DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee B

Sara Coffey, DO, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 02 — Laser Surgery
2. Board of Trustees Report 03 — Stark Law Self-Referral Ban
3. Board of Trustees Report 07 — Codification of the Chevron Deference Doctrine
4. Board of Trustees Report 15 — Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report
5. Board of Trustees Report 16 — Preservation of Medicaid
6. Board of Trustees Report 22 — Physician Assistant and Nurse Practitioner Movement Between Specialties
7. Resolution 202 — Deepfake Technology and Harm to Physicians and Patients
8. Resolution 204 — Addressing Anti-Physician Contractual Provisions
9. Resolution 210 — PBM Divestiture and Transparency
10. Resolution 212 — Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder
11. Resolution 218 — Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas
12. Resolution 226 — Transparency with the Term “Emergency Department”
13. Resolution 228 — Support Permanent Funding and Expansion of Native Hawaiian Healthcare
14. Resolution 230 — Banning Non-compete Agreements in States
15. Resolution 236 — Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs

RECOMMENDED FOR ADOPTION AS AMENDED

16. Board of Trustees Report 01 — Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis
17. Board of Trustees Report 04 — American Medical Association (AMA) Efforts on Addressing and Reducing Patient Boarding in Emergency Departments (EDs)
18. Board of Trustees Report 06 — Information Blocking Rule
19. Board of Trustees Report 12 — Support For Doula Care Programs
20. Board of Trustees Report 13 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
21. Resolution 201 — Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)

22. Resolution 206 — Restore Funding to U.S. Agency for International Development (USAID)
23. Resolution 207 — Support for a Federal Tax Incentive for Volunteer Community Preceptors
24. Resolution 215 — Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum
25. Resolution 224 — Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process
26. Resolution 227 — Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors
27. Resolution 229 — Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement
28. Resolution 231 — Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care
29. Resolution 232 — Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation
30. Resolution 233 — Renewing Mental Health Infrastructure in the School System
31. Resolution 234 — Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices
32. Resolution 235 — Ensuring Medical Liability Insurance Transparency and Continuity
33. Resolution 238 — Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation

RECOMMENDED FOR ADOPTION IN LIEU OF

34. Resolution 203 — Restore and Enhance Federal Loan Programs for Medical Education
    Resolution 217 — Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)
35. Resolution 213 — Pathways to U. S. Permanent Residency for H-1B Physicians
    Resolution 214 — Physician Visa Protection and Pathway to Serve Underserved Communities
36. Resolution 216 — Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs

RECOMMENDED FOR REFERRAL

37. Resolution 205 — Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care
38. Resolution 209 — Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
39. Resolution 211 — Access to, and Retention of, Electronic Medical Records
40. Resolution 220 — Medicare Should not Unfairly Penalize Physicians
    Resolution 223 — Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI) — A New Administration Offers an Opportunity
41. Resolution 221 — Not-for-Profit Status

42. Resolution 225 — Federal Legislation to Prohibit the Corporate Practice of Medicine

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

43. Resolution 208 — Centralization of Medicare Provider Data Sources
44. Resolution 219 — Addressing the Harms and Misleading Nature of Medicare Advantage Plans
45. Resolution 222 — Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path
46. Resolution 237 — Protecting and Improving Rural Health

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 02 — LASER SURGERY

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 02 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 02 adopted and remainder of Report filed.

ADOPTED LANGUAGE:

Laser Surgery H-475.989

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) 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. (Modify Current HOD Policy)**
2. **Our AMA encourages state medical associations to support state legislation and rulemaking in support of this policy.**

Addressing Surgery Performed by Optometrists H-475.980

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, "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, "Laser Surgery". (Modify Current HOD Policy)**

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)

Overwhelming supportive testimony was received for Board of Trustees Report 02. Testimony commended the Board for its thoughtful, comprehensive approach in this Report and for reaffirming our AMA’s long-standing position that surgery — including laser procedures — is the practice of medicine. Further supportive testimony noted that the Report addressed a major scope of practice issue and highlighted that the correct training and experience are always necessary for the safety and protection of our patients. Testimony appreciated the recognition that, when appropriate, safe delegation of laser procedures requires direct supervision of well-trained non-physicians. Therefore, your Reference Committee recommends that Board of Trustees Report 02 be adopted, and the remainder of the Report be filed.

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

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 03 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 03 adopted and remainder of Report filed.

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)

Supportive testimony was received for Board of Trustees Report 03. Testimony noted that the Report did a nice job of explaining the competing interests in this space and working to create a balanced approach for independent physician practices, which have a disadvantage to large hospital systems within this context currently. Further supportive testimony noted appreciation for the Board's balanced perspective in this Report. Though an amendment was offered, the majority of the testimony supported adoption of the Report as written. Therefore, your Reference Committee recommends that Board of Trustees Report 03 be adopted, and the remainder of the Report be filed.

(3) BOARD OF TRUSTEES REPORT 07 — CODIFICATION OF THE CHEVRON DEFERENCE DOCTRINE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 07 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 07 adopted and remainder of Report filed.

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

Supportive testimony was received for Board of Trustees Report 07. Testimony noted that while the *Loper Bright* decision eliminated the presumption of implicit deference, it preserved Congress' authority to delegate interpretive responsibility to the Administration explicitly where appropriate. Our AMA's policy favors statutory clarity and evidence-based rulemaking over blanket judicial deference, ensuring that courts retain an independent interpretive role while still giving due weight to agency expertise. Further testimony stated that codifying Chevron could undermine this balance, potentially granting agencies excessive interpretive authority without sufficient Congressional or judicial oversight. Additional testimony noted that, as stated in the Report, the Administrative Procedure Act

is a robust framework that allows agencies to do their work while complying with due process and democratic principles when implementing new regulations. Supportive testimony noted that, in alignment with the information in the Report, our AMA works to protect physician and patient interests by ensuring agencies do not exercise unchecked power to interpret laws, while still valuing their specialized scientific and medical expertise. Though an amendment was offered, the majority of the testimony supported adoption of the Report as written. Therefore, your Reference Committee recommends that Board of Trustees Report 07 be adopted, and the remainder of the Report be filed.

(4) BOARD OF TRUSTEES REPORT 15 — EVIDENCE-BASED MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND BIOMEDICAL RESEARCH REPORT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 15 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 15 adopted and remainder of Report filed.

ADOPTED LANGUAGE:

Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

1. **Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.**
2. **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.**

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.

Supportive testimony was received for Board of Trustees Report 15. Testimony praised the Report for its comprehensive summary of recent federal and state actions relating to evidence-based medicine, public health infrastructure, and biomedical research, and our AMA's response to such actions. Testimony emphasized the important role of our AMA in this space and urged continued work in these areas. Testimony also encouraged continued collaboration with, and education of, the House of Delegates on public health

initiatives and outcomes. Testimony from representatives of the Board of Trustees indicated that the issues covered by Board of Trustees Report 15 are of ongoing concern and that the Board of Trustees will continue to provide regular updates to the House of Delegates on our AMA's advocacy in these areas. Additionally, your Reference Committee would note that the Board of Trustees is always willing to provide updates upon request. Therefore, your Reference Committee recommends that Board of Trustees Report 15 be adopted, and the remainder of the Report be filed.

(5) BOARD OF TRUSTEES REPORT 16 — PRESERVATION OF MEDICAID

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 16 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 16 adopted and remainder of Report filed.

ADOPTED LANGUAGE:

Preservation of Medicaid H-290.951

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.**
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).**

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)

Testimony was overwhelmingly supportive of Board of Trustees Report 16. There was substantial testimony about the negative impacts threatened by the cuts to Medicaid included in Public Law 119-21 (the "One Big Beautiful Bill Act") and multiple testifiers

expressed appreciation for our AMA's advocacy efforts, such as the launching of a dedicated webpage with resources and informational materials on the Medicaid cuts, and agreed with the elevation of Medicaid to a top advocacy priority (see the discussion of Resolution 227, below, for more information on our AMA's recent advocacy work on the Medicaid cuts). No comments were received in opposition to the Report. Therefore, your Reference Committee recommends that Board of Trustees Report 16 be adopted, and the remainder of the Report be filed.

(6) BOARD OF TRUSTEES REPORT 22 — PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

RECOMMENDATION:

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

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

ADOPTED LANGUAGE:

Physician Assistant and Nurse Practitioner Movement Between Specialties H-35.960

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

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

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

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

Your Reference Committee heard unanimous testimony in support of Board of Trustees Report 22. This Report shares new data on specialty switching by nurse practitioners and physician assistants. The survey data discussed in the Report indicates that respondents from both professions view specialty switching as common and relatively easy to do. The findings also highlight that nurse practitioners and physician assistants rely heavily on physicians for training when transitioning to a new specialty. Testimony emphasized that these findings reinforce the importance of physician-led care. Therefore, your Reference Committee recommends that Board of Trustees Report 22 be adopted, and the remainder of the Report be filed.

(7) RESOLUTION 202 — DEEPFAKE TECHNOLOGY AND HARM TO PHYSICIANS AND PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 202 be adopted.

HOD ACTION: Resolution 202 adopted.

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)

Supportive testimony was received for Resolution 202. Testimony expressed strong support for the Resolution's focus on addressing the ethical and regulatory challenges of deepfake technology in healthcare, emphasizing the need for safeguards to protect patients, preserve trust, and prevent the spread of misinformation. Further testimony noted that Resolution 202 adds to the increasing breadth of AMA policy on AI by reflecting on the rapid advancement of deepfake technology in health care while emphasizing the need for appropriate safeguards that protect patients and preserve trust in the medical system. Commentors noted that while innovative applications of deepfakes may improve clinical education and patient communication, the current lack of meaningful standards leaves individuals and communities vulnerable to misinformation, exploitation, and serious harm. Supportive testimony highlighted that by directing collaboration among healthcare interested parties, policymakers, and technology leaders, this Resolution advances a responsible, forward-looking approach that strengthens professional integrity and prioritizes patient safety in an evolving digital landscape. Amendments was offered to replace the term "deepfake"; however, while the Reference Committee appreciates the recognition that "deepfake" may carry a negative connotation when reflecting on the harms that can arise when used inappropriately or manipulatively, the remainder of the resolve acknowledges the advantages of this technology for education and training, consequently the Reference Committee recommends retaining the original language of the Resolution for consistency and clarity regarding the duality of this form of AI. Therefore, your Reference Committee recommends that Resolution 202 be adopted.

