AMA
AMERICAN MEDICAL ASSOCIATION

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(312) 464-5000

INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Interim 2025 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations Key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Items highlighted in blue have been recommended for reaffirmation.
Items highlighted in red have been recommended for not consideration.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
1	E&B	CEJA 02 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows: Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~ Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy.	Delegate instructed to Strongly oppose and to testify in the Online Reference Committee.

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			Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing. When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing. (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical~~	

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			~~licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.	
2	E&B	Res. 004 – Patient Options to Restrict Secondary Use of Their Healthcare Data (Connecticut)	RESOLVED, that our American Medical Association support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including the ability to retroactively withdraw their data from de-identified data sets. (New HOD Policy)	Delegate instructed to listen.
3	E&B	Res. 007 – Improving Protection for Reproductive Health Information (California)	RESOLVED, that our American Medical Association support the prohibition against the use or disclosure of protected health information (PHI) to conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability for the mere act of seeking, obtaining, providing, or facilitating reproductive health care. (New HOD Policy)	Delegate instructed to strongly support.
4	E&B	Res. 008 – Health Plan In-Network Steering of Pathology/Laboratory Services (College of American Pathologists)	RESOLVED, that our American Medical Association support state and federal legislative efforts to expressly prohibit in-network steering by health insurance plans, or by laboratory benefit managers under contract with such plans, to "preferred" or "designated" in-network laboratories or pathologists, thereby excluding other in-network pathology and laboratory providers (New HOD Policy); and be it further RESOLVED, that our AMA advocate in partnership with state medical societies and medical specialty societies to protect ordering physician discretion to refer pathology and laboratory specimens to any in-network pathologist or in-network laboratory of their choice, based upon relevant medical considerations in the best interest of patient care, consistent with AMA Code of Medical Ethic. (Directive to Take Action)	Delegate instructed to listen.
5	B	Res. 219 – Addressing the	RESOLVED, that our American Medical Association emphasize to Congress the excessive cost, the use of taxpayer funding, the depletion of taxpayer monies	Delegate instructed to seek reaffirmation.

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		Harms and Misleading Nature of Medicare Advantage Plans (New York)	supporting traditional Medicare by the Medicare Advantage (MA) programs. (Directive to Take Action)	
6	B	Res. 220 – Medicare Should Not Unfairly Penalize Physicians (New York)	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)	Delegate instructed to seek reaffirmation.
7	B	Res. 223 – Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI) – A New Administration Offers and Opportunity (Private Practice Physicians Section)	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)	Delegate instructed to support referral.
8	B	Res. 230 – Banning Non-compete Agreements in States (American College of Rheumatology)	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)	Delegate instructed to listen and support reaffirmation.

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9	F	CLRPD 01 – Private Practice Physicians Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Private Practice Physicians Section through 2030 with the next review no later than the 2030 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
10	F	CLRPD 02 – Evaluation of the Structure of the AMA House of Delegates	The Council on Long Range Planning and Development recommends that the delegate apportionment for the AMA House of Delegates be paused at 2025 levels through year-end 2026 and that this report be filed.	Delegate instructed to strongly oppose. Delegate and Alternate Delegate asked to coordinate with CLRPD Liaisons to the IPPS.
11	F	Res. 601 – Reimagining and Modernizing the U.S. Healthcare Delivery System (New England)	RESOLVED, that our American Medical Association will convene a multidisciplinary Task Force, under the direction of the Board of Trustees, that may include physicians and trainees, allied health professionals, leaders from hospitals and health systems, public and private payers, health economists, ethicists, patient advocates, and other relevant parties from across the health sector, to develop a legislative roadmap to reform the U.S. healthcare delivery system, drawing from and building upon existing AMA policy, and positioning our AMA as a convener of a broader national coalition to advance this vision; and that this roadmap will be structured around the following components: 1. Foundational Principles: The roadmap will specifically incorporate the following principles: a. Equitable access to affordable, high-quality healthcare for all as a basic human right; b. Physician autonomy and the primacy of the patient-physician relationship; c. Physician-led care as the foundation of clinical decision-making and healthcare delivery; d. Freedom of patients and physicians to choose care settings and models of practice; e. Physician practice sustainability through fair and predictable payment; f. Science-based innovation that improves healthcare value and efficiency; and g. Prevention, public health, and health equity as central pillars of a sustainable	Delegate instructed to strongly support.

