2025. https://policysearch.ama-assn.org/policyfinder/detail/Guiding%20principles%20healthcare%20m igrants?uri=%2FAMADoc%2FHOD.xml-H-65.938.xml
3. Medical Society of the State of New York. Policy 120.876, Guiding Principles for the Healthcare of Migrants. Published April 2024. Accessed February 4, 2025. https://www.positionstatements.mssny.org/120-876-guiding-principles-for-the-healthcare-of-migr ants/
4. US Department of Homeland Security. Statement from DHS Spokesperson on Directives Expanding Law Enforcement and Ending Abuse. Published January 21, 2025. Accessed February 4, 2025. https://www.dhs.gov/news/2025/01/21/statement-dhs-spokesperson-directives-expanding-law-e nforcement-and-ending-abuse
5. US Department of Homeland Security. Guidelines for Enforcement Actions in or Near Protected Areas. Published October 27, 2021. Accessed February 4, 2025. https://www.dhs.gov/sites/default/files/publications/21_1027_opa_guidelines-enforcement-action s-in-near-protected-areas.pdf
6. US Immigration and Customs Enforcement. Enforcement Actions at or Focused on Sensitive Locations. Policy No. 10029.2. Published 2011. Accessed February 4, 2025. https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf
7. US Customs and Border Protection. Enforcement Actions at or Near Certain Community Locations. Published 2013. Accessed February 4, 2025. https://niwaplibrary.wcl.american.edu/wp-content/uploads/CBP-Sensitive-Locations-Policy-2013. pdf
8. National Association of Foreign Student Advisers (NAFSA). DHS Rescinds Biden "Protected Areas" Enforcement Policy. Accessed February 4, 2025. https://www.nafsa.org/regulatory-information/dhs-rescinds-biden-protected-areas-enforcement-p olicy

RELEVANT AMA POLICY

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-25)

Introduced by: New York

Subject: Addressing the Harms and Misleading Nature of Medicare Advantage Plans

Referred to: Reference Committee B

Whereas, although Medicare Advantage (MA) was initially purported to save taxpayer money, MA is now more costly than traditional Medicare. MA plans are wholly owned and administered by private insurance companies, especially the four biggest for- profit companies. All costs of these plans are paid by the U.S taxpayers. Therefore, the increased expense of MA is depleting the Medicare budget; and

Whereas, the term Medicare Advantage, is often a misnomer, especially to seniors with complex medical problems or chronic diseases, who are often disadvantaged when they need complex or chronic or long-term care. In addition, they may be disadvantage by a narrow drug formulary, the lack of appropriate specialists, the availability of hospitals near them accepting these plans, and even problems obtaining long term care for necessary times in rehabilitation facilities, nursing homes and hospice care, which do not participate in MA because of lower levels of reimbursement than in traditional Medicare; and

Whereas, MA has become the dominant plan, as more than half of the nation's seniors are enrolled in MA plans, rather than traditional Medicare. Each November and December, there is advertising to encourage seniors to enroll in MA. This advertising does not disclose the risks of MA enrollment and forgoing traditional Medicare, unlike other advertising (such as for medications) that disclose risks. In addition, "Medicare agents" working for insurance MA companies advertise for a "free service", while they are paid large amounts (up to 24 $1500 per enrollee) by the MA companies to get seniors into MA; and

Whereas, costs of actual patient care in MA is often capitated. Patients are not informed of this arrangement and do not understand capitation nor Valued Care. Valued Care means Cost, not the actual medical value, so again this is a misnomer; and

Whereas, when a senior wants to get out of a MA, the senior now has "preexisting conditions" preventing him from getting into a better traditional Medicare plan. In addition, MA plans have been known to do "cherry picking" choosing the healthiest seniors who require the least care, avoiding sicker more costly persons. Therefore, especially with capitation, they provide the least care and earn the most profit per patient. This also may contribute further to disparities in health care and increased morbidity and even mortality; and

Whereas, MA have the narrowest drug formularies to increase profit of the plan. This impacts both the patients, who might have to switch medications to a cheaper alternative, which might be less effective, even if they have been on another medication for a long time. In addition, it requires physicians or providers to submit Prior Authorizations (PA) and 5 Appeals in attempts to get the best medication for a patient; and

Whereas, MA plans have more preauthorization's for procedures than traditional Medicare. For example, every MRI needs preauthorization under MA, whereas traditional Medicare rarely needs preauthorization for an MRI. Again, this requires more work for physicians and providers and may delay or obstruct a medically necessary procedure; and

Whereas, MA plans required more PA for hospitalization and may require shorter hospitalizations than traditional Medicare. In addition, this might prevent hospitalization or proper long-term care for a patient, such as in rehabilitation or a long-term facility or hospice; and

Whereas, the PA work for medications, procedures and hospitalizations is discouraging and often unsuccessful, leading poorer patient care and to burnout or abdication of the attempt to get the best care for a patient; and

Whereas, this excess PA work is contributing to increased costs of maintaining a small practice, and physician burnout, and physicians leaving private practice to go to a larger group or institution or retiring. This may contribute to shortages in primary care for patients. In certain urban areas like New York City, physicians are no longer participating in Medicare, further depleting the group of physicians caring for senior citizens; and

Whereas, the mayoral administration in NYC has tried to force retirees into MA, but the retirees had successfully blocked this 13 times in the courts, as they do not want to be enrolled in MA; therefore be it

RESOLVED, that our American Medical Association emphasize to Congress the excessive cost, the use of taxpayer funding, the depletion of taxpayer monies supporting traditional Medicare by the Medicare Advantage (MA) programs. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-25)

Introduced by: New York

Subject: Medicare Should not Unfairly Penalize Physicians

Referred to: Reference Committee B

Whereas, in just six years, the administrative burdens imposed by the Health Information Technology for Economic and Clinical Health Act (2009), the value-based payment programs created by the Affordable Care Act (ACA, 2010), and the Medicare Access and CHIP Reauthorization Act (MACRA, 2015) led to a widespread acquisition of independent practices by hospitals, insurance companies, and private equity firms, ultimately relegating patients to a corporatized healthcare system; and

Whereas, despite their ability to leverage capital, management, and scale, vertically consolidated healthcare systems and corporate entities failed to reduce costs. Instead, they presented barriers to providing better care at a lower cost by diminishing competition and enabling monopolistic pricing of healthcare services; and

Whereas, research clearly demonstrates that healthcare costs are significantly higher for medical practices and hospitals affiliated with health systems or private equity groups than independent medical practices and solo community hospitals; and

Whereas, disturbingly, a January 2025 bipartisan Senate Budget Committee report warned the entry of private equity was associated with reductions in quality and “potentially poses a threat to the nation’s healthcare infrastructure.”[10] In addition, hospital-acquired practices offered no significant improvements in the quality of care; and

Whereas, of great concern are the conflicts of interest between physicians and patients inherent in value-based payment models, health system non-disclosure agreements, and profit-driven corporations, as they deny patients independent, unbiased medical opinions; and

Whereas, according to a survey from NORC at the University of Chicago, about 61% of employed physicians said they have moderate or no autonomy to make referrals outside of their practice or ownership system, and 47% said they adjust patient treatment options to reduce costs based on practice policies or incentives; and

Whereas, The Congressional Budget Office's (CBO) September 2023 report revealed that only six out of the 49 value-based payment (VBP) programs created by the Center for Medicare and Medicaid Innovation (CMMI) generated any savings. A staggering 88% of the VBP programs they launched did not meet their objectives. Initially, the CBO projected that CMMI's initiatives would significantly reduce federal spending. However, CBO's 10-year analysis revealed that CMMI's activities instead resulted in increased spending and alarmingly projected this trend to continue over the next 10 years; and

Whereas, The Medicare Trustees have cautioned, “expect access to Medicare-participating physicians to become a significant issue in the long term. ”One of several reasons, particularly

in New York County, is the escape to concierge medicine, projected to increase nationally by 10.4% annually; therefore be it

RESOLVED, that our American Medical Association advocate for the repeal of any law or regulation that imposes a penalty or deduction on Medicare physician payment based upon the result of a value-based payment program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

REFERENCES

1. Rooke-Ley H, Song Z, Zhu JM. Value-Based Payment and Vanishing Small Independent Practices. JAMA. 2024 Sep 17;332(11):871-872. doi: 10.1001/jama.2024.12900.
2. Ekaireb R, Yap A, Kucejko. Vertical integration and market consolidation in healthcare: Policy drivers and impact on physicians and patient care; https://www.sciencedirect.com/journal/seminars-in-colon-and-rectal-surgery/vol/35/issue/3
3. "The Rise Of Health Care Consolidation And What To Do About It" Health Affairs Forefront, September 9, 2024 DOI: 10.1377/forefront.20240906.397095
4. Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health Systems. JAMA. Jan 24 2023;329(4):325-335. doi:10.1001/jama.2022.24032
5. How I Was Wrong About Obamacare by Bob Kocher https://www.wsj.com/articles/i-was-wrong-about-obamacare-1469997311
6. BIG by Matt Stoller, "How Obamacare Created Big Medicine," Matt Stoller, April 4, 2023 https://www.thebignewsletter.com/p/how-obamacare-created-big-medicine
7. Ho V, Metcalfe L, Vu L, Short M, Morrow R. Annual Spending per Patient and Quality in Hospital-Owned Versus Physician-Owned Organizations: an Observational Study. J Gen Intern Med. 2020 Mar;35(3):649-655. doi: 10.1007/s11606-019-05312-z. Epub 2019 Sep 3. PMID: 31482340; PMCID: PMC7080686
8. Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014 Oct 22-29;312(16):1663-9. doi: 10.1001/jama.2014.14072. PMID: 253351
9. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. JAMA Health Forum. 2022 Sep 2;3(9):e222886. doi: 10.1001/jamahealthforum.2022.2886. PMID: 36218927; PMCID: PMC9440392.
10. The Harmful Effects of Private Equity on the U.S. Healthcare System https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf
11. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. JAMA. 2023 Dec 26;330(24):2365-2375. doi: 10.1001/jama.2023.23147
12. Bhatla A, Bartlett VL, Liu M, Zheng Z, Wadhera RK. Changes in Patient Care Experience After Private Equity Acquisition of US Hospitals. JAMA. Published online January 09, 2025. doi:10.1001/jama.2024.23450
13. Gabow PA, Wynia MK. Oaths, Conscience, Contracts, and Laws-The Gathering Storm Confronting Medical Professionalism. JAMA. 2024 Aug 27;332(8):615-616. doi: 10.1001/jama.2024.10761. PMID: 39083253
14. The Impact of Practice Acquisitions and Enplymnet on Physician Experience and Care Delivery https://www.physiciansadvocacyinstitute.org/PAI-Research/Employed-Physician-Survey
15. Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation https://www.cbo.gov/publication/59274
16. Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead https://www.congress.gov/event/116th-congress/senate-event/LC65700/text
17. U.S. Concierge Medicine Market Size, Share & Trends Analysis Report https://www.grandviewresearch.com/industry-analysis/us-concierge-medicine-market-report#:~:text=The%20U.S.%20concierge%20medicine%20market,anticipated%20to%20drive%20market%20growth
18. Wadhera RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia. JAMA. 2018 Dec 25;320(24):2542-2552. doi: 10.1001/jama.2018.19232
19. McWilliams JM. Pay for Performance: When Slogans Overtake Science in Health Policy. JAMA. 2022 Dec 6;328(21):2114-2116. doi: 10.1001/jama.2022.20945. PMID: 36472613.
20. Holmgren AJ, Adler-Milstein J, Apathy NC. Electronic Health Record Documentation Burden Crowds Out Health Information Exchange Use By Primary Care Physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-25)