(8) RESOLUTION 204 — ADDRESSING ANTI-PHYSICIAN CONTRACTUAL PROVISIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 204 be adopted.

HOD ACTION: Resolution 204 adopted.

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)

Supportive testimony was received for Resolution 204. Testimony noted that indemnity clauses imposing liability on physicians for actions taken by their employers — actions for which physicians are not responsible — are fundamentally unfair and must be prohibited. Additional testimony highlighted that both indemnity clauses and malpractice insurance stymie competition making state legislation to prohibit indemnification clauses necessary. Our AMA is committed to doing all it can to advocate for employed physicians, and that advocacy should include efforts to protect physicians from employers and others attempting to inappropriately shift liability to physicians. Your Reference Committee believes that the model bill and education called for by Resolution 204 would be a positive addition to our AMA's effort to protect employed physicians. Though amendments were offered, the majority of the testimony supported adoption of the Resolution as written. Therefore, your Reference Committee recommends that Resolution 204 be adopted.

(9) RESOLUTION 210 — PBM DIVESTITURE AND TRANSPARENCY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 210 be adopted.

HOD ACTION: Resolution 210 adopted.

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)

Supportive testimony was received for Resolution 210. Testimony recognized the growing harm caused by vertical integration and consolidation among pharmacy benefit managers (PBMs), insurers, and affiliated pharmacies or infusion centers. Significant testimony noted that existing AMA policies already oppose anticompetitive practices and embody the spirit of divestiture but emphasized that this Resolution goes further than existing AMA policy by explicitly calling for mandatory structural separation (divestiture) as a needed and timely step to restore transparency, competition, and fairness in the drug supply chain. Some testimony cautioned that the Resolution should more clearly define the legal mechanisms for divestiture and focus advocacy on strengthening Department of Justice and Federal Trade Commission antitrust enforcement, particularly regarding vertical integration and non-price-based market dominance. Despite differing views on strategy, testimony broadly agreed that federal attention and AMA leadership are urgently needed to confront PBM-driven consolidation and promote accountability, affordability, and physician-led care. Therefore, your Reference Committee recommends that Resolution 210 be adopted.

(10) RESOLUTION 212 — ACKNOWLEDGING FLEXIBILITY ON BUPRENORPHINE MONO-PRODUCT USE FOR OPIOID USE DISORDER

RECOMMENDATION:

Your Reference Committee recommends that Resolution 212 be adopted.

HOD ACTION: Resolution 212 adopted.

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)

Supportive testimony was received for Resolution 212. Testimony highlighted that the Resolution is in alignment with existing AMA advocacy to remove all barriers to medications for opioid use disorder, including prior authorization, fail-first and step-therapy policies. Using current policy, our AMA already has undertaken actions to engage the U.S. Department of Justice and state attorneys general on the issues raised by the first resolve. Our AMA also has advocated for all health insurers/payers to remove barriers to care for Medications for Opioid Use Disorder, including those raised by the second resolve. This Resolution adds specificity to our AMA policy base to further strengthen AMA advocacy efforts. Though one amendment was offered, testimony opposing this amendment noted that the terms used in the Resolution as originally written were currently used in practice and noted that these terms accurately relay the intent of the Resolution. The majority of the comments were in support of the Resolution as originally written. Therefore, your Reference Committee recommends that Resolution 212 be adopted.

(11) RESOLUTION 218 — AMEND AMA POLICY D-160.921 ON SENSITIVE LOCATIONS TO PROTECTED AREAS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 218 be adopted.

HOD ACTION: Resolution 218 adopted.

ADOPTED LANGUAGE:

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 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 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 protected areas; and (4) opposes the presence of ICE enforcement at healthcare facilities.

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)

Universally supportive testimony was received for Resolution 218. Testimony highlighted that our AMA policy should be updated to ensure it is aligned with the current terminology on this topic. As noted in the Whereas Clauses, the Department of Homeland Security currently uses the term "protected areas" instead of "sensitive locations." Accordingly, this update to our AMA policy D-160.921 is needed. Therefore, your Reference Committee recommends that Resolution 218 be adopted.

(12) RESOLUTION 226 — TRANSPARENCY WITH THE TERM "EMERGENCY DEPARTMENT"

RECOMMENDATION:

Your Reference Committee recommends that Resolution 226 be adopted.

HOD ACTION: Resolution 226 referred.

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)

While your Reference Committee heard mixed testimony on Resolution 226, the majority of the testimony favored adoption. The commenters who supported adoption of the resolution emphasized the importance of facilities that are designated as "emergency departments" or "emergency rooms" having at least one physician on-site and on-duty at all times. These commenters argued that such a requirement is in line with patient expectations and would enhance transparency. Other commenters who opposed the resolution argued that having a physician on-site 24/7 is not feasible in every circumstance, especially in the case of facilities located in rural areas. Responding to this point, supporters of the resolution noted that adopting this resolution would not require our AMA to advocate for the abolishment of facilities that offer emergency care without a physician on-site at all times, but rather that such facilities should use a different name. One commenter suggested that existing AMA policy H-130.929, "On-Site Physician Requirements for Emergency Departments," be reaffirmed in lieu of adoption.

Your Reference Committee appreciates that Resolution 226 involves a complex question with arguments on both sides of the issue. The Board of Trustees addressed this topic in Board of Trustees Report 02 (page 33) at the 2024 Interim Meeting ("On-Site Physician Requirements for Emergency Departments"). Your Reference Committee appreciates that Resolution 226 involves a complex question with arguments on both sides of the issue, however given the weight of the testimony in favor of adoption, your Reference Committee recommends adoption of Resolution 226.

(13) RESOLUTION 228 — SUPPORT PERMANENT FUNDING AND EXPANSION OF NATIVE HAWAIIAN HEALTHCARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 228 be adopted.

HOD ACTION: Resolution 228 adopted.

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)

Your Reference Committee heard testimony in strong support of Resolution 228. Testifiers noted that the Resolution is consistent with our AMA's past work in promoting health care for underserved populations and fills a gap in our AMA's policy compendium as it relates to Native Hawaiian health care. Further testimony highlighted the unique health challenges faced by Native Hawaiian communities and noted that Native Hawaiians are the only Indigenous population in the United States without a permanently authorized and funded health care system. Therefore, your Reference Committee recommends that Resolution 228 be adopted.

(14) RESOLUTION 230 — BANNING NON-COMPETE AGREEMENTS IN STATES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 230 be adopted.

HOD ACTION: Resolution 230 adopted.

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)

Your Reference Committee heard testimony in strong support of Resolution 230. Testimony was universally in favor of adoption and opposed to reaffirmation. Commenters expressed that existing policy does not go far enough to protect physicians from harmful non-compete contracts, and that the problem is increasingly salient as the proportion of physicians who are employees grows. Multiple commenters noted that non-compete contracts in medicine affect patients and can disrupt continuity of care. Multiple commentors also noted that it might be appropriate to have some guardrails surrounding small private physician practices.

One commenter, noting that large practice groups employ many physicians and use restrictive non-compete clauses in their employment contracts, suggested that the wording of the resolved clause be broadened to apply to employment contracts with large practice groups, rather than just contracts with a “hospital, hospital system, or staffing company.” However, another commenter recommended that the wording be left as-is.

Your Reference Committee would note that our AMA has engaged in significant work in this area, including a 90-page document titled “Legislative Template: Covenants not-to-Compete in Physician Contracts” that was developed and is repeatedly revised by the Advocacy Resource Center, and is available to any AMA member upon request. At the same time, the Committee acknowledges the importance of this issue and the strong sentiment in favor of Resolution 230. For these reasons, your Reference Committee recommends that Resolution 230 be adopted.

(15) RESOLUTION 236 — DECEPTIVE ADVERTISING IN ACCREDITED ALLIED HEALTH PROFESSIONAL, NON-PHYSICIAN GRADUATE PROGRAMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 236 be adopted.

HOD ACTION: Resolution 236 adopted.

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)

Supportive testimony was received for Resolution 236. Your Reference Committee would like to note that the existing Truth in Advertising Campaign is focused on promoting transparency and prohibiting deceptive advertising by licensed health care professionals. This campaign is built around ensuring that patients are informed about who is providing their care, something that has become more important given the increased complexity of the health care system. Therefore, your Reference Committee recommends that Resolution 236 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(16) BOARD OF TRUSTEES REPORT 01 — CALLING FOR A MULTIFACETED APPROACH TO THE ILLICIT FENTANYL CRISIS

RECOMMENDATION A:

Your Reference Committee recommends that recommendation one of Board of Trustees Report 01 be amended by addition to read as follows:

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

RECOMMENDATION B:

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

HOD ACTION: Board of Trustees Report 01 adopted as amended and remainder of Report filed.

ADOPTED LANGUAGE:

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 that respect human life and minimize harm by federal, state, and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds.**
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)

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)

Your Reference Committee heard unanimous support for Board of Trustees Report 01. Your Reference Committee heard strong support for an amendment to highlight the need to respect human life and minimize harm. Your Reference Committee, therefore, recommends that the Board of Trustees Report 01 be adopted as amended, and the remainder of the report be filed.