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			healthcare system; 2. Scope of Review: In developing the roadmap, the task force will consider issues related to healthcare delivery and financing, including, but is not limited to, the following systemic problems and potential solutions: a. Physician payment and workforce sustainability; b. Comprehensive valuation of physician work; c. Incentives that support timely, patient-centered care and uphold clinical judgment; d. Administrative, financial, and clinical interference by intermediaries; e. Uninsurance, underinsurance, and other cost-sharing issues; f. Universal coverage, including preventive services and public health; g. Equity in care delivery; h. Protection of physician-patient shared decision-making; i. Market consolidation, vertical integration, and profiteering; j. Drug pricing and access to evidence-based therapies; and k. Transparency and reporting of the true cost of care; 3. Environmental Scan: To inform the roadmap, the task force will conduct a comprehensive review of existing global and domestic healthcare programs and reform proposals to evaluate their strengths and weaknesses based on how each framework centers patients, upholds clinical judgment, and promotes healthcare system and physician practice sustainability; and 4. Reporting and Engagement: The task force will: a. Report at least annually to the AMA House of Delegates on its findings and progress; b. Provide recommendations to the AMA Board of Trustees on areas requiring further policy development to support this work;	

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			c. Regularly convene focus groups within and outside of the AMA House of Delegates to review draft elements of the roadmap as they are being developed; and d. Deliver a final comprehensive legislative roadmap to reform the U.S. healthcare delivery system for consideration by the AMA House of Delegates. (Directive to Take Action)	
12	F	Res. 602 – Standardizing the Appointment Process for AMA Councils (American Academy of Family Physicians)	RESOLVED, that our American Medical Association develop a phased implementation plan – including selection criteria, procedural steps, and necessary bylaw amendments – to establish a House of Delegates-elected Nominating Committee responsible for the appointment and reappointment of all Council members, subject to final approval by the Board of Trustees. (Directive to Take Action)	Delegate instructed to listen.
13	J	BOT 18 – Published Metrics for Hospitals and Hospital Systems	The Board of Trustees recommends the following be adopted and the remainder of this report be filed: 1. Our American Medical Association supports the use of metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians (New HOD Policy) 2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be rescinded as being accomplished by this report. (Rescind HOD Policy)	Delegate instructed to support.
14	J	CMS 02 – Telehealth Licensure	The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our AMA amend Policy H-480.969[1] by addition to read: (1) It is the policy of our American Medical Association (AMA) that medical boards of	Delegate instructed to listen.

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			states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: a. Exemption from such a licensure requirement for physician-to-physician consultations. b. Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient. c. Allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified. d. Exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition. e. Exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial that meets relevant federal, state, and ethical standards as well as those outlined in AMA policy. f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that: 1. The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy; 2. The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and 3. Physicians planning to use telehealth identify a physician licensed in the patient's state to address in-person care needs that may arise from the clinical trial. ~~d~~g. Application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current	

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			HOD Policy) 2. That our AMA reaffirm Policy D-480.960, which encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to existing patients if there is a pre-existing and ongoing physician-patient relationship and a previous in-person visit, and the care is incident to an existing care plan or one that is being modified. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy D-480.964, which encourages states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining the Compact; advocates for reduced application and state licensure(s) fees processed through the IMLC; supports state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in AMA policy; and encourages states to pass legislation enhancing patient access to and proper regulation of telehealth services. (Reaffirm HOD Policy)	
15	J	CMS 04 – Payment for Biosimilars	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 103-A-25, and the remainder of the report be filed: 1. That our American Medical Association (AMA) supports the revision of the Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent the cost of drugs for the physician practice. (New HOD Policy) 2. That our AMA encourages public and private payers to implement comprehensive payment structures that allow for fair and timely payment for biologic/biosimilar drugs that: a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician; b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug; c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician; and d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)	Delegate instructed to strongly amendments proposed by California.