Introduced by: New York

Subject: Not-for-Profit Status

Referred to: Reference Committee B

Whereas, a number of healthcare systems and individual hospitals have been granted not-for-profit status the rationale for the aforementioned status is based on giving back to the community, especially to the uninsured population; and

Whereas, insurability has changed due to the Affordable Care Act; and

Whereas, hospital systems receive increasingly large reimbursements, including professional fees for their staff, who are employed physicians; and

Whereas, these entities actually place a strain on their localities due to vastly reduced tax revenues; and

Whereas, there is very little oversight of these not-for-profit entities; and

Whereas, a huge amount of money is used to reward non-clinical leadership at the expense of patient care and physician income; therefore be it

RESOLVED, that our American Medical Association advocate that the granting and maintenance of healthcare entities of not-for-profit status be reassessed by both the state legislature and the US Congress. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path

Referred to: Reference Committee B

Whereas, a Trilliant Health analysis revealed that U.S. healthcare expenditures increased from $2.8 trillion in 2012 to $4.5 trillion in 2022—an increase of over 50 percent—with little change in the utilization of health services[1]; and

Whereas, in the 1980s, healthcare was organized around independent practices with minimal administrative support but over the past 40 years, significant changes driven by increasingly complex regulations and technology requirements have resulted in a staggering 4,500 percent increase in the number of administrators needed to manage the system while the number of physicians has only increased by 150 percent[2]; and

Whereas, the largest category of wasteful spending that could be eliminated without negatively impacting patient care is administrative costs; and

Whereas, the AMA has policy to monitor the effect of balance billing on rural health and to report back “at every HOD meeting its progress toward completion of all these goals” on balance billing though such reporting is obscure[1,2]; and

Whereas, the newly created U.S. Department of Government Efficiency presents physicians with a unique opportunity to leverage our knowledge to identify costly programs and requirements that neither improve the quality of care nor reduce costs but have contributed to the overwhelming number of healthcare administrators and their burgeoning associated costs; therefore be it

RESOLVED, that our American Medical Association work with all relevant government agencies to identify sources of administrative waste to advocate for elimination of high-cost bureaucratic excesses and revision or replacement of the counterproductive payment strategies of the past two decades. (Directive to Take Action)

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

Received: 9/22/25

REFERENCES

1. Trilliant Health (2024). 2024 trends shaping the health economy. https://www.trillianthealth.com/market-research/reports/2024-health-economy-trends. Accessed August 28, 2025.
2. Bureau of Labor Statistics. (2025). Occupational Outlook Handbook – Medical and Health Services Managers. https://www.bls.gov/ooh/management/medical-and-health-services-managers.htm. Accessed August 28, 2025.
3. American Hospital Association. (2024). Skyrocketing hospital administrative costs, burdensome commercial insurer policies are impacting patient care. https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-Are-Impacting-Patient-Care.pdf. Accessed August 28, 2025.
4. Rosenthal, E. (2014). Medicine's top earners are not the M.D.s. *The New York Times*. May 7, 2014: https://www.nytimes.com/2014/05/18/sunday-review/doctors-salaries-are-not-the-big-cost.html?searchResultPosition=1. Accessed August 28, 2025.
5. Congressional Budget Office. (2023). Federal budget effects of the activities of the Center for Medicare & Medicaid Innovation. September 28, 2023: https://www.cbo.gov/publication/59274. Accessed August 28, 2025.
6. McWilliams, J.M. (2022). Pay for performance: When slogans overtake science in health policy. *JAMA*; (328, 21). https://jamanetwork.com/journals/jama/article-abstract/2799177. Accessed August 28, 2025.

RELEVANT AMA POLICY

Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios D-155.993

Our AMA:
(1) will develop model state legislation and regulations that would require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs, using the format called for in AMA Policy H 155.963;
(2) supports state legislation to require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs; and
(3) supports the development and implementation of a uniform, national accounting and reporting system to report administrative expenses and medical expense ratios as part of greater, national uniformity of market regulation.

Citation: Res. 717, A-08; Reaffirmed in lieu of: Res. 106, A-17

Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios H-155.959

AMA policy is that private health plans should be required to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios to be consistent on the state level.

Citation: Res. 727, A-08; Reaffirmed in lieu of: Res. 106, A-17

Health Care Expenditures D-155.996

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.

2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Citation: Res. 103, A-05; Appended: Res. 121, A-10; Reaffirmed: CMS Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity

Referred to: Reference Committee B

Whereas, in their September 28, 2023 report "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation," the Congressional Budget Office revealed CMMI increased federal spending in its first 10 years and will do so again in the next 10 years[1]; and

Whereas, Health Affairs in September of 2024 said, "…the number and complexity of clinician payment models in Medicare Part B has grown substantially without yielding the expected savings or quality improvement;"[2] and

Whereas, in addition to the value-based payment (VBP) programs created directly by legislation, CMMI created and tested 50+ VBP programs, only six of which yielded statistically significant savings; thus a staggering 88 percent failed to meet this objective[3]; and

Whereas, research shows that the overall impact of VBP models on care quality is inconsistent at best, with some programs leading to increased mortality rates (the Hospital Readmission Reduction Program) and exacerbating healthcare disparities (the Merit-Based Payment Incentive Program)[3,4,5,6]; and

Whereas, fifty tries and ten years should have been enough before the patient—the U.S. healthcare system—says enough is enough, evaluates the results, and disbands CMMI, saving its $10 billion budget; therefore be it

RESOLVED, that our American Medical Association advocate and urge Congress to halt the Center for Medicare & Medicaid Innovation's (CMMI) creation and rollout of new value-based payment models, quickly discontinue programs that have had negative effects on care, while supporting CMMI's evaluation of the models currently being tested. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

REFERENCES

1. Congressional Budget Office. (2023). Federal budgetary effects of the activities of the Center for Medicare & Medicaid Innovation. September 28, 2023: https://www.cbo.gov/publication/59274. Accessed August 28, 2025.
2. Everhart, A.O, Lyu, P.F., Hockenberry, J.M., & Johnston, K.J. (2024). Medicare Part B clinician payment programs and the growing costs of administrative complexity. September 11, 2024: https://www.healthaffairs.org/content/forefront/medicare-part-b-clinician-payment-programs-and-growing-costs-administrative-complexity. Accessed August 28, 2025.
3. The Commonwealth Fund. (2022). The impact of the payment and delivery system reforms of the Affordable Care Act. April 28, 2022: https://www.commonwealthfund.org/publications/2022/apr/impact-payment-and-delivery-system-reforms-affordable-care-act. Accessed August 28, 2025.
4. Khera, R.; Dharmarajan, K., & Wang, Y. (2018). Association of the Hospital Readmissions Reduction Program with mortality during and after hospitalization for acute myocardial infarction, heart failure, and pneumonia. *JAMA Network Open*, Vol. 1, No. 5. September 28, 2018: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2703947. Accessed August 28, 2025.
5. Samarghandi, A. & Qayyum, R. (2023). Effect of Hospital Readmission Reduction Program on hospital readmissions and mortality rates. *Journal of Hospital Medicine*, Vol. 14, no. 9. August 10, 2023: https://shmpublications.onlinelibrary.wiley.com/doi/abs/10.12788/jhm.3302. Accessed August 28, 2025.
6. McWilliams, J.M. (2022). Pay for performance: When slogans overtake health policy. *JAMA*, Vol. 328, No. 21. December 6, 2022: https://jamanetwork.com/journals/jama/article-abstract/2799177. Accessed August 28, 2025.

RELEVANT AMA POLICY

CMMI Payment Reform Models D-385.950

Our AMA will: (1) continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and (3) advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties.
Citation: Res. 213, A-21

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901

1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

Citation: Res. 817, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process

Referred to: Reference Committee B

Whereas, the AMA has adopted policies on health plan recoupment but the problems are not decreasing; they are exponentially increasing; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) is asking the industry for ideas to increase opportunities for recoupment using claims data mining to detect fraud and abuse and offering significant finder fees equal to 15 percent of the amount, often more than what physicians make on office-administered medications, but using claims data is an imprecise tool that cannot easily discern legitimate claims from fraud; and

Whereas, requests for medical records by Medicare Recovery and Audit Contractors (RAC) is a costly process, both financially and administratively, which is not fully compensated by the meager payments by Medicare RAC and requires separate processes for records submission from the usual Medicare Administrative Contractor portal and often requires faxing or mailing information, as was the case with Peformant RAC, a contractor of NGS Medicare in New York; and

Whereas, on a recorded call, the Medicare RAC Performant Medical Director stated that Performant is “not looking for fraud or abuse” but is looking for “documentation technicalities;” and

Whereas, this illustrates that Medicare RAC contractors have a conflict of interest in the appeals process as they get 15 percent if they deny; and

Whereas, physicians are often forced through the process illegitimately where there is neither fraud nor abuse and are forced to spend significant amounts of time and money to clear their good name; and

Whereas, physicians who appeal may win after multiple appeals but still lose financially as every minute fighting illegitimate recoupment determinations adds to losses; and

Whereas, while physicians earn 4.3 percent on office-administered drugs with sequestration, RUC contractors are not obligated to appear in administrative law judge proceedings, but may if they choose to, creating one-sided rights and depriving physicians from mounting an adequate defense by not being able to take deposition from and perform discovery on the RAC contractors; therefore be it

RESOLVED, that our American Medical Association advocates for legislation and regulation that Medicare contractors must be compelled to appear during administrative or legal proceedings if requested (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that Medicare contractors (recovery and audit contractors and others) must pay the physician for expenses incurred during the appeal process (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that successful appeals be further compensated equal to the amount that the Centers for Medicare & Medicaid Services pays to contractors to recoup successfully. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

RELEVANT AMA POLICY

Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926
Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

Citation: Res. 815, A-01; Reaffirmed: I-04; Reaffirmed: A-08; Reaffirmed in lieu of: Res. 202, I-13; Reaffirmed: Res. 707, A-16; Reaffirmed: Res. 227, A-25

Payment for Pre-Certified/Preauthorized Procedures H-385.900

1. Our American Medical Association supports the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification.
2. Our AMA will continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan.
3. Our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment.