(17) BOARD OF TRUSTEES REPORT 04 — AMERICAN MEDICAL ASSOCIATION (AMA) EFFORTS ON ADDRESSING AND REDUCING PATIENT BOARDING IN EMERGENCY DEPARTMENTS (EDS)

RECOMMENDATION A:

Your Reference Committee recommends that the recommendation of Board of Trustees Report 04 be amended by addition and deletion to read as follows:

The Board of Trustees recommends that Policy D-130.957 be amended, in the sixth clause, by deletion of "Interim Meeting 2025" and addition of "Interim Meeting 2026", ~~by deletion of the sixth clause since it has been accomplished by this report~~ and that the remainder of the report be filed.

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 04 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 04 adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

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

Addressing and Reducing Patient Boarding in Emergency Departments D-130.957

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 2026 Interim Meeting on progress addressing and reducing patient boarding in emergency departments**.

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.

Supportive testimony was received for Board of Trustees Report 04. Your Reference Committee recognizes that the persistent predicament of boarding in emergency treatment units highlights profound systemic imbalances in access to health care and appreciates that emergency department healthcare staff also face parallel challenges to their patients when boarding occurs. Testimony noted an appreciation for the Board's detailed response to the requests that originated this Report and the Board's continued commitment to improving patient care and system efficiency. An amendment was proposed to require a report back at the 2026 Interim Meeting and received broad support. Therefore, your Reference Committee recommends that Board of Trustees Report 04 be adopted as amended, and the remainder of the Report be filed.

Addressing and Reducing Patient Boarding in Emergency Departments D-130.957

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.

(18) BOARD OF TRUSTEES REPORT 06 — INFORMATION BLOCKING RULE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Board of Trustees Report 06 be amended by deletion to read as follows:

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.

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Board of Trustees Report 06 be amended by addition and deletion to read as follows:

2. Our AMA supports the ability of patients to request physician or surrogate review of ~~potentially life-altering~~ reports and results ~~information~~ prior to ~~its~~ their release, when consistent with the harm exception to the Information Blocking Rule.

RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 06 be adopted as amended, and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 06 adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

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

1. **Our American Medical Association supports the use of patient-directed, short-term embargoes for results, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)**
2. **Our AMA supports the ability of patients to request physician or surrogate review of reports and results prior to their release, when consistent with the harm exception to the Information Blocking Rule. (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)**

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)

Supportive testimony was received for Board of Trustees Report 06. Supportive testimony noted that the Report allows for expanded physician discretion and judgment related to the potential harm of releasing test result to patients before their physicians by including emotional and psychological harm exception criteria, allowing for discussions to take place within the framework of the physician-patient relationship, where these harms can be appropriately mitigated and addressed by the clinician in a safe environment. Testimony further highlighted the importance of recognizing the emotional and psychological harm that patients experience when they receive results that require clinical nuance to correctly understand and noted that it is unfair for patients to suffer from undue distress after receiving an easily misunderstood lab result. Additional testimony noted support for interoperability and open notes when safe and feasible, however, this testimony also

agreed with the Board, that it is essential to respect patient autonomy and preference. Your Reference Committee discussed the concern around the definition of "short term" and felt the definition remains at the discretion of the patient-physician relationship.

An amendment was also offered which supported the spirit of the Report but which would delete some of the descriptive words including "debilitating" and "life-limiting" while retaining the patient-directed aspect which is critical because as noted, patients have a legal right to view their results immediately and any infringement of that may only be done at the patient's request. Your Reference Committee heard additional supportive testimony around this amendment which highlighted that the removal of this language would help to further clarify who decides what is serious and life-altering and therefore which results will not be made available to the patient right away. This testimony also noted that the definition of life altering could vary widely between patients and therefore needed to be removed. Your Reference Committee agrees that this amendment will help to strengthen this Report. Therefore, your Reference Committee recommends that Board of Trustees Report 06 be adopted, and the remainder of the Report be filed.

(19) BOARD OF TRUSTEES REPORT 12 — SUPPORT FOR DOULA CARE PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that the second clause of Board of Trustees Report 12 be amended by deletion to read as follows:

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:

RECOMMENDATION B:

Your Reference Committee recommends that clause 2(a) of Board of Trustees Report 12 be amended by addition to read as follows:

a. possess registrations/licenses/certifications that include training specifically limited to nonclinical support and adhere to state certification requirements;

RECOMMENDATION C:

Your Reference Committee recommends that clause 2(b) of Board of Trustees Report 12 be amended by addition to read as follows:

b. retain registrations/licenses/certifications that are continuously monitored and overseen by a

disciplinary board within the state that the doula is certified and delivering services;

RECOMMENDATION D:

Your Reference Committee recommends that Board of Trustees Report 12 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 12 adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

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

1. **Our American Medical Association (AMA) recognizes that access to doula services for pregnant and birthing individuals can have a positive impact on birth outcomes.**
2. **To help ensure that doula services enhance patient care, our AMA supports doula services when doulas provide non-clinical peripartum and birthing support and:**

    a) **possess registrations/licenses/certifications that include training specifically limited to nonclinical support and adhere to state certification requirements;**
    b) **retain registrations/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)**

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)

Supportive testimony was received for Board of Trustees Report 12. Testimony thanked the Board for a thoughtful approach that struck a balance between physician-led team-based care and access to additional maternal care. Supportive testimony noted that the Report underscored the importance of balancing patient safety, quality outcomes, reimbursement issues, and scope of practice when shaping guidance for doula services. Additional testimony noted that the recommendations of this Report strike an excellent balance between recognizing the benefits of doula services on the health outcomes of the mother-infant dyad while also establishing a broad set of guidelines that recognizes the ongoing changes regarding payment, training, and oversight for doula services. Though the spirit of the Report was supported amendments were offered. One related to removing a requirement for liability coverage, the Reference Committee did not accept this amendment due to concerns about patient safety and access to remedies should improper doula care be provided. Another proposed amendment suggested making our policy focus on state-based requirements, however since not all states have requirements the amendment was not accepted.

An additional amendment requested that reference to "registration" be added in, since currently some states are using that metric. Your Reference Committee accepted this additional amendment but kept references to licensure and certifications since certifications are currently utilized in some states and since this space is quickly growing and it is likely that licensure will follow in the near future. This way our AMA policy can remain flexible and relevant as this field continues to grow. Additionally, the word "only" was removed to create additional flexibility for our AMA to support doulas regardless of the different state laws that exist in this space. Therefore, your Reference Committee recommends that Board of Trustees Report 12 be adopted as amended, and the remainder of the Report be filed.

(20) BOARD OF TRUSTEES REPORT 13 — ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation of Board of Trustees Report 13 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 13 adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

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

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

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)

Your Reference Committee heard mostly supportive testimony for Board of Trustees Report 13, highlighting the benefits of having sexual orientation and gender identity (SOGI) data among foster youth, only if privacy is carefully protected. Testimony highlighted the need for increased protection of this important SOGI data as well as the importance of being able to utilize this data, when appropriate and in the best interest of the child. Testimony further noted that accurate SOGI data is essential to understanding and addressing the disproportionate challenges faced by LGBTQ+ youth, especially those within foster care systems, such as higher rates of placement instability, mental health concerns, and discrimination. However, the concern for protecting LGBTQ+ communities, especially those within foster care remained. An amendment was offered, and the Board supported the amended language noting that the language further clarified the purpose of data collection and aggregation and encompassed the need for sensitivity and privacy in this data gathering. Your Reference Committee made amendments to their initial recommendation to remove references to "federal agencies" based on additional testimony. Therefore, your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended, and the remainder of the Report be filed.

(21) RESOLUTION 201 — MODEL STATE LEGISLATION INCORPORATING MEDICAL MALPRACTICE TORT REFORM BASED ON UTAH H.B. 503 (2025)

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association develop model state legislation incorporating state medical liability ~~malpractice~~ tort reforms, ~~based on Utah H.B. 503 enacted into law March 27, 2025~~. including but not be limited to provisions that: (1) limit economic damages for past medical expenses to amounts actually paid; (2) safeguard physicians' personal assets; (3) prohibit plaintiffs from making allegations that are irrelevant, coercive, or pertain to a physician's income or personal assets; (4) address prelitigation review panels; and (5) expand circumstances where physicians are entitled to attorney fees.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 201 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 201 be changed to read as follows:

MODEL STATE LEGISLATION INCORPORATING MEDICAL MALPRACTICE TORT REFORM

HOD ACTION: Resolution 201 adopted as amended with a change in title.

ADOPTED LANGUAGE:

MODEL STATE LEGISLATION INCORPORATING MEDICAL MALPRACTICE TORT REFORM

RESOLVED, that our American Medical Association develop model state legislation incorporating state medical liability tort reforms, including but not limited to provisions that: (1) limit economic damages for past medical expenses to amounts actually paid; (2) safeguard physicians' personal assets; (3) prohibit plaintiffs from making allegations that are irrelevant, coercive, or pertain to a physician's income or personal assets; (4) address prelitigation review panels; and (5) expand circumstances where physicians are entitled to attorney fees.

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)

Supportive testimony was received for Resolution 201. Testimony noted that our AMA's policy favors clarity and consistency in standards for alleging malpractice and stated that the Resolution's objectives align with AMA policy on medical liability reform. However, additional testimony stated that our AMA policy typically does not reference specific state or federal bills because these bills can shift and be altered over time in a manner that is outside the control of our AMA. In alignment with this, an amendment was proposed, and supported by the Resolution author, that contains the main topics covered in H.B. 503, thereby preserving the essence of the Resolution, while at the same time providing our AMA with flexibility and strong principled policy that can be successfully implemented regardless of the success of Utah H.B. 503. Therefore, your Reference Committee recommends that Resolution 201 be adopted as amended.