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			3. That our AMA supports calculating the ASP for biologic/biosimilar drugs under Medicare Part B as the average price paid for a reference biologic and its interchangeable biosimilars adjusted by the market share of each product while ensuring payment is adequate to maintain the financial viability of physician practices. (New HOD Policy) 4. That our AMA reaffirm Policy H-100.940, which supports incentivizing the use of biosimilars when appropriate, eliminating acquisition costs/reimbursement disparities, and patient education. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy H-110.959, which opposes drug payment methodologies that result in physicians being paid less than cost of the drug and related clinical services. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy H-125.972, which supports the education of physicians on biosimilars and their involved processes as well as encourages data collection and evaluation by the Food & Drug Administration. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy D-110.987, which presents guidelines supportive of the regulation of pharmacy benefit managers in a manner that encourages transparency. (Reaffirm HOD Policy)	
16	DNC	Res. 803 – Ensuring Physician Input in the Development of Alternative Payment Models (APMs) (Integrated Physician Practice Section)	RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be CMMI APM model participants throughout the model development process, prior to approval for testing or implementation (Directive to Take Action).	Delegate instructed to support, seek methods for incorporating language into Res. 223 and/or Res. 827.
17	J	Res. 809 – Ensuring Patient Safety and Physician Oversight	RESOLVED, that our American Medical Association undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and	Delegate instructed to listen.

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		in the Integration of Hospital Inpatient Virtual Nursing (Organized Medical Staff Section)	documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to ensure physician-led, high-quality, patient-centered care in the integration of inpatient virtual nursing, (New HOD Policy)	
18	J	Res. 818 – Universal Out-of-Network Benefits (New York)	RESOLVED, that our American Medical Association will advocate for federal and state laws that requires all private insurers to offer health insurance plans with out-of-network benefits. (Directive to Take Action)	Delegate instructed to listen.
19	J	Res. 827 – Opposition to Prior Authorization in Medicare Fee-For-Service, Burdensome Administration Requirements (Association for Clinical Oncology)	RESOLVED, that our American Medical Association opposes the use of prior authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS), including the proposed Wasteful and Inappropriate Service Reduction (WISeR) Model which would implement a technology-enabled review system (including augmented intelligence/artificial intelligence) (New HOD Policy); and be it further RESOLVED, that our AMA will advocate against the implementation of the WISeR Model and any similar programs that impose new PA requirements in Medicare FFS, while continuing its efforts to educate Congress, the Centers for Medicare & Medicaid Services, and the public on the harms of PA to both patients and physicians, leveraging data from its own surveys and the experiences of its members (Directive to Take Action); and be it further RESOLVED, that our AMA will continue to advocate for a legislative and regulatory framework that streamlines administrative processes, prioritizes patient access to timely care, and replaces burdensome PA with clinically-sound alternatives, such as the adoption of "gold card" programs for high-performing providers and the greater use of evidence-based clinical guidelines. (Directive to Take Action)	Delegate instructed to support and incorporate Res 803 if possible.

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20	K	Res. 919 – Strengthening Trust Through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines) (American Association of Public Health Physicians)	RESOLVED, that our American Medical Association will serve as a convener of key stakeholders to advance science-based vaccine recommendations (Directive to Take Action); and be it further RESOLVED, that our AMA will establish itself as a trusted, centralized source and public-facing megaphone for science-based vaccine guidance (Directive to Take Action); and be it further RESOLVED, that our AMA will contribute expertise and funding, as appropriate, to advance the mission of coordinating and promoting scientifically grounded and reliable vaccine guidance. (Directive to Take Action)	Delegate instructed to support.
21	K	Res. 925 – Evidence-Based Vaccine and Preventive Services Recommendations (Washington)	RESOLVED, that our American Medical Association will replace all references in our policies to the Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) with “current evidence-based recommendations developed by authoritative medical entities” (Directive to Take Action); and be it further RESOLVED, that our AMA will study options for replacing, to the extent possible, the ACIP and USPSTF at the earliest possible time with a national entity which will develop and publish credible evidence-based recommendations for vaccines and preventive services. (Directive to Take Action)	Delegate instructed to support amendments from California.

END