Citation: Res. 818, I-24; Reaffirmed in lieu of: Res. 225, A-25; Reaffirmed: Res. 227, A-25

Medical Office Screens H-335.981
It is the policy of the AMA to take the following actions:
(1) seek specific clarification from CMS on the process, procedures, and criteria of physician office postpayment review and recoupment;
(2) lobby for full due process protection for carrier postpayment review and recoupment situation;
(3) oppose the concept and application of extrapolation;
(4) oppose arbitrary, erratic, or inappropriate components of postpayment review and recoupment; and
(5) seek appropriate relief to achieve equitable treatment of physicians in office postpayment review and recoupment situations.

Citation: Sub. Res. 271, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 227, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-25)

Introduced by: American Academy of Emergency Medicine

Subject: Federal Legislation to Prohibit the Corporate Practice of Medicine

Referred to: Reference Committee B

Whereas, the interests of patients are best served when medical decisions regarding their care are made by licensed physicians, unencumbered by influence from corporate, business, or financial interests; and

Whereas, lay corporations that employ physicians have been known to interfere with physician autonomy, in a manner that prioritizes corporate financial interests over the interests of patient care; and

Whereas, specific corporate behaviors that compromise physician autonomy have been enumerated, to enable a clear definition of instances where the "Corporate Practice of Medicine"(CPOM) is occurring (for such an enumeration, see AMA Policy H-160.891, Item 1-j[3]); and

Whereas, CPOM threatens physician autonomy, interferes with the physician-patient relationship, and prioritizes financial interests over patient care; and

Whereas, our American Medical Association (AMA) opposes undue corporate influence in medicine, advocating for policies that ensure physicians retain independent medical judgment; and

Whereas, AMA policy H-215.981 affirms our AMA's opposition to CPOM, emphasizing the need for physician autonomy and patient-centered care, and while acknowledging the need for federal legislation not to pre-empt state legislation, stronger language is necessary to advocate for federal baseline standards[1]; and

Whereas, AMA policies H-225.950 and H-160-891 address concerns regarding physician employment arrangements and corporate influence in medicine, emphasizing the importance of maintaining physician autonomy and professional integrity[2,3]; and

Whereas, the growing consolidation of healthcare entities and private equity acquisitions of medical practices have led to increased costs, decreased competition, and reduced access to quality care for patients; and

Whereas, many states have enacted laws prohibiting or restricting CPOM, but the lack of uniform enforcement allows corporations to circumvent such regulations, undermining the effectiveness of state laws; and

Whereas, health policy legal opinion[4] supports federal jurisdiction over CPOM as staffing corporations, hospitals, and insurance companies often operate across state lines, and there is precedent for federal involvement with laws such as EMTALA and HIPAA; and

Whereas, a federal framework prohibiting CPOM should serve as a baseline standard while preserving stronger state regulations; and

Whereas, the National Academy for State Health Policy (NASHP) has developed model legislation for state oversight of healthcare mergers and corporate influence[5], which can serve as a guide for federal legislation to prevent corporate control over medical practice; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation that prohibits lay corporations, including insurance companies, private equity firms, and other non-physician-owned entities, from owning or controlling medical practices and healthcare decision-making, and prohibits such entities from participation in federal healthcare payment programs, in order to protect physician autonomy and strengthen the physician-patient relationship (Directive to Take Action); and be it further

RESOLVED, that our AMA amend Policy H-215.981 - Corporate Practice of Medicine under items #1 and #2 by addition and deletion as follows:

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

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

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

REFERENCES

1. American Medical Association. Policy H-215.981 - Corporate Practice of Medicine. Available at: https://policysearch.ama-assn.org/policyfinder/detail/corporate%20practice?uri=%2FAMADoc%2FHOD.xml-0-1440.xml
2. American Medical Association. Policy H-225.950 - Principles for Physician Employment. Available at: https://policysearch.ama-assn.org/policyfinder/detail/%22AMA%20Principles%20for%20Physician%20Employment%20H-225.950%22?uri=%2FAMADoc%2FHOD.xml-0-1535.xml
3. American Medical Association Policy H-160.891 - Corporate investors and other corporate entities. Available at: https://policysearch.ama-assn.org/policyfinder/detail/Corporate%20Practice%20of%20Medicine?uri=%2FAMADoc%2FHOD.xml-H-160.891.xml
4. Hall, M., Fuse-Brown, E., and Rooke-Ley, H. Letter regarding federal authority to regulate corporate ownership and control of medical practices. 11/2023
5. National Academy for State Health Policy (NASHP). A Model Act for State Oversight of Proposed Healthcare Mergers. Available at: https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/

RELEVANT AMA POLICY

H-215.981 - Corporate Practice of Medicine

1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

H-225.950 - Principles for Physician Employment
1. Addressing Conflicts of Interest
a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b. Physicians should never be coerced into employment with hospitals, health care systems, medical

groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis.
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.
6. Payment Agreements
a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

AMA Policy H-160.891 - Corporate Investors and Other Corporate Entities
1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under “friendly” physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor/entity.
b. Due diligence should be conducted that includes, at minimum, review of the corporate

investor/entity's business model, strategic plan, leadership and governance, and culture.
c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
1. Determining which diagnostic tests are appropriate;
2. Determining the need for referrals to, or consultation with another physician or licensed health professional;
3. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
4. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
5. Determining the content of patient medical records;
6. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
7. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
8. Making decisions regarding coding and billing procedures for patient care services; and
9. Approving the selection of medical equipment and medical supplies.
k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.
l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-25)

Introduced by: American Academy of Emergency Medicine

Subject: Transparency with the Term “Emergency Department”

Referred to: Reference Committee B

Whereas, a recent study has shown that one out of every 13 emergency departments in the country does not have a physician staffing on-site[1]; and

Whereas, the Emergency Medical Treatment and Active Labor Act of 1986, commonly known as “EMTALA” (42 U.S.C. § 1395dd) mandates that Medicare-participating hospitals with an emergency department must provide a medical screening exam to any patient requesting emergency care and provide stabilizing treatment or an appropriate transfer, regardless of ability to pay or insurance status; and

Whereas, EMTALA defines an “emergency department” functionally, not explicitly by name, and refers to a department or facility that provides emergency care 24/7, not necessarily one named “Emergency Department.”; and

Whereas, under Medicare, billing for emergency services uses revenue codes and CPT/HCPCS codes that reflect the type of care delivered, not necessarily the department name, with reimbursement reflecting: the scope and level of service provided, the licensing/certification of the facility and clinicians, and the documentation of emergency care delivered; and

Whereas, Critical Access Hospitals (CAHs) do not require a specifically named “Emergency Department” but must be able to provide emergency care necessary to meet the needs of its inpatients and outpatients, as per the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F regarding “Conditions of participation: Critical Access Hospitals (CAHs)[3]; and

Whereas, AMA policy H130.929 On-Site Physician Requirements for Emergency Departments recognizes that the preferred model of emergency care is having a physician on-site in the emergency department 24/7[2], but does not address the misleading use of the term “emergency department” for facilities without a physician present; and

Whereas, via patient rights and informed consent standards 42 CFR § 482.13 and 42 CFR § 489.20(w)(5)[4,5], a hospital should disclose with conspicuous signage if no physician is staffing the emergency department, but there is no enforcement for them to do so; and

Whereas, patients may assume that any and all facilities which are referred to as emergency departments (EDs) or emergency rooms (ERs) will provide emergency medical care by a physician; therefore be it

RESOLVED, that our American Medical Association advocates for the designation of “emergency department” or “emergency room” to be restricted to facilities with the presence of

at least one physician on-site and on-duty, who is responsible for the emergency department at all times (Directive to Take Action); and be it further

RESOLVED, that our AMA recommends that facilities without physician staffing use alternative terminology, such as Acute Care Unit, as a matter of truth and transparency for patients, so that patients are not expecting care by a physician (New HOD Policy); and be it further

RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV), and other authorities/regulators to educate them about this issue, and to encourage them to implement correct "emergency department" terminology designations to ensure truth and transparency at all times for our patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

REFERENCES

1. Carlos A. Camargo, Krislyn M. Boggs, Ashley F. Sullivan, Janice A. Espinola, Maeve Swanton, Deborah D. Fletcher. Lack of 24/7 Attending Physician Coverage in US Emergency Departments, 2022, JACEP Open, Volume 6, Issue 2, 2025, https://doi.org/10.1016/j.acepjo.2025.100050.
2. AMA policy H130.929 On-Site Physician Requirements for Emergency Departments. Available at: https://policysearch.ama-assn.org/policyfinder/detail/emergency%20physician?uri=%2FAMADoc%2FHOD.xml-H-130.929.xml
3. Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F, 485.618 regarding "Conditions of participation: Critical Access Hospitals (CAHs)
4. Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 482, Subpart B, 482.13, "Conditions of participation for Hospitals: Administration: Patients' Rights"
5. Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B, 489.20 (w) (5), "Essentials of Provider Agreements: Basic Commitments"

RELEVANT AMA POLICY

H130.929 On-Site Physician Requirements for Emergency Departments

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-25)

Introduced by: Senior Physicians Section

Subject: Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors

Referred to: Reference Committee B

Whereas, our American Medical Association has declared that healthcare is a human right; and

Whereas, our AMA has policy opposing work requirements in Medicaid; and

Whereas, the recently enacted 'One Big Beautiful Bill Act' (Public Law No: 119-21) [OBBBA] includes an estimated $1 trillion in cuts to the Medicaid program, with negative impacts on state budgets across the country[1]; and

Whereas, the OBBBA is projected to result in the loss of healthcare coverage for millions of eligible Medicaid recipients, including seniors[2]; and

Whereas, six leading medical organizations have taken the bold step of suing the U.S. Department of Health & Human Services (HHS) for its stance on immunization practices[3]; and

Whereas, the fiscal changes in the OBBBA will lead to the closure of rural hospitals across the country[4]; and

Whereas, the previous policy decisions of our AMA were not sufficient to block or mitigate the passage of the OBBBA; therefore be it

RESOLVED, that our American Medical Association publicly denounce cuts to Medicaid in the 'One Big Beautiful Bill Act' (Public Law No: 119-21) in no uncertain terms (Directive to Take Action); and be it further

RESOLVED, that our AMA through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and reinvigorated lobbying on House and Senate leadership, work to reverse or mitigate the ‘One Big Beautiful Bill Act,’ as it relates to Medicaid (Directive to Take Action); and be it further

RESOLVED, that our AMA build coalitions with state medical societies, patient advocacy groups, hospital systems and safety net organizations to unite and advocate with a single voice for the reversal of Medicaid-related cuts in the ‘One Big Beautiful Bill Act.’ (Directive to Take Action); and be it further

RESOLVED, that our AMA hold policymakers publicly accountable using public scorecards and highlight the electoral consequences for cutting funding to essential health care (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the AMA's House of Delegates at A-26 on measurable progress to remove cuts, passage of any mitigating legislation and maintain its robust communications with coalition partners and our elected representatives. (Directive to Take Action)

Fiscal Note: $88,442 – Create and compile report.