(22) RESOLUTION 206 — RESTORE FUNDING TO U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 206 be deleted.

~~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~~

RECOMMENDATION B:

Your Reference Committee recommends Resolution 206 be amended by addition of a new resolve clause to read as follows:

RESOLVED, that our American Medical Association policy D-250.986 be reaffirmed.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

ADOPTED LANGUAGE:

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)

RESOLVED, that our American Medical Association policy D-250.986 be reaffirmed.

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)

Your Reference Committee heard strong testimony in support of Resolution 206, with multiple testifiers emphasizing the critical work of the United States Agency for International Development (USAID) and arguing that existing AMA policy does not fully cover the asks contained in the resolution. Your Reference Committee agrees with respect to the second and third resolves, but believes that existing AMA policy D-250.986 encompasses the objectives of the first resolve, and further believes that the existing policy is preferable because it allows our AMA to oppose future cuts to USAID that would threaten global health initiatives, as well as advocating for the restoration of recent cuts to funding. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

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

1. Our AMA opposes withdrawal from the World Health Organization (WHO) as a continued public health threat to the U.S population by limiting early access to evolving worldwide epidemics.
2. Our AMA opposes any cuts to USAID (United States Agency for International Development) programs that would increase the risk of infection among vulnerable populations, that would increase the risk or burden of disability, or that would withhold funding from critical initiatives supporting agriculture, economic development, environmental protection, education, democracy, human rights, and governance in developing countries.

(23) RESOLUTION 207 — SUPPORT FOR A FEDERAL TAX INCENTIVE FOR VOLUNTEER COMMUNITY PRECEPTORS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 207 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~advocate for the establishment of a national~~ support proposals to establish a federal 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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 207 be adopted as amended.

HOD ACTION: Resolution 207 adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association support proposals to establish a federal 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)

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)

Your Reference Committee heard universally supportive testimony on Resolution 207. Multiple testifiers noted the importance of community-based preceptors to medical education and agreed that creating incentives for physicians to volunteer in this capacity is a worthy goal. Two friendly amendments were offered. One commenter offering an amendment noted in their testimony that the resolution would require our AMA staff to advocate for an outcome that is not clearly defined and proposed alternative language that would give clear guidance to staff to support proposals put forward in Congress to establish a federal tax credit or deduction for physicians who serve as community preceptors. Your Reference Committee agrees with this rationale and therefore recommends that Resolution 207 be adopted as amended.

(24) RESOLUTION 215 — EXTENDING THE MEDICAID WORK REQUIREMENT EXEMPTION UP TO 12 MONTHS POSTPARTUM

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports a clear, mandatory exemption from Medicaid work requirements for all postpartum individuals for ~~women up to~~ 12 months postpartum.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 215 be adopted as amended.

HOD ACTION: Resolution 215 adopted as amended.

ADOPTED LANGUAGE:

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

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)

Supportive testimony was received for Resolution 215. Significant testimony emphasized the importance of continuous coverage during the postpartum period and noted that postpartum women should be exempt from Medicaid work requirements for a full year following the end of a pregnancy. Additional testimony expressed opposition to work requirements as a condition of Medicaid coverage and highlighted that existing AMA policy opposes Medicaid work requirements. Further testimony noted that, while the law includes exemptions for postpartum women, these exemptions may not capture all postpartum women for the full 12-month period following the end of a pregnancy and supported the addition of the policy in Resolution 215 to fill this potential gap. An amendment was offered to clarify that the exemption to the work requirement for postpartum women should be for the full 12-month period following the end of a pregnancy and not “up to” 12 months following the end of a pregnancy. This amendment was supported by additional commentors, and your Reference Committee accepted this amendment. Another amendment proposed to use more inclusive language when referring to postpartum individuals, and your Reference Committee accepted this

amendment as well. Therefore, your Reference Committee recommends that Resolution 215 be adopted as amended.

(25) RESOLUTION 224 — RECOUPMENT BY CMS RECOVERY AND AUDIT CONTRACTORS (RAC) — DUE PROCESS

RECOMMENDATION A:

Your Reference Committee recommends that the second and third resolves of Resolution 224 be deleted.

~~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)~~

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 224 be amended by addition of a new resolve to read as follows:

RESOLVED, that existing AMA policies D-320.991, H-330.921, and H-335.981 be reaffirmed.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 224 be adopted as amended.

HOD ACTION: Resolution 224 adopted as amended.

ADOPTED LANGUAGE:

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 existing AMA policies D-320.991, H-28 330.921, and H-335.981 be reaffirmed.

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)

Your Reference Committee heard testimony that was largely in favor of adopting Resolution 224. Many commenters testified about the lack of due process in the Medicare recovery audit contractor recoupment process, as well as the skewed incentives that disproportionately reward RACs for recouping overpayments rather than identifying underpayments. Testimony was offered in favor of reaffirming existing AMA policies in lieu of adopting Resolution 224, noting that existing policies already address the core intent of the resolution and create a comprehensive and balanced framework for protecting physicians from unfair audit practices while upholding program integrity. Other commenters disagreed that existing policies were sufficient, while another commenter agreed that existing policies overlap with many of the goals of the resolution but argued that some of the goals of the resolution are not addressed by existing policy.

An additional point was raised that D-320.991 already directs our AMA to seek fines, penalties, and cost recovery when physicians prevail in RAC appeals, as reflected in section 8 of that policy. During the live hearing, several commenters strongly supported the original language, describing significant burdens placed on practices and highlighting the absence of any meaningful deterrent against aggressive audit activity.

Your Reference Committee agrees that existing AMA policies do address many of the goals of Resolution 224 but also finds that Resolution 224 includes novel objectives. Therefore, your Reference Committee recommends that the first resolve of Resolution 224 be adopted and existing AMA policies D-320.991 section 8, H-330.921, and H-335.981 be reaffirmed in lieu of the second and third resolves of Resolution 224.

Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-

payment audits, as medical necessity is quintessentially a physician determination and judgment.

3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.
4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.
5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.
6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Medicare Prepayment and Postpayment Audits H-330.921

1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:
    a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;

b) CMS should discontinue random prepayment audits of E&M services;
c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.

2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.
3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:
    a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician
    b) The requirement for the repayment to be placed in escrow until the appeals process is complete
    c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors
    d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits
    e) The full disclosure of contract terms with audit contractors
    f) The elimination or improvement of the extrapolation formula
    g) The payment for costly documentation requests
    h) Imposition of penalties on auditors for inaccurate findings, and
    i) Incentivizing the auditors to perform more physician education.
4. Our AMA will formally request that Medicare employ rules for prepayment and postpayment audits that are at least as protective as the Recovery Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician’s determination of medical necessity.
5. Our AMA will propose to Medicare that there be a mechanism by which prepayment and postpayment audit denials can be resolved via the telephone or other electronic communications.

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.

(26) RESOLUTION 227 — CALL FOR IMMEDIATE AND AGGRESSIVE ACTION BY THE AMA TO REVERSE MEDICAID CUTS IMPACTING SENIORS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA publicly denounce cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025") ~~the 'One Big Beautiful Bill Act' (Public Law No: 119-21) in no uncertain terms~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 227 be amended by addition and deletion to read as follows:

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,'~~ Public Law 119-21 as it relates to Medicaid (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~build coalitions~~ continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net

organizations to ~~unite and~~ advocate ~~with a single voice~~ for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21 ~~the 'One Big Beautiful Bill Act.'~~ (Directive to Take Action); and be it further

RECOMMENDATION D:

Your Reference Committee recommends that the fourth resolve of Resolution 227 be deleted:

~~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~~

RECOMMENDATION E:

Your Reference Committee recommends that the fifth resolve of Resolution 227 be amended by deletion to read as follows:

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)

RECOMMENDATION F:

Your Reference Committee recommends that Resolution 227 be adopted as amended.

RECOMMENDATION G:

Your Reference Committee recommends that the title of Resolution 227 be changed to read as follows:

CALL FOR ACTION BY THE AMA TO REVERSE OR MITIGATE MEDICAID CUTS

HOD ACTION: Resolution 227 adopted as amended with a change in title.

ADOPTED LANGUAGE:

CALL FOR ACTION BY THE AMA TO REVERSE OR MITIGATE MEDICAID CUTS

RESOLVED, that our AMA publicly denounce cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025"); 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 lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid; and be it further

RESOLVED, that our AMA continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21; and be it further

RESOLVED, that our AMA report back to the AMA's House of Delegates at A-26.

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)

Your Reference Committee heard substantial testimony in support of Resolution 227. Commenters focused on the importance of the Medicaid program to the health care system and argued that the severe cuts to Medicaid included in Public Law 119-21

demand a correspondingly strong response from our AMA. There was no testimony opposing adoption.

The background information provided on the online forum page was also taken into consideration by your Reference Committee. This background information demonstrated the significant AMA policy and ongoing work by our AMA to reverse or mitigate the Medicaid cuts made by Public Law 119-21. The totality of the comments and the background information demonstrated a need to align Resolution 227 with our existing AMA policy on Medicaid and provide a platform for our AMA to effectively advocate for the reversal or mitigation of these Medicaid cuts.

At the 2025 Annual Meeting of the House of Delegates, the House of Delegates adopted policy H-290.951, which "elevates Medicaid to an urgent and top legislative priority." In alignment with this policy, our AMA has taken strong actions with respect to Public Law 119-21, both while the law was being debated in Congress and after it was enacted into law.

During Congressional consideration, in addition to extensive in-person lobbying on Capitol Hill, our AMA sent letters expressing opposition to the bill (and the Medicaid cuts in particular) to the House of Representatives on May 13, 2025, and May 20, 2025, and to the Senate on June 20, 2025. Our AMA also issued public statements opposing the bill, including but not limited to social media posts such as an X thread "sounding the alarm" about the harmful cuts to Medicaid and a video statement on Instagram in which AMA President Dr. Mukkamala described the cuts to Medicaid as "disappointing, maddening, and unacceptable."