Received: 9/26/25

REFERENCES

1. Congressional Budget Office (CBO), "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate" (July 21, 2025), available at: https://www.cbo.gov/publication/61569.
2. Tanne J., Looi M. "Some 11.8 million Americans projected to lose health insurance as Trump's One Big Beautiful Bill Act passes." BMJ. 2025 Jul 4;390:r1400. doi: 10.1136/bmj.r1400. PMID: 40615164.
3. Mandavilli, A. "Medical Societies Sue Kennedy and H.H.S. Over Vaccine Advice." New York Times [Digital Edition], 7 July 2025. Available at: Medical Societies Sue Kennedy and H.H.S. Over Vaccine Advice - The New York Times.
4. "The 'One Big Beautiful Bill,' Now Law, Does Not Protect Rural Hospitals", Health Affairs Forefront, July 23, 2025. DOI: 10.1377/forefront.20250722.555330

RELEVANT AMA POLICY

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
    a. Health insurance coverage for all Americans.
    b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps.
    c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.
    d. Investments and incentives for quality improvement and prevention and wellness initiatives.
    e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care.
    f. Implementation of medical liability reforms to reduce the cost of defensive medicine.
    g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.
2. Our AMA advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our AMA House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our AMA supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages

from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
    a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services.
    b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system.
    c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted.
    d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate.
    e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another.
    f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

14. Our AMA will continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing.

Citation: Reaffirmed: CMS Report 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed A-22; Reaffirmed: CMS Rep.02, I-23; Appended CMS Rep. 02, I-24; Appended: CMS Rep. 02, I-24; Reaffirmed: CMS Rep. 02, I-24; Reaffirmed: Res. 826, I-24

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility.
Citation: Res. 802, I-17; Reaffirmation: A-18

Cuts in Medicare and Medicaid Reimbursement H-330.932

1. Our American Medical Association continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients.
2. Our AMA supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology.
3. Our AMA aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services.
4. If the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee.
5. Our AMA supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Citation: Reaffirmed: Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13; Reaffirmed: Res. 212, I-21; Reaffirmed in lieu of: Res. 225, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-25)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Support Permanent Funding and Expansion of Native Hawaiian Healthcare

Referred to: Reference Committee B

Whereas, Native Hawaiians (or Kānaka Maoli) are the Indigenous peoples of Hawai'i who trace their ancestry to the Hawai'ian islands since time immemorial and/or since pre-Western Pacific navigation[1,2]; and

Whereas, the Kingdom of Hawai'i was a sovereign Indigenous nation from 1795-1893 serving Native Hawaiians and other Hawaiian citizens in the Hawai'ian Islands and which obtained international treaties recognizing its existence, including with the United States[2]; and

Whereas, the illegal 1893 overthrow and 1898 annexation of the Hawaiian Kingdom by the United States directly harmed the Native Hawaiian people and their political sovereignty[2]; and

Whereas, after Western contact and American occupation, Native Hawaiians sustained intergenerational biopsychosocial wounds manifesting in socioeconomic disparity, community discord, and disparate rates of metabolic disorders, cancers, infectious disease, and mental health distress at higher rates than other populations in the United States[1,3-13]; and

Whereas, Native Hawaiian and Pacific Islander youth experience disproportionately high rates of suicide, with suicide being the leading cause of death for ages 15–24, while Native Hawaiians overall are less likely to receive mental health treatment compared with non-Hispanic whites[9]; and

Whereas, culturally grounded identity and traditional healing practices serve as protective factors against stress and poor health outcomes among Native Hawaiians, with studies showing that stronger engagement in Native Hawaiian culture is associated with reduced stress and improved well-being among young adults[14,15]; and

Whereas, in recognition of its wrongful termination of Native Hawaiian sovereignty and the adversity experienced by Native Hawaiians, the United States Congress codified a political trust relationship with Native Hawaiians as an Indigenous community and has since repeatedly reaffirmed this relationship through subsequent acts, in parallel with legislation concerning American Indian and Alaska Native tribes[2]; and

Whereas, this trust relationship obligates the United States to provide funding and policy support to Native Hawaiians to better their conditions[2,16,17]; and

Whereas, on this trust principle and with precedent from the 1976 Indian Health Care Improvement Act (IHCIA), the federal government enacted the Native Hawaiian Health Care Improvement Act (NHHCIA), codified under 42 U.S. Code Chapter 122 and initially enacted as the Native Hawaiian Health Care Act of 1988, to improve health outcomes for Native Hawaiians by funding disease prevention, health promotion, and culturally relevant services,[2,16,17,18]; and

Whereas, the NHHCIA funds the Native Hawaiian Health Care Systems (NHHCS) which deliver essential subsidized primary care services to Native Hawaiians with system sites on the Hawaiian islands of Oʻahu, Kauaʻi, Molokaʻi, Maui, and Hawaiʻi[2,16,17]; and

Whereas, the NHHCIA established Papa Ola Lōkahi, a public health and NHHCS oversight body with the responsibility of advancing the public health and wellbeing of Native Hawaiians through community-based initiatives, research, and public policy[2,16,17]; and

Whereas, the NHHCS and Papa Ola Lōkahi are uniquely designed to improve the condition of Native Hawaiian health by delivering health care that is attuned to Native Hawaiian values, language, culture, history, intergenerational traumas, and traditional medicines[2,16,17]; and

Whereas, the NHHCIA is funded through HRSA Health Center Program appropriation[2,8,19,20]; and

Whereas, unlike the Indian Health Care Improvement Act which established the Indian Health Service for American Indians and Alaska Natives, the NHHCIA is subject to periodic reauthorization and limited discretionary funding, meaning Native Hawaiians are the only Indigenous population with a federal trust relationship who do not have a permanently authorized and funded health care system[2,8,18,19,21,22]; and

Whereas, Native Hawaiian physician workforce shortages, insufficient funding, and limited system locations are impeding the effectiveness of the NHHCIA, with experts recognizing a need for permanent funding to implement wider access and increased workforce development[23-26]; therefore be it

RESOLVED, that our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care (New HOD Policy); and be it further

RESOLVED, that our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands (New HOD Policy); and be it further

RESOLVED, that our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care (New HOD Policy); and be it further

RESOLVED, that our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/29/25

REFERENCES

1. Look MA, Soong S, Kaholokula JK. Assessment and Priorities for the Health and Well-Being in Native Hawaiians and Pacific Islanders. Published online 2020.
2. 42 USC Ch. 122: Native Hawaiian Health Care.; 2025. Accessed March 27, 2025. https://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter122&edition=prelim
3. Ka'apu K, Burnette CE. A Culturally Informed Systematic Review of Mental Health Disparities Among Adult Indigenous Men and Women of the USA: What is known? Br J Soc Work. 2019;49(4):880-898. doi:10.1093/bjsw/bcz009
4. Taparra K, Qu V, Pollom E. Disparities in Survival and Comorbidity Burden Between Asian and Native Hawaiian and Other Pacific Islander Patients With Cancer. JAMA Netw Open. 2022;5(8):e2226327. doi:10.1001/jamanetworkopen.2022.26327
5. Kaholokula JK, Samoa RA, Miyamoto RES, Palafox N, Daniels SA. COVID-19 Special Column: COVID-19 Hits Native Hawaiian and Pacific Islander Communities the Hardest. Hawaii J Health Soc Welf. 2020;79(5):144-146. Accessed July 24, 2025. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7226312/
6. Ndugga N, Latoya Hill, Samantha Artiga. Racial Disparities in Health Status and Outcomes - Key Data on Health and Health Care by Race and Ethnicity. KFF. June 11, 2024. Accessed July 8, 2025. https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=health-status-and-outcomes-racial-disparities-in-health-status-and-outcomes
7. Office of Hawaiian Affairs, Research, Demography. Native Hawaiian Health Fact Sheet 2022. Volume IV: Native Hawaiian Health Status. Published online 2022.
8. Morisako AK, Tauali'i M, Ambrose AJH, Withy K. Beyond the Ability to Pay: The Health Status of Native Hawaiians and Other Pacific Islanders in Relationship to Health Insurance. Hawaii J Med Public Health. 2017;76(3 Suppl 1):36-41.
9. MOKUAU NOREEN, DELEON PATRICKH, KAHOLOKULA JOSEPHKEAWEAIMOKU, et al., editors. CHALLENGES AND PROMISE OF HEALTH EQUITY FOR NATIVE HAWAIIANS. In: National Academy of Medicine; Alexander C, Murry VMB, Bogard K, editors. Perspectives on Health Equity and Social Determinants of Health. Washington (DC): National Academies Press (US); 2017. 10. Available from: https://www.ncbi.nlm.nih.gov/books/NBK595255/
10. U.S. Department of Health and Human Services, Office of Minority Health. Mental and Behavioral Health – Native Hawaiians/Pacific Islanders. Published 2021. Accessed August 24, 2025.
11. Schumacher S, Hamel L, Artiga S, Hill L, Montalvo J. Health care experiences of Native Hawaiian or Pacific Islander adults. KFF. December 3, 2024. Accessed August 24, 2025. https://www.kff.org/racial-equity-and-health-policy/health-care-experiences-of-native-hawaiian-or-pacific-islander-adults/.
12. Climbing diabetes in Molokai. Diabetes.co.uk. October 9, 2007. Accessed August 31, 2025. https://www.diabetes.co.uk/news/2007/oct/climbing-diabetes-in-molokai.html.
13. Kennedy B. The Hawaiian Diet: Traditional native vs. "local" food - delishably. Delishably. March 6, 2025. Accessed August 31, 2025. https://delishably.com/Hawaiian-Food-Culture-The-Evolution-and-Effects-of-Local-Food.
14. Jara C, Phan N. Understanding Hawaiian Identity and Well-being to Improve Mental Health Outcomes for Hawaiian Young Adults. Hawaii J Health Soc Welf. 2024;83(5):124-131. doi:10.62547/HHGI9020
15. Tribes - native voices. U.S. National Library of Medicine. Accessed August 31, 2025. https://www.nlm.nih.gov/nativevoices/timeline/723.html#:~:text=The%20principle%20foods%20in%20the,revival%20of%20Native%20Hawaiian%20culture.
16. U.S. Government Accountability Office. Native Hawaiian Health Care: Information on the Native Hawaiian Health Care Systems and Their Services. GAO-24-106407. Published October 2023. Accessed August 24, 2025. https://www.gao.gov/assets/d24106407.pdf
17. U.S. Senate. Report on S. 702 – Native Hawaiian Health Care Improvement Reauthorization Act of 2003. S Rep No. 108-405. Washington, DC: Government Printing Office; 2004. https://www.govinfo.gov/content/pkg/CRPT-108srpt405/html/CRPT-108srpt405.htm
18. United States Code. Title 25, Chapter 18: Indian Health Care Improvement Act. Indian Health Service. Published n.d. Accessed September 5, 2025.
19. State of Hawai'i Department of Health. Primary Care Needs Assessment Data Book. Honolulu, HI: State of Hawai'i; 2021. Accessed August 24, 2025. https://health.hawaii.gov/opppd/files/2020/12/Primary-Care-Leg-Rept-2021.pdf
20. U.S. Congress. S. 2681 – Native Hawaiian Health Care Improvement Act Amendments of 1992. 102nd Cong. 1992. https://www.congress.gov/bill/102nd-congress/senate-bill/2681
21. U.S. Department of Health and Human Services, Health Resources and Services Administration. Fiscal Year 2025 (FY25) Native Hawaiian Health Care Improvement Act (NHHCIA) Non-Competing Continuation (NCC) Progress Report Instructions for FY24 Award Recipients. Published [if known: e.g., December 2024]. 17 pages. Accessed August 24, 2025. https://bphc.hrsa.gov/sites/default/files/bphc/funding/nh-ncc-instructions.pdf
22. U.S. Department of Health and Human Services, Indian Health Service. Indian Health Care Improvement Act Made Permanent. Press release; March 27, 2010. Updated March 27, 2010. Accessed August 24, 2025. https://www.ihs.gov/newsroom/pressreleases/2010pressreleases/indianhealthcareimprovementactmadepermanent/
23. McKeague ML. To Raise the Health Status of Native Hawaiians to the Highest Possible Level: An Expansive Reading of the Native Hawaiian Health Care Improvement Act. Asian-Pac Law Policy J. 2022;24(1):120-159. Accessed August 13, 2025. https://heinonline.org/HOL/P?h=hein.journals/aplpj24&i=122
24. Taparra K, Deville C. Native Hawaiian and Other Pacific Islander Representation Among US Allopathic Medical Schools, Residency Programs, and Faculty Physicians. JAMA Netw Open. 2021;4(9):e2125051. doi:10.1001/jamanetworkopen.2021.25051
25. Calac AJ, Taparra K. Attrition of Indigenous Medical Students Requires Swift Institutional Response. JAMA Intern Med. 2022;182(12):1330. doi:10.1001/jamainternmed.2022.4933
26. Connolly KK, Hong T, Buenconsejo-Lum LE. Addressing Physician Shortage in Hawai'i - Kaua'i Medical Training Opportunities. Hawaii J Health Soc Welf. 2024;83(11):306-308. doi:10.62547/GRQB2504

RELEVANT AMA POLICY

H-350.976 Improving Health Care of American Indians and Alaska Natives
Our AMA… (2) Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives… (13) strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

H-350.937 Improving Healthcare of Minority Communities in Rural Areas
Our AMA… (2) Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life. [Res. 433, A-24; Modified: CSAPH Rep. 07, A-25]

H-350.939 Health Care Access for American Indians and Alaska Natives
Our American Medical Association supports (a) the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system; (b) collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement; (c) studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care; and (d) federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices. [Res. 242, A-24]

H-350.977 Indian Health Service
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends… (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; (d) Improvement in transportation to make access to existing private care easier for the American Indian population; (e) that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation; and (f) the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-25)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement

Referred to: Reference Committee B

Whereas, reporting by the Associated Press revealed that in July 2025, the Trump administration, through a Centers for Medicare & Medicaid Services – Department of Homeland Security (CMS–DHS) agreement, granted Immigration and Customs Enforcement (ICE) access to personal data, including names, home addresses, ethnicities, birth dates, and Social Security numbers, of approximately 79 million Medicaid enrollees, to enable enforcement actions;[1] and

Whereas, Reuters confirmed that the U.S. Department of Health and Human Services provided ICE with Medicaid recipients' personal data under the pretext of verifying eligibility and preventing misuse;[2] and

Whereas, Medicaid data contain highly sensitive health and demographic information protected as defined under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule 45 CFR Part 164 and other federal privacy statutes, which are intended to prevent unauthorized disclosure;[3] and

Whereas, the use of Medicaid beneficiary information for immigration enforcement purposes is sure to discourage eligible individuals, including U.S. citizen children in mixed-status families, from enrolling in and/or using needed health services, thereby worsening health disparities; and

Whereas, the release of Medicaid information to ICE undermines the ethical duty of physicians to safeguard patient confidentiality and safety as defined by the Hippocratic Oath;[4] and

Whereas, this release of private information erodes trust between the general public, especially among immigrant communities, and our health system, undermining public health efforts such as immunizations, prenatal care, and treatment of communicable diseases; and

Whereas, state attorneys general, including California's, filed a lawsuit challenging the legal authority of CMS to share Medicaid data with ICE;[5] and

Whereas, a federal judge subsequently issued a preliminary injunction blocking this practice due to its potential to disrupt vital health programs and violate legal protections;[6] and

Whereas, AMA Policy H-440.876 ("Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients") affirms the AMA's commitment to oppose governmental actions that deter or penalize immigrants seeking medical care; and

Whereas, AMA Policy H-315.983 ("Patient Privacy and Confidentiality") supports the protection of patient information and opposes disclosure without consent except as required by law for public health purposes; therefore be it

RESOLVED, that our American Medical Association amend H-315.966 "Patient and Physician Rights Regarding Immigration Status" by addition and deletion to read as follows:

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, ~~to pursue immigration enforcement actions against patients who are undocumented~~ for immigration enforcement purposes (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA work with interested parties to educate physicians and patients about existing privacy protections and available legal remedies to safeguard confidential health information, particularly for immigrant and mixed-status families. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 09/29/25

REFERENCES

1. Kindy K, Seitz A. Trump administration hands over Medicaid recipients' personal data, including addresses, to ice. AP News. July 17, 2025. Accessed September 8, 2025. https://apnews.com/article/immigration-medicaid-trump-ice-ab9c2267ce596089410387bfcb40eeb7.
2. Aboulenein A, Singh K. US Health Department hands over Medicaid personal data to ice | reuters. Reuters. July 17, 2025. Accessed September 9, 2025. https://www.reuters.com/business/healthcare-pharmaceuticals/us-health-department-hands-over-medicaid-personal-data-ice-2025-07-17/.
3. Title 45, Subtitle A, Subchapter C, Part 164 - Security and Privacy. National Archives - Code of Federal Regulations. Accessed September 8, 2025. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164.
4. Moskop JC, Marco CA, Larkin GL, Geiderman JM, Derse AR. From Hippocrates to HIPAA: privacy and confidentiality in emergency medicine--Part I: conceptual, moral, and legal foundations. Ann Emerg Med. 2005;45(1):53-59. doi:10.1016/j.annemergmed.2004.08.008
5. Attorney general Bonta: Trump administration's unprecedented move to allow ice to access Medicaid database is violation of privacy, illegal, and horrifying. State of California - Department of Justice - Office of the Attorney General. July 17, 2025. Accessed September 8, 2025. https://oag.ca.gov/news/press-releases/attorney-general-bonta-trump-administration%E2%80%99s-unprecedented-move-allow-ice.
6. Alder S. Federal judge Blocks HHS from sharing Medicaid data with ice. The HIPAA Journal. August 18, 2025. Accessed September 9, 2025. https://www.hipaajournal.com/federal-judge-blocks-hhs-sharing-medicaid-data-ice/.

RELEVANT AMA POLICY

H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
Our AMA opposes;
any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
any policies, regulations, or legislation requiring physicians, other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status;
proof of citizenship as a condition of providing health care; and
withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status.
Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24; Modified: Res. 011, A-25]

H-315.966 Patient and Physician Rights Regarding Immigration Status
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. [Res. 018, A-17]

Patient Privacy and Confidentiality H-315.983
Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
Our AMA affirms:
that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients;
that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;
that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the

retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:
the establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records;
the establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes;
the establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider.
Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation. [BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22; Reaffirmation: A-23; Reaffirmed: CSAPH Rep. 08, A-24]

H-65.932 Reducing the Harmful Impacts of Immigration Status on Health
Our AMA supports protecting the human right to seek asylum.
Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.

Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. [Res. 004, A-25]

H-65.958 Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. [Res. 013, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-25)

Introduced by: American College of Rheumatology, American College of Physicians, American Association of Geriatric Psychiatry, American Society for Gastrointestinal Endoscopy

Subject: Banning Non-compete Agreements in States

Referred to: Reference Committee B

Whereas, non-compete agreements are contract clauses that restrict an employee or independent contractor from working for a competitor or opening a competing business for a set time and within a geographic area; and

Whereas, non-compete agreements often prevent physicians and other healthcare workers from practicing within a radius of their former workplace for 1–2 years, which can force relocation or long commutes; and

Whereas, non-compete agreements leave physicians and other healthcare workers with less power to negotiate salary, call schedules, or resources; and

Whereas, non-compete agreements suppress wages, reduce job mobility, and stifle innovation; and

Whereas, non-compete agreements are particularly burdensome on physicians and other healthcare workers who provide care in rural and other underserved areas; and

Whereas, non-compete agreements compromise patient access to quality care by imposing longer wait times and reducing the number of specialists practicing in a certain area; and

Whereas, non-compete agreements often disrupt the continuity of care by forcing patients to abruptly switch providers; and

Whereas, the Federal Trade Commission's decision to not appeal the District Court's ruling in *Ryan, LLC v. FTC* puts the impetus on the states to enact legislation or regulation that either ban non-compete agreements or restrict their use; and

Whereas, only 4 states ban the use of non-compete agreements entirely and 34 states only partially restrict their use; and therefore be it

RESOLVED, that our American Medical Association will work with state medical societies, national specialty societies and/or other interested parties to advocate for legislation or regulation that would prohibit covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers, across all states in which a ban on non-to-compete agreements is not in place. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

RELEVANT AMA POLICY

Prohibiting Covenants Not-To-Compete in Physician Contracts D-265.988
Our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers. 1) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program. 2) Our AMA will study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.
Policy Timeline
Res. 237, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-25)

Introduced by: LGBTQ+ Section

Subject: Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care

Referred to: Reference Committee B

Whereas, physicians providing evidence-based medical care, including abortion and gender-affirming care, are increasingly targeted by state laws that criminalize or otherwise penalize such care, despite its adherence to widely accepted medical standards; and

Whereas, physicians may seek to relocate or obtain licensure in new states in response to legislative bans or professional risk, and unjust delays in licensure due to prior provision of legally and ethically appropriate care pose a barrier to physician mobility and access to care for patients; and

Whereas, the American Medical Association has policy supporting the protection of physicians who provide reproductive and gender-affirming care in accordance with established medical guidelines (e.g., AMA Policies H-160.915, H-65.963, and H-5.952); and

Whereas, discrimination against physicians in the licensure process based on their provision of abortion or gender-affirming care undermines the ethical obligations of the profession and patient access to essential healthcare services; therefore be it