Following passage of Public Law 119-21, our AMA issued a statement that the law "moves health care in the wrong direction." With the bill now law, our AMA has continued to work to mitigate the negative impacts of the Medicaid cuts. In September our AMA launched a dedicated webpage on the changes made by Public Law 119-21—the webpage is updated on a regular basis and includes resources such as issue briefs, summaries of key provisions, and implementation timelines.

Through the Advocacy Resource Center, our AMA is deeply engaged in assisting state medical associations with implementation of Public Law 119-21 and is providing educational opportunities for all physicians such as the November 5, 2025, webinar on the impact of Public Law 119-21 on physicians and patients. At the federal level, our AMA continues to engage with key policymakers and will be offering preemptive comments to the Centers for Medicare & Medicaid Services regarding the implementation of several important provisions to ensure that they are implemented in a manner that minimizes the potential harm to patients and physicians.

The amendments proposed by your Reference Committee take these efforts into account and support advocacy to reverse the Medicaid cuts while also continuing the robust and ongoing work of advocating at the federal and state levels to mitigate the impact of the law's implemented provisions. To this end, your Reference Committee also recommends that the fourth resolve, which calls for our AMA to hold policymakers accountable using public scorecards, be deleted. While the Committee understands the intent to hold policymakers accountable for harmful Medicaid cuts, adopting a strategy of public scorecards or highlighting electoral consequences would undermine our AMA's credibility

and nonpartisan relationships with key decisionmakers in both political parties. Such an approach risks alienating allies whose cooperation is essential to reversing or mitigating the cuts and advancing broader reforms. Our AMA's influence depends on constructive, evidence-based engagement, not political tactics that could diminish access and trust.

Your Reference Committee also notes that, while a report back is included in this Resolution, a Board of Trustees report providing updates on our AMA's advocacy activities is provided at every meeting of the House of Delegates. This meeting, that is Board of Trustees Report 09 "2025 AMA Advocacy Efforts." Your Reference Committee would also like to highlight Board of Trustees Report 16 "Preservation of Medicaid", which addresses some of the issues noted in Resolution 227.

A friendly amendment was offered to the third resolve to add a reference to specialty societies. This more accurately reflects the coalition of interested parties our AMA is engaging with, and the Reference Committee accepts this amendment.

Finally, your Reference Committee agrees with the suggestion to remove references to the "One Big Beautiful Bill Act" and instead to reference the official law — Public Law 119-21. This amendment will also ensure that our AMA policy is tied to existing law rather than a piece of legislation, thereby making our AMA policy more accurate.

Your Reference Committee agrees that Medicaid is an essential program and that the cuts to Medicaid require a strong and effective response from our AMA. Your Reference Committee therefore recommends that Resolution 227 be adopted as amended.

(27) RESOLUTION 229 — PROTECTION OF MEDICAID BENEFICIARIES' PRIVATE HEALTH INFORMATION FROM IMMIGRATION ENFORCEMENT

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~work with~~ support efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections ~~and available legal remedies~~ to safeguard confidential health information, ~~particularly for~~ and to help ensure that this information reaches immigrant and mixed-status families.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

ADOPTED LANGUAGE:

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, for immigration enforcement purposes (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA support efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections to safeguard confidential health information, and to help ensure that this information reaches immigrant and mixed-status families.

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)

Supportive testimony was received for Resolution 229. However, two amendments were also offered, both of which your Reference Committee accepted. One amendment expanded this Resolution to include medical students. The other amendment noted that there are no known confidential health information protections specific to immigrants/noncitizens or related programs. Accordingly, the practicality of implementing Resolution 229 would be mostly a Health Insurance Portability and Accountability Act (HIPAA) education campaign. However, the amendment noted that protections guaranteed by HIPAA are not specific to immigrant and mixed-status families but rather apply to all individuals. In alignment this, the amendment made the Resolution actionable.

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

(28) RESOLUTION 231 — ENSURING EQUITABLE AND TIMELY MEDICAL LICENSURE FOR PHYSICIANS PROVIDING ABORTION AND GENDER-AFFIRMING CARE

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 231 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support policies, ~~and~~ legislation, and state medical society initiatives that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 231 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with relevant interested parties ~~stakeholders~~, including state medical boards and specialty societies, to ~~develop~~ support the development of guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming care practices.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 231 be adopted as amended.

HOD ACTION: Resolution 231 adopted as amended.

ADOPTED LANGUAGE:

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; and be it further

RESOLVED, that our AMA support policies, legislation, and state medical society initiatives that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care; and be it further

RESOLVED, that our AMA work with relevant interested parties, including state medical boards and specialty societies, to support the development of guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming care practices.

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)

Supportive testimony was received for Resolution 231. Testimony acknowledged our AMA's existing policies in support of gender-affirming care and reproductive health services, but argued that additional policies are needed to protect physicians from being punished for providing evidence-based care. Your Reference Committee notes that Policy G-605.009 established a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted which is directed to coordinate actions to protect physicians against professional liability and retaliation for providing needed medical care. The Task Force established by Policy G-605.009 has created a website, the Reproductive Health Resource Navigator, to serve as a comprehensive and

accessible clearinghouse, empowering physicians with reliable, evidence-based resources to navigate the increasingly complex landscape of reproductive care in the United States. This website includes resources to assist physicians with licensing issues.

An amendment was offered to streamline coordination and focus on engagement with licensing authorities and boards responsible for implementation which your Reference Committee accepted. Therefore, your Reference Committee recommends that Resolution 231 be adopted as amended.

(29) RESOLUTION 232 — SAFEGUARDING ACCESS TO IVF AMID RESTORATIVE REPRODUCTIVE MEDICINE LEGISLATION

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 232 be amended by deletion to read as follows:

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; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 232 be adopted as amended.

HOD ACTION: Resolution 232 adopted as amended.

ADOPTED LANGUAGE:

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 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)

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)

Mixed testimony was received for Resolution 232. A number of individuals testified on behalf of themselves, opposing adoption of this Resolution. However, multiple Sections and States provided supportive testimony for this Resolution. Testimony was also provided asking for an equalized approach in advocating for expanded research funding. In alignment with this, your Reference Committee recommends that Resolution 232 be adopted as amended.

(30) RESOLUTION 233 — RENEWING MENTAL HEALTH INFRASTRUCTURE IN THE SCHOOL SYSTEM

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 233 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support sustained, stable, and equitable state and federal funding and infrastructure, ~~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; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 233 be amended by addition and deletion to read as follows:

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 services ~~care~~ and workforce stability when federal appropriations are delayed or rescinded. (Directive to Take Action)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 233 be adopted as amended.

HOD ACTION: Resolution 233 adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association support sustained, stable, and equitable state and federal funding and infrastructure, for the training, placement, and retention of school-based mental health professionals, with priority given to rural and underserved communities; 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 services and workforce stability when federal appropriations are delayed or rescinded.

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)

Your Reference Committee heard broad support in favor of Resolution 233. Many commenters testified about the importance of school-based mental health services in increasing access to mental health services and reducing barriers to care. An amendment was offered to replace the word “care” with “services” in the second resolve and received support from two other commenters. Another commenter offered an amendment that, in addition to making this change, would also change the first resolve to provide additional flexibility to AMA advocacy staff in achieving the goal of increased funding for school-based mental health services. The commenter noted that this change is advisable because otherwise our AMA would be limited to pursuing only one model for funding school-based services even if other models were more feasible. Another commenter supported this amendment. Another amendment was offered to express support for the development of sustainable infrastructure for school-based mental health services. Your Reference Committee agrees with the testimony about the importance of access to school-based mental health services and with the rationale behind the proposed amendments. Therefore, your Reference Committee recommends that Resolution 233 be adopted as amended.

(31) RESOLUTION 234 — STUDY ON IMPACT OF INFLATION REDUCTION ACT ON ONCOLOGY, OTHER PHYSICIAN PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association will work with ~~relevant stakeholders to conduct a comprehensive study~~ interested parties to monitor, evaluate, and educate 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

RECOMMENDATION B:

Your Reference Committee recommends that the second and third resolves of Resolution 234 be deleted:

~~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).~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

ADOPTED LANGUAGE:

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; and be it further

RESOLVED, that our AMA will specifically evaluate the potential impact of the Inflation Reduction Act on the sustainability of community-based physician practices, with a particular focus on oncology practices; and be it further

RESOLVED, that our AMA will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiation provisions on the sustainability of community based practices 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.

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).

Your Reference Committee heard mixed testimony on Resolution 234. Testifiers broadly agreed that while the Inflation Reduction Act (IRA) aims to improve drug affordability and patient access, its implementation may have unintended consequences for community-based physician practices, particularly in oncology and other specialties that rely on provider-administered drugs. Testimony in support of Resolution 234 expressed concern that current reimbursement mechanisms, especially the use of the “Maximum Fair Price”

(MFP), could threaten the financial sustainability of independent practices and limit patient access to care.

At the same time, other commenters emphasized that the IRA is still in early stages of implementation, with limited new data available to justify a comprehensive study. One commenter proposed an amendment to encourage targeted collaboration with other interested parties to monitor, evaluate, and educate around the IRA's effects rather than launching a full-scale study prematurely. The commenter also recommended striking the second resolve for consistency. Another commenter spoke in favor of this proposed amendment and offered a separate amendment to strike the third resolve, also in the interest of internal consistency.