RESOLVED, that our American Medical Association advocate that no physician be disqualified from medical licensure or subject to unnecessary delay in the licensure process solely due to having provided abortion care or gender-affirming care in accordance with then-current standards of medical practice and/or while such care was legal in their jurisdiction (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant stakeholders, including state medical boards and specialty societies, to develop guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming care practices. (Directive to Take Action)

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

Received: 9/29/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-25)

Introduced by: American Society for Reproductive Medicine

Subject: Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation

Referred to: Reference Committee B

Whereas, “restorative reproductive medicine” (RRM), is a selective rebranding of certain medical practices in ways that mislead patients and threaten access to timely, effective fertility care including IVF; and

Whereas, some organizations suggest that RRM is a safer and more effective alternative to evidence-based infertility treatments; and

Whereas, the Arkansas legislature has passed[1], and the US government has introduced[2] legislation that would codify RRM coverage in statute and refers to IVF as “suppressive” or “circumventive” to natural fertility; and

Whereas, Board-certified physicians providing infertility assessment and treatment are trained to provide a comprehensive assessment of patients’ medical, surgical, and family histories and social determinants of health as the standard of care to optimize wellness and fertility and pregnancy outcomes; and

Whereas, while some symptoms of some infertility-associated conditions such as Polycystic Ovary Syndrome (PCOS), endometriosis, and erectile dysfunction, can be improved through attention to diet and lifestyle, medical and technological intervention may be necessary for successful pregnancy with these conditions; and

Whereas, other infertility-associated conditions such as azoospermia, bilateral tubal blockage, and uterine agenesis are treatable only with medical and technological intervention; and

Whereas, delays in accessing evidence-based fertility treatments such as IVF can further exacerbate age-related infertility; and

Whereas, our American Medical Association is committed to safeguarding public health infrastructure and maintaining the integrity of evidence-based medicine; therefore be it

RESOLVED, that our American Medical Association opposes any efforts to limit patient access to the full scope of evidence-based fertility treatments, including but not limited to: In Vitro Fertilization (IVF) (New HOD Policy); and be it further

RESOLVED, that our AMA should advocate for increased NIH funding for women's health, including reproductive health, so that we can expand research on the potential underlying causes of infertility (Directive to Take Action); and be it further

RESOLVED, that our AMA acknowledges that practices considered “restorative reproductive medicine” constitute part of what Reproductive Endocrinology and Infertility physicians, Urologists, and other fertility specialists provide in their daily practice through patient-centered evaluation and individualized treatment of underlying conditions (New HOD Policy); and be it further

RESOLVED, that our AMA acknowledges that IVF is an important part of the comprehensive, evidence-based infertility treatment options that should be offered to patients and is often the most successful option for many patients looking to grow or start their families. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 09/30/25

REFERENCES

1. Act 859, 95th Gen. Assemb., Reg. Sess. (AR. 2025). https://arkleg.state.ar.us/Bills/Detail?id=hb1142&ddBienniumSession=2025%2F2025R
2. RESTORE Act, S. 1882, 119 Congress. (2025). https://www.congress.gov/bill/119th-congress/senate-bill/1882

RELEVANT AMA POLICY

D-425.989 Protecting Access to IVF Treatment
Our American Medical Association opposes any legislation or ballot measures that could criminalize in-vitro fertilization. Our AMA will work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that would: (a) equate gametes (oocytes and sperm) or embryos with children; and/or (b) otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, will report back at I-24, on the status of, and AMA’s activities surrounding, proposed ballot measures or legislation and pending court rulings, that would:
equate gametes or embryos with children; and/or otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). [Res. 217, A-24]

D-440.905 Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research
Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization’s mission. Our AMA assertively and publicly leads 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. Our AMA will report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy. [Res. 242, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(I-25)

Introduced by: American Academy of Child and Adolescent Psychiatry

Subject: Renewing Mental Health Infrastructure in the School System

Referred to: Reference Committee B

Whereas, in May 2025 the U.S. Department of Education rescinded more than $1 billion in multiyear school-based mental health grants established under the Bipartisan Safer Communities Act, which had supported the training, placement, and diversification of school mental health professionals; and

Whereas, these rescissions disproportionately impact rural and underserved districts, disrupting continuity of care and destabilizing the workforce pipeline for counselors, psychologists, social workers, and physicians engaged in school-based health services; and

Whereas, existing AMA policy (H-60.991, H-60.900, H-60.947, H-60.902, H-60.943, H-60.937, H-95.932, H-345.977, H-515.952, H-345.984, H-200.955, D-200.982, H-450.935) demonstrates strong support for school-based health services, trauma-informed care, pediatric mental health screening, equitable workforce distribution, and evidence-based policy, but does not provide permanent funding or resilience mechanisms; and

Whereas, the Federal Medical Assistance Percentage (FMAP) is the longstanding federal–state cost-sharing formula for Medicaid, and provides a tested model for creating predictable, equitable, and sustainable financing structures; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation establishing a permanent School Mental Health Infrastructure Fund, modeled on a federal–state partnership such as the FMAP, to ensure stable and equitable financing for the training, placement, and retention of school-based mental health professionals, with priority given to rural and underserved communities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation incorporating automatic continuity protections (such as bridge funding or carryover authority) within school-based mental health programs, to prevent disruptions in student care and workforce stability when federal appropriations are delayed or rescinded. (Directive to Take Action)

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

Received: 9/30/25

REFERENCES

1. Rones, M., Hoagwood, K. School-Based Mental Health Services: A Research Review. Clin Child Fam Psychol Rev 3, 223-241 (2000). https://doi.org/10.1023/A:1026425104386
2. Brown C, Carrington NK. Increasing access to school-based mental health services for youth subsequent to the COVID-19 pandemic. Health Aff Sch. 2025 Apr 5;3(4):qxaf073. doi: 10.1093/haschl/qxaf073. PMID: 40264701; PMCID: PMC12013806.
3. Hoagwood, Kimberly, and Holly D. Erwin. "Effectiveness of school-based mental health services for children: A 10-year research review." Journal of Child and Family Studies 6.4 (1997): 435-451.

RELEVANT AMA POLICY

H-60.991 Providing Medical Services through School-Based Health Programs

1. Our American Medical Association supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors.
2. Where school-based services exist, our AMA recommends that they meet the following minimum standards:
    a. Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis.
    b. On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom.
    c. There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment.
    d. Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council.
    e. Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council.
    f. Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted.
    g. School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs.
    h. Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

[CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-60.900 Student-Centered Approaches for Reforming School Disciplinary Policies

1. Our American Medical Association supports evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior.
2. Our AMA supports the consultation with school-based mental health professionals in the student discipline process.
3. Our AMA supports efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline.
4. Our AMA supports transitions to restorative approaches that individually address students' medical, social, and educational needs.
5. Our AMA supports ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students.

6. Our AMA supports limiting the presence of law enforcement patrolling in schools to only those settings and times where student and staff safety is at active risk.

[Res. 008, A-22; Modified: CSAPH Rep. 04, A-23]

H-60.947 Guns in School Settings

Our American Medical Association recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

[Res. 402, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

H-60.902 School Resource Officer Qualifications and Training

1. Our American Medical Association encourages:
    1. an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child and adolescent psychology and development, trauma-informed care, restorative justice, peer mediation, conflict resolution, crime awareness, implicit/explicit biases, how to work with children with disabilities and special needs, diversity inclusion, cultural humility competence of the distinct cultural groups represented at schools, de-escalation training, bullying and cyberbullying training, and individual and institutional safety and others deemed necessary for school resource officers.
    2. the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.
2. Our AMA encourages:
    1. school districts initiating SROs develop and those with existing SROs maintain an up-to-date Memorandum of Understanding (MOU) that clearly outlines processes for officer selection and assessment, defines roles and responsibilities of SROs and their scope relative to school personnel, identifies data to be collected, and establishes a mechanism for program evaluation and oversight.
    2. SROs to have access to local public health resources.
    3. schools with SRO programs to collect and report data to help evaluate the impact of SROs in schools;
    4. federal and state grant programs which provide funding for SRO programs, require collection and reporting of data to inform policymaking on these programs.
    5. adequate federal funding to the Bureau of Indian Education to develop and implement SRO programs in consultation with tribal leaders.
3. Our AMA acknowledges that:
    1. if a school chooses to utilize SROs, they are part of the school staff at large and their responsibilities should be defined within the context of the school team.
    2. community-based policing practices are essential for a successful SRO program.
4. Our AMA supports:
    1. efforts to address physical and mental trauma experienced by children in preschool-12th grade by eliminating disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline.
    2. transitions to restorative approaches that individually address students' medical, social, and educational needs.
    3. ensuring that any law enforcement presence in preschool-12th grade schools focuses on maintaining student and staff safety and not on disciplining students.

[Res. 926, I-19; Modified: CSAPH Rep. 04, A-23]

H-60.943 Bullying Behaviors Among Children and Adolescents

1. Our American Medical Association recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim.
2. Our AMA advocates for federal support of research:

a. for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes.
b. for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying.
c. to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors.
d. to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents.

3. Our AMA urges physicians to
    a. be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents.
    b. enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors.
    c. screen for psychiatric comorbidities in at-risk patients.
    d. counsel affected patients and their families on effective intervention programs and coping strategies.
    e. advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression.
4. Our AMA advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes:
    a. Programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving.
    b. Violence reduction curricula as part of education and training for teachers, administrators, school staff, and students.
    c. Age and developmentally appropriate educational materials about the effects of violence and aggression.
    d. Proactive steps and policies to eliminate bullying and other aggressive behaviors; and
    e. Parental involvement.
5. Our AMA advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors.
6. Our AMA urges parents and other caretakers of children and adolescents to:
    a. Be actively involved in their child's school and community activities.
    b. Teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress.
    c. Build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.

[CSA Rep. 1, A-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-60.937 Youth and Young Adult Suicide in the United States

1. Our American Medical Association recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Our AMA 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. Our AMA 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. Our AMA encourages 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.
5. Our AMA encourages 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.
6. Our AMA 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.
7. Our AMA supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
8. Our AMA 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.
9. Our AMA 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.
10. Our AMA 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.
11. Our AMA 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.

[Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21; Modified: Res. 419, A-23]

H-95.932 Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications

1. Our American Medical Association supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose,

especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.

11. Our AMA supports the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations.

[BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21; Modified: Res. 505, A-23; Reaffirmed: BOT Rep. 11, A-24; Modified: Res. 512, A-24]

H-345.977 Improving Pediatric Mental Health Screening

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
[Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18]

H-515.952 Adverse Childhood Experiences and Trauma-Informed Care

1. Our American Medical Association recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
    a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs).
    b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs.
    c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
    d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting.
    e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.
    f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
4. Our AMA will collaborate with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them.
5. Our AMA will work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions.
6. Our AMA will support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child.

[Res. 504, A-19; Appended: CSAPH Rep. 3, A-21; Appended: Res. 914, I-23]

H-345.984 Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses

1. Our American Medical Association encourages:
    a. medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose,

and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition.
b. all physicians providing clinical care to acquire the same knowledge and skills.
c. additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA:
   a. will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings.
   b. encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model.
   c. will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

[Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19; Reaffirmed: Res. 425, A-22]

H-200.955 Revisions to AMA Policy on the Physician Workforce

It is our American Medical Association policy that:

1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection

inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

[CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19; Reaffirmation: I-22; Reaffirmed in lieu of: Res. 218, A-25]

D-200.982 Diversity in the Physician Workforce and Access to Care

1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

[CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: CME Rep. 5, A-21; Reaffirmation: Res. 240, A-24]

H-450.935 Health Care Standards

Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines.

[Res. 205, A-10; Reaffirmation I-10; Reaffirmed: Res. 105, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(I-25)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices

Referred to: Reference Committee B

Whereas, the Inflation Reduction Act (IRA) allows the Centers for Medicare & Medicaid Services to negotiate the prices of certain high-cost drugs under Medicare, beginning with Part D medications and expanding to Part B in 2029; and

Whereas, our American Medical Association (AMA) has existing policy supporting efforts to ensure patients have affordable access to medications and encourages all payers, both public and private, to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending; and

Whereas, our AMA Council on Medical Service released a report at A-25 on the enactment of the IRA and its health care sector impacts, including Medicare drug pricing; and

Whereas, the IRA has been lauded for its provision to cap out-of-pocket spending for Medicare Part D beneficiaries at $2,000 annually, a "milestone" that provides much-needed financial relief to patients with cancer; and

Whereas, despite these positive patient-facing provisions, the Association for Clinical Oncology (ASCO) and other medical organizations share concerns that the IRA's drug price negotiation program could negatively impact patient access, particularly to drugs covered under Medicare Part B which includes many infused and injectable oncology therapies; and

Whereas, ASCO has warned that the potential reimbursement reductions for provider-administered drugs under the IRA's negotiation program could threaten the sustainability of community-based cancer care practices; and

Whereas, Medicare drug negotiation is expected to expand to Part B plans in 2029, which is the primary payment mechanism for many physician-administered medications, including a substantial portion of cancer therapies; therefore be it

RESOLVED, that our American Medical Association will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician-administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA's potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is provided (Directive to Take Action); and be it further

RESOLVED, that our AMA will specifically evaluate the potential impact on the sustainability of community-based physician practices, with a particular focus on oncology practices (Directive to Take Action); and be it further

RESOLVED, that our AMA will consider using the findings of this study to inform its advocacy efforts to ensure that any future drug pricing policies balance patient affordability with the stability of physician practices, patient access, and the continued advancement of drug innovation. (Directive to Take Action).

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

Received: 9/30/25

REFERENCES

1. AMA CMS Report 6-A-25 Prescription Medication Price Negotiation (Resolution 113-A-24)
2. FAQs about the Inflation Reduction Act's Medicare Drug Price Negotiation Program | KFF
3. ASCO Position Statement: Out-of-Pocket Costs for Cancer Care
4. Four Cancer Drugs Included in Next Round of Part D Drug Price Negotiation - ASCO

RELEVANT AMA POLICY

Prescription Medication Price Negotiation H-110.959

1. Our AMA supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services.

Prescription Drug Prices and Medicare D-330.954

1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(I-25)

Introduced by: College of American Pathologists

Subject: Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs

Referred to: Reference Committee B

Whereas, our AMA advocates for 'Truth & Transparency' legislation to combat medical title misappropriation ensuring non-physicians clearly and accurately state their level of training, credentials, and board licensure in patient interactions, advertising, and marketing materials[1]; and

Whereas, the "Truth & Transparency" legislation currently advocated by our AMA, under current AMA policy, does not directly address deceptive advertising by accredited allied health professional, non-physician graduate programs; and

Whereas, Pathologists' Assistants serve an important role in the Pathologist-led laboratory healthcare team; and

Whereas, numerous universities offering NAACLS-accredited Pathologists' Assistants educational programs, are deceptively advertising the scope of practice of Pathologists' Assistants as independent practice to prospective students while dismissing and omitting physician supervision; and

Whereas, universities have inaccurately advertised that Pathologists' Assistants are 'advanced practitioners' and have claimed that Pathologists' Assistants can and will prospectively expand their scope of practice autonomy; and

Whereas, such misleading advertising can lead a potential student to select a career that may not reflect their talents and career goals, whereby other healthcare career choices may better serve the student, and ultimately the healthcare system; and

Whereas, deceptive advertising by universities to prospective students inaccurately characterize the appropriate, accepted, standard scope of practice for Pathologists' Assistants and thereby may lead to future lobbying efforts to permit independent practice of Pathologists' Assistants which is not in the best interest of patient diagnosis and care; and

Whereas, states such as Texas[3] have introduced legislation that states that a person who provides a post graduate health education program for a healing art that is regulated under this title may not use the term "residency" or fellowship" in the name of the program unless the program is intended for physicians, dentists, podiatrist or pharmacist; therefore be it

RESOLVED, that our AMA support state and national medical societies to advance "Truth & Transparency" legislation, inclusive of accredited allied health professional, non-physician graduate education programs to instill transparency in non-physicians' scope of practice and training under the direction of a licensed physician (New HOD Policy); and be it further

RESOLVED, that Our AMA advocate for legislation and refinements to "Truth & Transparency" laws to prohibit production and dissemination of deceptive advertising and marketing materials by accredited allied health professional, non-physician graduate programs. These requirements should:

1. Prohibit deceptive, misleading or false advertising inclusive of professional titles and scope of the allied health professional completing the program.
2. Require that the advertised course of study at such programs is clearly consistent with applicable state laws and well-established and widely accepted medical standards for allied health professionals' training, certification, and scope of practice.
3. Mandate all advertising materials include clear and unambiguous statements that clarify the requisite levels of physician supervision for non-physician, allied health professionals, that will complete the program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

REFERENCES

1. https://policysearch.ama-assn.org/policyfinder/detail/truth in advertising?uri=%2FAMADoc%2Fdirectives.xml-D-405.974.xml
2. https://policysearch.ama-assn.org/policyfinder/detail/truth in advertising?uri=%2FAMADoc%2FHOD.xml-H-405.951.xml
3. https://capitol.texas.gov/BillLookup/History.aspx?LegSess=89R&Bill=SB2181

RELEVANT AMA POLICY

H-175.992 Deceptive Health Care Advertising | AMA
D-405.974 Clarification of Healthcare Physician Identification: | AMA
H-405.951 Definition and Use of the Term Physician | AMA

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(I-25)

Introduced by: California, Idaho, New Mexico

Subject: Protecting and Improving Rural Health

Referred to: Reference Committee B

Whereas, rural communities already suffering from physician shortages, hospitals closures, less health insurance coverage, and thus, higher rates of chronic disease and age-adjusted mortality are at even greater risk with the significant $1 trillion in Medicaid and Affordable Care Act (ACA) funding cuts (CBO) recently imposed by Congress through the passage of HR 1; and

Whereas, to mitigate some of these cuts, Congress enacted the Rural Health Transformation Program that provides $50 billion to states to address rural health care challenges; and

Whereas, given that more than half of rural adults and children are either on Medicaid, the ACA or uninsured, and up to 14 million Medicaid and ACA enrollees could lose coverage nationwide under HR 1 (CBO), the need for AMA to provide leadership and assistance to rural physicians and communities is even greater; and

Whereas, while the AMA has extensive policy on improving rural health provider shortages, infrastructure, health care disparities, and access to care, this resolution includes additional specific policies that are warranted to augment AMA's rural health advocacy; and

Whereas, 54% of rural residents report that access to medical specialists is a problem in their community and telehealth has helped to address some physician shortages, provide access to specialty care, and reduce patient burden of traveling long distances to receive care;[2] and

Whereas, rural hospitals that have difficulty retaining subspecialists have developed telehealth programs in coordination with larger urban hospitals that allow them to consult on patient care as needed and treat complex patients at local facilities - helping patients avoid the cost and time associated with traveling long distances to larger medical centers;[3] and

Whereas, some patients cannot get the services they need via telehealth and need a variety of less costly transportation options to help them access physicians outside their communities - as rural residents, compared with urban residents who lack transportation feel that the distance to receive care (50% vs. 37%) is a significant barrier to obtaining care;[2] and

Whereas, a GAO analysis found that the availability of health care providers in counties with rural hospital closures was lower and declined more over time when compared to counties without rural hospital closures and a Health Affairs study found that the availability of physicians and the viability of hospitals are related which makes the argument that more should be done to sustain rural physician practices to protect the entire health care system in rural areas;[4] and

Whereas, there is evidence that administrative requirements, which are a challenge for physicians regardless of setting, can impose additional challenges for physicians in rural areas,

such as a 2018 GAO study of Medicare quality improvement programs that found small and rural practices were more likely to receive a negative payment adjustment citing lack of technology, financial resources to hire staff to manage the programs, and limited capacity to monitor program requirements which ultimately led to 18% of rural physician practices being penalized in the Medicare quality payment program in 2022;[5,6] and

Whereas, for example, a California Department of Health Services study found that providers in rural areas don't have access to basic health information technology or networks to engage in data exchange and while there is wide adoption of EHRs among physicians, physicians who had not adopted EHRs were more likely to be in rural or solo practice;[7] and

Whereas, while AMA is working to reduce the administrative burdens in the Medicare Merit-Based Incentive Payment System (MIPS), rural practices need more direct financial assistance to modernize; and

Whereas, counties that lack maternity care resources, have no hospitals or birth centers offering obstetric care, or have no obstetric providers, are called maternity care deserts, or "OB deserts; more than half of current rural hospitals in the United States lack a maternity ward and according to the Center for Healthcare Quality and Payment Reform (CHQPR), more than 700 rural hospitals in 2025 were at risk of closure due to financial problems;[9,10] and

Whereas, hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, low public and private reimbursement, and declining birth rates. Labor and delivery units are one of the most expensive departments for hospitals to maintain, second only to emergency departments;[11,12] and

Whereas, a study by the American Journal of Public Health that looked at adverse maternal outcomes in rural and urban areas across the country found that pregnant individuals residing in rural areas experienced slightly increased rates of Intensive Care Unit admissions and maternal mortality rates almost twice the rate of individuals in urban areas;[13] and

Whereas, a CHQPR study shows that half of the patients in rural hospitals have private insurance and in most cases it is the amount that private insurance pays, not Medicaid that determines whether a rural hospital loses money. To preserve and enhance essential hospital services in rural areas, CHQPR recommends that small rural hospitals receive Standby Capacity Payments from both public and private payers to cover the hospital's fixed costs for maintaining essential services and access to necessary care;[14] and