Your Reference Committee agrees that a full-scale study of the effects of the IRA is premature at this point and believes that the proposed amendments to the first resolve appropriately balance the need for more information about IRA's impacts and the need to wait until the law has been more fully implemented to conduct a more formal study. Given the amendments to the first resolve, the second and third resolves are not needed. Your Reference Committee also heard two minor technical amendments within the commenters' testimony that did not alter the outcome of the preliminary recommendation and for which testimony was inconsistent and limited. Therefore, your Reference Committee recommends that Resolution 234 be adopted as amended.

(32) RESOLUTION 235 — ENSURING MEDICAL LIABILITY INSURANCE TRANSPARENCY AND CONTINUITY

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for legislation requiring ~~immediate (within 3 business days)~~ prior notification of at least 30 business days by the medical liability insurance carrier to the covered physician for any policy changes~~,~~ or cancellation, ~~or~~ and immediate (within 3 business days) notification of a missed payment (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 235 be adopted as amended.

HOD ACTION: The first resolve of Resolution 235 adopted as amended. The second resolve of Resolution 235 referred. The third resolve of Resolution 235 adopted.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for legislation requiring prior notification of at least 30 business days by the medical liability insurance carrier to the covered physician for any policy changes or cancellation, and immediate (within 10 business days) notification of a missed payment (Directive to Take Action); and be it further

RESOLVED, that our AMA policy D-215.980 "Support Before, During, and After Hospital Closure or Reduction in Services" be amended so as to include physician group closures. (Modify HOD Policy)

Support Before, During, and After Hospital or Physician Group Closure or Reduction in Services D-215.980

1. **Our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital or physician group closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should:**
    a. **assure adequate capacity exists in the immediate service area surrounding the hospital or physician group closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area;**
    b. **allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals or physician groups should be waived for an appropriate period of time; and**
    c. **ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.**
2. **Our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility or physician group closures, change in ownership, or significant reductions in services via provision of information, resources, and effective, actionable advocacy.**

RESOLVED, that our American Medical Association advocate for legislation requiring immediate (within 3 business days) notification by the medical liability insurance carrier to the covered physician for any policy changes, cancellation, or missed payment (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize that occurrence-based medical liability insurance or claims-made medical liability insurance with a pre-paid tail is the gold standard for medical liability coverage (New HOD Policy); and be it further

RESOLVED, that our AMA policy D-215.980 "Support Before, During, and After Hospital Closure or Reduction in Services" be amended so as to include physician group closures. (Modify HOD Policy)

Your Reference Committee heard testimony overwhelmingly in support of the spirit of Resolution 235. Your Reference Committee received an amendment that would require a medical liability carrier to give a physician advance notice of at least 30 business days, rather than three days, of any changes to or cancellation of the physician's medical liability insurance coverage. Your Reference Committee heard testimony supporting this amendment because it would provide greater protection to physicians who are put into positions where they urgently need to find alternative medical liability insurance coverage. Your Reference Committee agrees that amending Resolution 235 to require an advance notice period of at least 30 business days offers more protection than the three-day notice period in the original language of Resolution 235. Therefore, your Reference Committee recommends that Resolution 235 be adopted as amended.

(33) RESOLUTION 238 — OPPOSE UNFAIR HOSPITAL PRIVILEGE DECISION BASED ON INSURANCE PLAN PARTICIPATION

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for legislation, regulation, or other ~~regulatory~~ interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment ~~of~~ or care of ~~for~~ a patient at that hospital; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA collaborate~~s~~ with specialty societies and state medical societies to ~~develop model legislation to~~ oppose ~~such~~ unfair and/or coercive business practices which undermine patient access and/or physician practices.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 238 be adopted as amended.

HOD ACTION: Resolution 238 adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital; and be it further

RESOLVED, that our AMA collaborate~~s~~ with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.

RESOLVED, that our American Medical Association advocate for legislation or other regulatory intervention to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment of care for a patient at that hospital (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with specialty societies and state medical societies to develop model legislation to oppose such unfair and coercive business practices which undermine patient access and physician practices. (Directive to Take Action)

Your Reference Committee heard testimony in support of AMA advocacy to prevent implementation of this Anthem BCBS policy, as it will hurt patient access and pressure physician practices to either take contracts that are not a good fit for their practice or become employed by hospitals. Your Reference Committee also heard that this policy is in direct conflict with the No Suprises Act. However, some testimony expressed concern about the limited forms of advocacy directed by the Resolution and suggested that private sector advocacy, in addition to potential legislative or regulatory advocacy if appropriate, may need to happen. Therefore, your Reference Committee recommends that Resolution 238 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(34) RESOLUTION 203 — RESTORE AND ENHANCE FEDERAL LOAN PROGRAMS FOR MEDICAL EDUCATION

RESOLUTION 217 — PROTECTING ACCESS TO PUBLIC SERVICE LOAN FORGIVENESS (PSLF), INCOME-DRIVEN REPAYMENT (IDR), AND DIRECT PLUS LOANS FOR GRADUATE OR PROFESSIONAL STUDENTS (GRAD PLUS LOANS)

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 203 be adopted in lieu of Resolutions 203 and 217.

RESOLVED, that our American Medical Association continue to advocate for federal student loan limits that accurately reflect the cost of attendance of graduate medical education programs.

RESOLVED, that our AMA continue to support diverse and beneficial repayment plans for federal student loans, including income-based repayment plans that are favorable to individuals who took out loans for graduate medical education.

RESOLVED, that our AMA continue to advocate for the protection of the Public Service Loan Forgiveness (PSLF) Program for physicians.

HOD ACTION: Alternate Resolution 203 adopted in lieu of Resolutions 203 and 217.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association continue to advocate for federal student loan limits that accurately reflect the cost of attendance of graduate medical education programs.

RESOLVED, that our AMA continue to support diverse and beneficial repayment plans for federal student loans, including income-based repayment plans that are favorable to individuals who took out loans for graduate medical education.

RESOLVED, that our AMA continue to advocate for the protection of the Public Service Loan Forgiveness (PSLF) Program for physicians.

Resolution 203 — Restore And Enhance Federal Loan Programs For Medical Education

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)

Resolution 217 — Protecting Access To Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), And Direct Plus Loans For Graduate Or Professional Students (Grad Plus Loans)

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)

Mixed testimony was received for Resolutions 203 and 217. However, testimony was unanimous in the opinion that the elimination of the GRAD Plus student loan program, the student loan caps, the change in repayment plans, and the changes to the Public Service Laon Forgiveness (PSLF) Program will cause students from low-income backgrounds to be unable to afford medical school. Your Reference Committee acknowledges the significant negative impacts and outcomes that these changes will have, especially for individuals who want to engage in graduate medical education.

Additional testimony noted that our AMA has consistently worked to ensure that medical students have adequate access to federal student loans, regardless of the name of the federal student loan program. Thanks to our existing AMA policy, our AMA has sent out multiple letters opposing the elimination of the Grad PLUS program and supporting providing medical students with adequate financial assistance during their education and training years. Additional letters supporting the PSLF program were also recently sent out

and can be found here and here. Additional information about our AMA advocacy on student loans and graduate medical education (GME) issues can be found here.

Commentors also noted that Resolutions 203 and 217 covered similar issues and recommended that these two Resolutions be considered together. Your Reference Committee agrees that it is appropriate to handle these two Resolutions as one.

Moreover, your Reference Committee notes that tying our AMA policy to programs which are being phased out, like GRAD Plus, will quickly make our AMA policy outdated. In order to ensure that appropriate advocacy can continue in this space our AMA policy should not be tied to a specific loan program but rather to the concept of providing adequate access to federal student loans, and student loan repayment plans, to ensure that individuals can graduate from medical school without having to struggle to find multiple funding streams to support their education. Your Reference Committee heard significant testimony in favor of Alternate Resolution 203. Therefore, your Reference Committee recommends that Alternate Resolution 203 be adopted in lieu of Resolutions 203 and 217.

(35) RESOLUTION 213 — PATHWAYS TO U. S. PERMANENT RESIDENCY FOR H-1B PHYSICIANS

RESOLUTION 214 — PHYSICIAN VISA PROTECTION AND PATHWAY TO SERVE UNDERSERVED COMMUNITIES

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 213 be adopted in lieu of Resolutions 213 and 214.

PHYSICIAN VISA PROTECTION AND PATHWAY TO U. S. PERMANENT RESIDENCY

RESOLVED, that our American Medical Association support a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.

HOD ACTION: Alternate Resolution 213 adopted in lieu of Resolutions 213 and 214.

ADOPTED LANGUAGE:

PHYSICIAN VISA PROTECTION AND PATHWAY TO U.S. PERMANENT RESIDENCY

RESOLVED, that our American Medical Association advocate for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.

RESOLVED, that our AMA advocate for the creation of a dedicated visa pathway specifically for physicians.

Resolution 213 — Pathways To U. S. Permanent Residency For H-1b Physicians

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)

Resolution 214 — Physician Visa Protection And Pathway To Serve Underserved Communities

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, through feasible alternatives such as 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)

Supportive testimony was received for Resolutions 213 and 214. Testimony universally acknowledged the important role that international medical graduates (IMGs) play in the U.S. health care system. Additional testimony highlighted the backlog that exists for some physicians who apply for green cards. Further testimony supported the creation of a dedicated non-immigrant visa pathway. Multiple amendments were offered for these

Resolutions, and it was noted that these two Resolutions cover similar issues and have some overlapping asks.

Additionally, your Reference Committee notes that our AMA has policy that supports ensuring that IMGs are properly certified, licensed, and trained before they are allowed to practice medicine in the U.S. in opposition to Resolution 213 which states that it would support "enabling [IMGs] to practice immediately and without restrictions" upon first entering the U.S.

Your Reference Committee would also like to highlight that our AMA is consistently supporting programs like Conrad 30, which makes it easier for physicians to remain in the U.S. Additionally, our AMA participates in groups such as the Advisory Commission on Additional Licensing Models. Furthermore, our AMA led a sign on letter to the Department of Homeland Security (DHS) in opposition to the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers" that implemented the $100,000 H-1B visa fee. In addition, our AMA has had meetings with Congress to discuss the issue of the increased H-1B visa fee and to educate Congress on the importance of H-1B physicians. Our AMA has also created a grassroots campaign on the H-1B visa fee issue: Be Heard | Physicians Grassroots Network. Please see more of our advocacy work regarding visas and green cards here.

An additional amendment was offered for Alternate Resolution 213. Your Reference Committee heard that this amendment would provide greater latitude for our AMA to seek a viable pathway for physicians to obtain permanent residence. Testimony noted that this amendment would help our AMA to avoid the unintended consequence of Congress passing legislation that may create a separate pathway for physicians but then restrict physicians from obtaining visas through other existing visa programs that ultimately lead to a green card. Your Reference Committee agrees.

Given the overlapping content of Resolution 213 and 214, the existing AMA policy and advocacy work in this space, and the multiple amendments that were offered, your Reference Committee recommends that Alternate Resolution 213 be adopted in lieu of Resolutions 213 and 214.

(36) RESOLUTION 216 — ENSURING TIMELY J-1 VISA PROCESSING TO PROTECT IMG PARTICIPATION IN RESIDENCY PROGRAMS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 216 be adopted in lieu of Resolution 216.

RESOLVED, that our American Medical Association work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs.

HOD ACTION: Alternate Resolution 216 adopted in lieu of Resolution 216.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs.

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)

Mixed testimony was received for Resolution 216. Testimony universally acknowledged the important role that international medical graduates (IMGs) play in the U.S. medical system. However, testimony noted that our AMA already has existing policy in place that ensures that our AMA works with interested parties, relevant government agencies, and Congress to achieve timely and reliable visa acquisition for J-1 medical students. Our existing AMA policy highlights the importance of working with entities such as Department of State, Intealth/ECFMG, and others to help and assure smooth visa processes for incoming medical students and residents. Furthermore, testimony highlighted that our AMA consistently responds when there is a systemic visa delay that impacts J-1 physicians, and physicians in other visa categories.

Additional testimony noted that our AMA is rightfully an active collaborator but not the lead entity when it comes to J-1 physicians. While our AMA continues to advocate strongly for IMGs, the primary operational authority lies with Intealth/ECFMG, which oversee J-1 sponsorship, documentation, and compliance. Our AMA's role is to support, coordinate, and amplify these efforts through policy advocacy and federal engagement, which testimony highlighted our AMA is already doing. Our AMA is engaged in ongoing advocacy with Congress and federal agencies to address J-1 processing disruptions. Examples of recent correspondence include:

- Letter to the U.S. Department of State urging resumption of J-1 visa interviews (June 18, 2025) shortly after the AMA's State Department letter, the Department of State resumed visa processing and prioritized J-1 physicians.
- Letter to the U.S. Department of Homeland Security urging for the exclusion of foreign national physicians in the Department of State's (DOS) Exchange Visitor Program in J-1 visa status, and their J-2 dependents, from the proposed rule which would eliminate duration of status. (September 24, 2025).
- Letter to the U.S. Senate in support of the Healthcare Workforce Resilience Act, which would expand visa availability (September 30, 2025).

These ongoing advocacy efforts demonstrate that our AMA has already taken, and continues to take, the actions outlined in Resolution 216.

Your Reference Committee also received an Alternate Resolution that received supportive testimony. Your Reference Committee accepted the majority of this Alternate Resolution while making minor technical amendments to ensure that our AMA can continue to advocate on these important issues. These technical amendments recognize that the United States is only in control of a portion of the visa processing, while the home country oversees the remainder of this process and acknowledges that our AMA works in collaboration with other organizations on this issue including Intealth. Therefore, your Reference Committee recommends that Alternate Resolution 216 be adopted in lieu of Resolution 216.

RECOMMENDED FOR REFERRAL

(37) RESOLUTION 205 — RESTORING BALANCE BILLING AND ALLOWING COPAY FORGIVENESS TO PRESERVE INDEPENDENT PRACTICE AND IMPROVE ACCESS TO CARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 205 be referred.

HOD ACTION: Resolution 205 referred.

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)

Mixed testimony was received for Resolution 205. Some testimony supported the entire Resolution noting the importance of the financial stability of small physician practices. However, additional testimony only supported portions of the Resolution, in particular noting that the last resolve brought in topics that did not align with the rest of the Resolution such as anti-kickback rules. Others opposed the Resolution in its entirety or offered amendments. Further testimony stated that referral was appropriate since our AMA already has policy on this topic. Given the lack of consensus, the existence of relevant AMA policy, and the need to ensure consistency within the Resolution, your Reference Committee recommends that Resolution 205 be referred.

(38) RESOLUTION 209 — SUPPORT FOR LEGISLATIVE CHANGES ALLOWING PARTIAL MEDICARE OPT-OUT FOR PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 209 be referred.

HOD ACTION: Resolution 209 referred.

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)

Mixed testimony was received for Resolution 209. Some testimony advocated for adoption noting that the current system of all-in or all-out for Medicare was antiquated and needed to be remedied. Other testimony opposed the Resolution stating that the approach suggested in the Resolution may lead to patient confusion. Additional testimony recommended referral highlighting the need to allow our AMA time to examine key questions related to feasibility, administrative impact, and policy alignment before determining whether new policy is necessary. Given the mixed testimony and the exitance of AMA policy on this topic, your Reference Committee recommends that Resolution 209 be referred.

(39) RESOLUTION 211 — ACCESS TO, AND RETENTION OF, ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 211 be referred.

HOD ACTION: Resolution 211 referred.

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)

Mixed testimony was received for Resolution 211. Testimony broadly supported the goal of ensuring timely access to and retention of medical records to improve patient care, facilitate forensic and clinical processes, and prevent data loss during transitions between electronic medical record (EMR) systems. Testimony also supported the concepts of interoperability, accountability of EMR vendors, and continuity of care. However, some testimony expressed concern about aspects of the Resolution as written and offered amended language. Several commentors noted that terms like "timely" should be clearly defined, and that EMR vendors should not serve as the primary repositories of patient data, as this could raise privacy, legal, and ethical risks. Other testimony warned that federal standardization of medical record retention could conflict with or weaken existing state laws and impose costly burdens on smaller practices. Significant testimony recommended referral for further study to address the complex overlap of federal and state regulations, vendor accountability, and data ownership issues before pursuing legislation. Therefore, your Reference Committee recommends that Resolution 211 be referred.

(40) RESOLUTION 220 — MEDICARE SHOULD NOT UNFAIRLY PENALIZE PHYSICIANS

RESOLUTION 223 — HALT THE ROLLOUT OF NEW PAYMENT MODELS BY THE CENTER FOR MEDICARE & MEDICAID INNOVATION (CMMI) — A NEW ADMINISTRATION OFFERS AN OPPORTUNITY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 220 and 223 be referred.

HOD ACTION: Resolution 220 and 223 referred.

Resolution 220 — Medicare Should Not Unfairly Penalize Physicians

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)

Resolution 223 — Halt The Rollout Of New Payment Models By The Center For Medicare & Medicaid Innovation (CMMI) — A New Administration Offers An Opportunity

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)

Mixed testimony was received for Resolutions 220 and 223. Testimony noted that Medicare reimbursement processes can be burdensome and frequently penalize physicians and other providers. Additionally, significant testimony noted that the Center for Medicare and Medicaid Innovation (CMMI) had previously implemented value based payment models that have negative impacts on care, but there was disagreement over how best to address the problems with CMMI. Multiple testifiers recommended reaffirmation of these two Resolutions together noting concerns about the complexity and limited success of CMMI payment models. Testimony in favor of reaffirmation stated that the directive to halt the development of all new CMMI payment models would conflict with established AMA policy that supports voluntary, physician developed payment reform. Testimony further highlighted that referral would provide our AMA with the opportunity to evaluate how to strengthen advocacy around CMMI accountability and model redesign, while making certain that any future models reflect physician leadership, local flexibility, and data driven evaluation. Live testimony emphasized the high failure rate of CMMI models and the burdens of the upcoming WISeR program, while additional testimony focused on the need for referral since the WISeR model will begin on January first and our AMA Board is already engaged in active work on this issue. This additional testimony reinforced that perspectives on the best course of action remain mixed and that referral would allow the most complete and coordinated approach. Your Reference Committee believes that referral of Resolution 223, along with Resolution 220, preserves consistency with our AMA's existing policy framework and avoids creating conflicting directives in the policy compendium. Therefore, your Reference Committee recommends that Resolutions 220 and 223 be referred.

(41) RESOLUTION 221 — NOT-FOR-PROFIT STATUS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 221 be referred.

HOD ACTION: Resolution 221 referred.

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)

Your Reference Committee heard mixed testimony on Resolution 221. Multiple testifiers expressed concern with the vagueness of the language, the complicated legal and technical questions involved, and the potential for unintended consequences. Two testifiers opposed the resolution altogether on these bases, while three others recommended referral. An amendment to clarify the intent of the resolution was proposed.

Your Reference Committee agrees that Resolution 221 involves highly technical questions of federal and state tax law and should be carefully considered to ensure that our AMA does not advocate for an outcome that could lead to harmful unintended consequences. Therefore, your Reference Committee recommends that Resolution 221 be referred.

(42) RESOLUTION 225 — FEDERAL LEGISLATION TO PROHIBIT THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 225 be referred with report back at A-26.

HOD ACTION: Resolution 225 referred with report back at A-26.