Whereas, even states with high numbers of OB-GYNs have a geographic maldistribution within states. One opportunity to expand the number of physicians providing maternity care in rural areas is to increase the number of Family Practice Obstetricians which is a medical specialty that provides full obstetrical care as part of family practice. Family physicians complete a Family Practice Obstetrics fellowship and other requirements to become board certified in Family Medicine Obstetrics through the American Board of Physician Specialties (ABPS); and

Whereas, according to a 2024 National Public Radio (NPR) investigation, half of the active duty U.S. military installations are located in federally designated health professional shortage areas (HPSAs), including maternal care deserts and as the military has downsized and outsourced health care over the last decade to private physicians and hospitals, military personnel and their

families cannot find physicians accepting new patients, exacerbating the health care demands and access to care problems in rural areas;[15] and

Whereas, the military is also contracting with more people to provide services on military bases, such as janitorial cleaning staff, rather than hiring them as employees and many of these people are low-income, uninsured women who need maternal health care but can't obtain it on or near the base; and

Whereas, many states have examples of successful maternal care models, such as the California Maternal Quality Care Collaborative (CMQCC) created by Stanford University School of Medicine in partnership with the State of California and multiple stakeholder organizations that used research, data, toolkits and outreach to reduce maternal mortality by 65% from 2006-2016;[16] and

Whereas, there is a need to creatively engage in efforts to ensure that pregnant patients in rural regions have access to the care necessary to ensure healthy outcomes for both baby and mother; therefore be it

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

RESOLVED, that our AMA continue to assist state medical associations and physician practices with the HR 1 implementation of the Rural Transformation Program to ensure funding and assistance for physician practices (Directive to Take Action); and be it further

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

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

RESOLVED, that our AMA support investments in and payment for a wide variety of medical transportation options to connect rural residents to primary and specialty care services and return to their communities (New HOD Policy); and be it further

RESOLVED, that our AMA continue to address the nation's obstetrics and gynecology training and workforce needs, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, increasing ACGME funding, and evaluating other ways to increase physicians providing OB-GYN services in shortage areas (Directive to Take Action); and be it further

RESOLVED, that our AMA support expansion of Family Practice Obstetricians (FPOB) who are family practice physicians that are certified after completing an obstetrics fellowship (New HOD Policy); and be it further

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

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

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

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

Received: 9/30/25

REFERENCES

1. Access to Care [Issue Brief], AMERICAN MEDICAL ASSOCIATION (2024), available at https://www.ama-assn.org/system/files?check_logged_in=1&file=issue-brief-access-to-care.pdf.
2. Confronting Rural America's Health Care Crisis, BIPARTISAN POLICY CENTER RURAL HEALTH TASK FORCE (April 2020), available at https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/.
3. Tate Hinkle, Telemedicine Filling Gap for Rural Community, AMERICAN ACADEMY OF FAMILY PHYSICIANS (September 10, 2019), available at https://www.aafp.org/news/blogs/freshperspectives/entry/20190910fp- telemedicine.html/.
4. Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services, GOVERNMENT ACCOUNTABILITY OFFICE.
5. Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-based Incentive Payment System, GOVERNMENT ACCOUNTABILITY OFFICE (December 22, 2020), available at https://www.gao.gov/assets/gao-18-428.pdf.
6. Tanya Albert Henry. It's time to revamp Medicare's broken MIPS program, AMERICAN MEDICAL ASSOCIATION (July 8, 2024), available at https://www.ama-assn.org/practice-management/payment-delivery-models/it-s-time- revamp-medicare-s-broken-mips-program.
7. California Data Exchange Landscape, CALIFORNIA HEALTH AND HUMAN SERVICES (July 1, 2022), available at https://www.cdii.ca.gov/wp-content/uploads/2023/01/3_CalHHS_DxF_California-Data-Exchange- Landscape_Final_v1_07-01-2022.pdf.
8. Beatty, K., Heffernan, M., Hale, N., & Meit, M. (2020). Funding and service delivery in rural and urban local US health departments in 2010 and 2016. American Journal of Public Health, 110, 1293-1299. https://doi.org/10.2105/AJPH.2020.305757.
9. Maternity Care Deserts" March of Dimes, September 5, 2024. https://www.marchofdimes.org/peristats/data?top=23
10. Tony Leys. Rural Hospitals Built During Baby Boom Are Now Face a Baby Bust. California Healthline. July 15, 2024.Rural Hospitals Built During Baby Boom Now Face Baby Bust - California Healthline.
11. Tony Leys. Rural Hospitals Built During Baby Boom Are Now Face a Baby Bust. California Healthline. July 15, 2024. Rural Hospitals Built During Baby Boom Now Face Baby Bust - California Healthline.
12. Kristen Hwang, Ana B. Ibarra, & Erica Yee. Vast Stretches of California Lose Maternity Care as Dozens of Hospitals Shut Labor Wards, CALMATTERS. November 15, 2023. https://calmatters.org/health/2023/11/california-hospitals-close-maternity-wards/
13. Kristen Hwang, Ana B. Ibarra, & Erica Yee. Vast Stretches of California Lose Maternity Care as Dozens of Hospitals Shut Labor Wards, CALMATTERS. November 15, 2023. https://calmatters.org/health/2023/11/california-hospitals-close-maternity-wards/
14. Gamble, Molly. 703 Hospitals at Risk of Closure, State by State. Becker's Hospital Review. August 5, 2024. 703 hospitals at risk of closure, state by state (beckershospitalreview.com).
15. https://www.npr.org/2024/06/17/nx-s1-4991098/50-of-u-s-military-bases-are-in-a-health-care-desert-npr-probe-finds#:~:text=Transcript-,An%20ongoing%20NPR%20investigation%20into%20military%20health%20care%20reveals%20that,this%20map%20at%20npr.org.;
16. Toolkits. California Maternal Quality Care Collaborative. https://www.cmqcc.org/resources-tool-kits/toolkits.

RELEVANT AMA POLICY

D-190-969 Rural Hospital Payment Models
1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural H
ealth Model (PARHM).

D-465.994 New Reimbursement System Needed for Rural Hospital Survival
Our AMA will study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

H-130-954 Non-Emergent Patient Transportation Systems
Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

H-160.885 Impact of Integration and Consolidation on Patients and Physicians
3. Our American Medical Association will continue to monitor the impact of **hospital**-physician practice and **hospital**-**hospital** mergers and **acquisitions** on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
4. Our AMA will continue to monitor how provider mix may change following mergers and **acquisitions** and how non-compete clauses may impact patients and physicians.
5. Our AMA will support efforts to collect relevant information regarding **hospital**-physician practice and **hospital**-**hospital** mergers and **acquisitions** in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
6. Our AMA will encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.
7. Our AMA will encourage physicians to share their experiences with mergers and **acquisitions**, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form.

H-200.949 Principles & Actions to Address Primary Care Workforce
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice

primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

H-200.954 U.S. Physician Shortages
1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:

a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

H-200.955 Revision to AMA Policy on Physician Workforce
It is our American Medical Association policy that:
1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

H-200.972 Primary Care Providers in Underserved Areas
1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and

g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:

a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and

b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H-215.960 Hospital Consolidation

1. Our American Medical Association affirms that:

a. Health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs.

b. The AMA strongly supports and encourages competition in all health care markets.

c. The AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers.

d. Antitrust relief for physicians remains a top AMA priority.

2. Our AMA will continue to support actions that promote competition and choice, including:

a. Eliminating state certificate of need laws.

b. Repealing the ban on physician-owned hospitals.

c. Reducing administrative burdens that make it difficult for physician practices to compete.

d. Achieving meaningful price transparency.

3. Our AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

H-215.969 Hospital Merger Study

1. It is the policy of the AMA that, in the event of a **hospital** merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:

(A) medical staff representation on the board of directors;
(B) clinical services to be offered by the institutions;
(C) process for approving and amending medical staff bylaws;
(D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
(E) credentialing and recredentialing of physicians and limited licensed providers;
(F) quality improvement;
(G) utilization and peer review activities;
(H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
(I) conflict resolution mechanisms;
(J) the role, if any, of medical directors and physicians in joint ventures;
(K) control of medical staff funds;
(L) successor-in-interest rights;
(M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and

3. Our AMA will work to ensure, through appropriate state oversight agencies, that where **hospital** mergers and **acquisitions** may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

H-350.937 Improving Health Care of Minority Communities in Rural Areas

1. Our AMA encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to **minority communities in rural areas**.

2. Our AMA encourages enhanced understanding by federal, state and local governments **of** the unique health and health-related needs, including mental health, **of minority communities in rural areas in** an effort to improve their quality **of** life.

3. Our AMA encourages the collection **of** vital statistics and other relevant demographic data **of minority communities in rural areas**.
4. Our AMA will advise organizations **of** the importance **of minority** health **in rural areas**.
5. Our AMA will channel existing policy for telehealth to support improved broadband internet access **in minority communities in rural areas** to increase the availability **of** telemedicine where clinically appropriate.
6. Our AMA supports **minority** health **in rural areas** through programming, equity initiatives, and other representation efforts.
7. Our AMA encourages the development **of** strategies and mechanisms for **communities** to share resources and best practices to serve their **rural minority** populations.

H-420.946 Advancing Evidence-Based Strategies to Improve Rural Obstetrical Health Care and Access
8. Our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit.
9. Our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities.
10. Our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team and improve perinatal health outcomes in rural communities.
11. Our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities.

H-465-977 FQHCs and Rural Health Clinic Care
1. Our American Medical Association supports certification requirements and other policies that reduce the administrative burden for physicians practicing in Federally Qualified Health Center (FQHCs).
2. Our AMA supports sufficient federal funding to maintain the operation and costs associated with establishing and operating a FQHC, FQHC “Look- Alike”, or Outpatient Tribal Facility.
3. Our AMA advocates for regular updates to the Medicaid FQHC Prospective Payment System that at least keep pace with inflation.

H-465-981 Enhancing Rural Physician Practices
1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

H-465.988 Educational Strategies for Meetings Rural Health Physician Shortages
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements,

and to provide early and continuing exposure to those programs for medical students and residents.

b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

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

m. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
n. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

H-465.994 Improving Rural Health

1. Our American Medical Association:
   a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
   b. urges physicians practicing in rural areas to be actively involved in these efforts, and
   c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
   a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
   b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel

funding mechanisms to support public health initiatives that are led and managed by local public health authorities.

d. Advocate for adequate and sustained funding for public health staffing and programs

3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.

4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.

5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas.

H-465.997 Access to Quality Rural Health Care

1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.

2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

H-465.998 Addressing Payment & Delivery in Rural Hospitals

1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:

a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.

b. Provide adequate service-based payments to cover the costs of services delivered in small communities.

c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.

d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.

e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.

f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.

2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.

3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

H-478.980 Increasing Access to Broadband

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