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)

Your Reference Committee heard mixed testimony on Resolution 225. Multiple commenters testified that ownership of medical practices by corporate and other non-physician-owned entities undermines physician autonomy and can threaten patient care. They emphasized the accelerating pace of private equity and corporate consolidation in health care and argued that our AMA must adopt stronger advocacy positions opposing the corporate practice of medicine (CPOM). While generally in agreement that our AMA should oppose the corporate practice of medicine, other testifiers raised concerns about the appropriateness and feasibility of pursuing a federal

CPOM ban and noted that prohibiting all non-physician entities from owning a practice or participating in federal health care payment programs may carry unintended consequences that merit careful evaluation.

Three amendments were offered. One proposed that our AMA advocate for legislation prohibiting the corporate practice of medicine “as it is legally defined.” The other two would create flexibility for our AMA to pursue CPOM prohibitions at either the state or federal level, with one specifically calling on our AMA to investigate the feasibility and impact of restricting non-physician-owned entities in federal payment programs.

Your Reference Committee appreciates the urgency driving Resolution 225. Your Reference Committee notes that the proposed amendments, online testimony, and verbal testimony collectively raise significant questions of law and policy, including, for example, around the legal definition of CPOM, the extent to which federal action would preempt state law, the appropriate scope of CPOM prohibitions, and the potential impact of excluding non-physician-owned entities from health care payment programs. This is a deeply important but also highly complex area of law and health policy, and your Reference Committee believes that further research and analysis are required to ensure that AMA policy is well-grounded and legally sound. Your Reference Committee appreciates the sentiment of the need for our AMA to investigate the feasibility and potential impact of prohibiting non-physician owned entities from participation in federal healthcare payment programs and feels that referral will address these and other concerns.

Accordingly, your Reference Committee recommends that Resolution 225 be referred, with a report due back at the 2026 Annual Meeting of the AMA House of Delegates.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(43) RESOLUTION 208 — CENTRALIZATION OF MEDICARE PROVIDER DATA SOURCES

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-285.902, D-478.984, and H-355.979 be reaffirmed in lieu of Resolution 208.

HOD ACTION: Existing AMA policies H-285.902, D-478.984, and H-355.979 reaffirmed in lieu of Resolution 208.

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)

Minimal and mixed testimony was received for Resolution 208. The intent of this resolution directs our AMA to advocate that the Centers for Medicare & Medicaid Services (CMS) adopt centralized, standardized, and interoperable provider data repositories for Medicare and Medicare Advantage provider directory purposes, including the use of validated data from national sources such as the Coalition for Affordable Quality Healthcare (CAQH) or equivalent, and to eliminate duplicative attestations by physicians when accurate data has already been submitted through such systems. The resolution also calls for harmonized directory requirements across programs, improved automation, and data governance standards to enhance directory accuracy, reduce administrative burden, and promote timely patient access to reliable provider information. As noted in the testimony, our AMA already has existing policy that fulfills the asks of Resolution 208 including submitting accurate directories annually, creating and using centralized data repositories, and ensuring accessibility, accuracy, and governance of practitioner data repositories. Therefore, your Reference Committee recommends that existing AMA policies H-285.902, D-478.984, and H-355.979 be reaffirmed in lieu of Resolution 208.

(44) RESOLUTION 219 — ADDRESSING THE HARMS AND MISLEADING NATURE OF MEDICARE ADVANTAGE PLANS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-330.888, D-185.979, D-330.923, H-330.878, D-70.950, D-330.930, D-390.967, H-390.832, and H-330.862 be reaffirmed in lieu of Resolution 219.

HOD ACTION: Existing AMA policies D-330.888, D-185.979, D-330.923, H-330.878, D-70.950, D-330.930, D-390.967, H-390.832, and H-330.862 reaffirmed in lieu of Resolution 219

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)

Mixed testimony was received for Resolution 219. Supportive testimony argued that Medicare Advantage plans mislead patients, drain the Medicare Trust Fund, and impose administrative barriers that restrict access to necessary care. This testimony emphasized that MA programs divert taxpayer dollars and often trap patients in narrow networks with limited options to return to traditional Medicare. Additional testimony during the live hearing highlighted ongoing MA abuses despite existing AMA policy and called for stronger action, but other delegations reiterated that current AMA directives already address the core concerns in this space. Further substantive testimony in favor of reaffirmation noted that MA plans do have shortcomings but maintained that our AMA has extensive policy on parity, physician participation, oversight, and the need for improved accountability. This testimony also stressed that value-based care models within MA continue to hold potential for improvement rather than rejection.

Your Reference Committee also notes that adopting this resolution would not create a substantive change in our advocacy efforts since our AMA already has extensive directives on these issues and significant work in this space is already underway. Therefore, your Reference Committee recommends that existing AMA policies D-330.888, D-185.979, D-330.923, H-330.878, D-70.950, D-330.930, D-390.967, H-390.832, and H-330.862 be reaffirmed in lieu of Resolution 219.

Medigap, Pre-Existing Conditions, and Medicare Coverage Education D-330.888

1. Our AMA will create an educational campaign on both Medicare Advantage (MA) and Medicare Fee-for-Service (FFS) coverage.
2. Our AMA will advocate for the elimination of Medigap insurers' ability to deny coverage due to a patient's pre-existing health conditions and work with Congress and the Centers for Medicare & Medicaid Services

(CMS) to ensure coverage in MA is, at a minimum, no less than coverage provided under Medicare FFS that includes Part A, Part B, Part D, and a Medigap policy.

Aligning Clinical and Financial Incentives for High-Value Care D-185.979

1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of "clinical nuance," recognizing that
    a. medical services may differ in the amount of health produced.
    b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.
3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that
    a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
    b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

Medicare Advantage Plans D-330.923
Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates.

Medicare Advantage Policies H-330.878
2. Our American Medical Association supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
3. Our AMA will advocate:
    a. for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients.
    b. that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided.
    c. that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Standardization of Advance Beneficiary Notification of Non-Coverage Forms for Medicare Advantage Plans and Original Fee-For-Service Medicare D-70.950
1. Our AMA will request the Centers for Medicare & Medicaid Services provide a standardized Advance Beneficiary Notice of Non-coverage (ABN) that will be sufficient notification to inform all Medicare Advantage Plan and Original (Fee-For-Service) Medicare beneficiaries when Medicare may deny payment for an item or service.
2. Our AMA will advocate that Medicare Advantage Plan requirements for carrier specific advance beneficiary notice of non-coverage and similar forms be eliminated.

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Elimination of Subsidies to Medicare Advantage Plans D-390.967

1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.

Saving Traditional Medicare H-390.832

1. Our American Medical Association will continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion.
2. Our AMA will continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians.
3. Our AMA acknowledges that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans.

Increasing Transparency Surrounding Medicare Advantage Plans H-330.862

Our AMA supports policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, and provider networks.

(45) RESOLUTION 222 — TACKLING ADMINISTRATIVE WASTE—LET US BE PART OF THE SOLUTION TO PUTTING OUR HEALTH SYSTEM ON A SUSTAINABLE PATH

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy D-155.996 be reaffirmed in lieu of Resolution 222.

HOD ACTION: Existing AMA policy D-155.996 reaffirmed in lieu of Resolution 222

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)

Your Reference Committee heard testimony in support of reaffirming existing policy in lieu of adopting Resolution 222 with limited testimony in favor of adoption. Your Reference Committee agrees with the majority of testifiers, who noted that our AMA has strong existing policy on the issue of administrative waste and is already doing extensive advocacy work on the topic, making new policy unnecessary. Therefore, your Reference Committee recommends reaffirming existing AMA policy D-155.996 in lieu of Resolution 222.

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.

(46) RESOLUTION 237 — PROTECTING AND IMPROVING RURAL HEALTH

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-290.951, H-130.954, H-465.99, H-200.949, and H-200.954 be reaffirmed in lieu of Resolution 237.

HOD ACTION: Existing AMA policies H-290.951, H-130.954, H-465.99, H-200.949, and H-200.954 reaffirmed in lieu of Resolution 237.

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)

Your Reference Committee heard mixed testimony on Resolution 237. While most testifiers supported adoption, many testifiers acknowledged that our AMA has existing policies on the issues covered by the resolution. One commenter testified in favor of reaffirmation, noting that existing AMA policies "encompass the Resolution's intent to mitigate the negative effect of Medicaid and Affordable Care Act (ACA) cuts, strengthen the rural health workforce, and expand access to care through telehealth, transportation, and targeted support for physician practices." This commenter also noted that our AMA is already deeply engaged in assisting state medical associations with the implementation of Public Law 119-21, including by providing technical support related to the newly established Rural Health Transformation Program (see Board of Trustees Report 16 "Preservation of Medicaid" and this report's discussion of Resolution 227 for more information about our AMA's work on recent Medicaid and ACA cuts).

During the live hearing, your Reference Committee received an amendment that would replace the original Resolves with three new Resolves. Your Reference Committee is concerned that the Resolves offered may not be germane and believes that there was not enough time to adequately consider the new concepts proposed by the amendment at this meeting. Your Reference Committee suggests that the amendment be offered again at a future meeting as its own Resolution.

Your Reference Committee agrees that existing policy accomplishes the goals of Resolution 237 and therefore recommends that existing AMA policies H-290.951, H-130.954, H-465.99, H-200.949, and H-200.954 be reaffirmed in lieu of Resolution 237.

Preservation of Medicaid H-290.951

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.

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).

Non-Emergency Patient Transportation Systems H-130.954

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.

Improving Rural Health H-465.994

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.

Principles of and Actions to Address Primary Care Workforce H-200.949

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.

US Physician Shortage H-200.954

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.

This concludes the report of Reference Committee B**. I would like to thank Jennifer Hone, MD, Carlos Latorre, MD, Eli Freiman, MD, Rachel Kyllo, MD, Michael Cromer, MD, Robert Emmick, MD, and all those who testified before the Committee.**

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