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REPORT 06 OF THE BOARD OF TRUSTEES (I-26)

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

EXECUTIVE SUMMARY

Resolution 205-I-25, referred at the 2025 Interim Meeting, asks that our American Medical Association (AMA) prioritize advocacy to restore private physicians' ability to balance bill for non-emergency outpatient services regardless of network status, oppose caps on balance billing amounts, support the continuation of balance billing protections for emergency care and vulnerable populations, and advocate for reform of the rules governing physician waiver of patient cost-sharing. This report responds to that referral.

The environment in which balance billing operates has changed substantially since our AMA's foundational policies in this area were adopted. The "No Surprises Act," effective in 2022, now establishes a comprehensive federal framework that governs when balance billing is permitted, what commercially insured patients owe, and how physicians contest inadequate payment. In the settings the statute reaches, and for a broad category of hospital-based and ancillary services, balance billing is unavailable by statute rather than regulation, and restoring it would require Congress to amend a bipartisan framework our AMA helped shape and continues to support.

The Board of Trustees shares the House of Delegates concern for the financial stability of independent practices, but concludes that the constraint physicians most acutely experience is not a ceiling on what they may charge. Where balance billing remains permissible, no federal cap applies. What governs physician revenue is the qualifying payment amount and the accessibility and integrity of the dispute resolution process. Our AMA has directed sustained advocacy at exactly those mechanisms, in comments on the qualifying payment amount methodology and the federal independent dispute resolution process, and existing policy provides ample authority for that work, and our AMA remains committed to defending physicians' billing autonomy and to securing fair payment through sustained advocacy on QPA methodology, dispute resolution accessibility, network adequacy, and plan accountability.

Two matters warrant new policy. Our AMA lacks an explicit position supporting the continuation of balance billing protections for patients who cannot exercise meaningful choice over the network status of their treating physician, and adopting one clarifies that our AMA's objection is to inadequate plan payment rather than to patient protection. Our AMA also lacks any policy addressing physician discretion to waive cost-sharing for patients in financial hardship, an area where the practical obstacle is regulatory uncertainty and administrative burden rather than outright prohibition, since federal law already permits waiver based on an individualized, good-faith determination of financial need.

The Board therefore recommends reaffirmation of six existing policies, adoption of the third resolve, and adoption as amended of the fourth resolve.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 06-I-26

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

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee B

1 At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates
2 (HOD), Resolution 205, “Restoring Balance Billing and Allowing Copay Forgiveness to Preserve
3 Independent Practice and Improve Access to Care,” was referred. It asked the following:

4
5 RESOLVED, that our American Medical Association assign high priority to advocacy to
6 support legislation or regulatory reform to restore private physicians’ ability to balance bill
7 patients for non-emergency, outpatient medical services, regardless of insurance network
8 participation status (Directive to Take Action); and be it further
9

10 RESOLVED, that our AMA oppose artificial caps on private physician balance billing
11 amounts, especially of less than 100 percent above the insurer’s allowed amount, to reflect
12 and offset decades of reimbursement erosion (New HOD Policy); and be it further
13

14 RESOLVED, that our AMA support the continuation of protections from balance billing
15 for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently
16 required under state and federal law (New HOD Policy); and be it further
17

18 RESOLVED, that our AMA advocate at the federal level for reform of anti-kickback and
19 payer contracting rules that prohibit physicians from waiving co-pays and deductibles for
20 patients experiencing financial hardship. (Directive to Take Action)
21

22 Testimony before the Reference Committee was mixed. Some testimony supported the Resolution
23 in its entirety, noting the importance of the financial stability of small physician practices. Other
24 testimony supported only certain resolves, noting in particular that the final resolve introduced
25 topics, such as federal anti-kickback rules, that did not align with the balance billing focus of the
26 remaining resolves and warranted separate consideration. Testimony was divided on the first and
27 second resolves, with some expressing concern that advocacy for balance billing by in-network
28 physicians is in tension with the premise of network contracting and could disturb patient
29 protections enacted in the No Surprises Act. Testimony was broadly supportive of the third resolve
30 and of the objective underlying the fourth. Additional testimony opposed the Resolution in its
31 entirety or offered amendments, and further testimony stated that referral was appropriate because
32 our AMA already has policy on this topic. Given the lack of consensus, the existence of relevant
33 AMA policy, and the need to ensure consistency within the Resolution, the Reference Committee
34 recommended that Resolution 205 be referred, and the House concurred.

BACKGROUND

Balance billing is the practice of billing a patient for the difference between a physician's charge and the amount allowed by the patient's health plan. It has been the subject of federal and state regulation for decades. In the Medicare program, the "Omnibus Budget Reconciliation Act of 1989" established limiting charges that cap the amount a nonparticipating physician may bill a Medicare beneficiary above the Medicare-approved amount. Many states subsequently enacted statutes restricting balance billing in the commercial market, particularly for emergency services and for care delivered by out-of-network physicians at in-network facilities.

The most consequential recent development is the federal "No Surprises Act" (NSA), enacted as part of the "Consolidated Appropriations Act, 2021," with its principal provisions effective January 1, 2022. The NSA prohibits out-of-network physicians, other providers, and facilities from balance billing commercially insured patients in defined circumstances, and establishes methodologies for determining both patient cost-sharing and the out-of-network payment owed by the health plan.

The NSA's balance billing prohibition applies in two principal settings: out-of-network emergency services furnished at a hospital emergency department, an independent freestanding emergency department, or by air ambulance; and non-emergency care rendered by out-of-network physicians at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center, unless the physician has furnished advance written notice and obtained the patient's written consent to be balance billed.

The notice-and-consent exception is unavailable for a substantial category of services. Under 45 C.F.R. § 149.420(b), a physician may not seek patient consent to balance bill for items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; items and services provided by a nonparticipating provider where no participating provider is available to furnish the service at the facility; and items or services furnished as a result of unforeseen, urgent medical needs arising at the time of service. For these services, an out-of-network physician practicing at an in-network facility is limited to collecting in-network cost-sharing and may not balance bill under any circumstance.

Where the NSA applies and the parties cannot agree on payment, the statute establishes a federal independent dispute resolution (IDR) process. A health plan must issue an initial payment or notice of denial within 30 days of receiving a clean claim, after which a dissatisfied physician may initiate a 30-day open negotiation period and, failing agreement, IDR. The certified IDR entity selects between the parties' final offers, considering the qualifying payment amount (QPA), generally the median of the plan's contracted rates as of January 31, 2019, indexed for inflation, along with additional permitted factors including physician training and experience, patient acuity and case complexity, market share, and prior contracting history. The IDR entity may not consider usual and customary charges, billed charges, or public payer rates. The federal IDR process does not apply where a specified state law establishes the out-of-network payment methodology.

Arising from a separate body of law, federal fraud and abuse authorities govern the waiver of patient cost-sharing. The federal anti-kickback statute and the civil monetary penalty provisions addressing beneficiary inducement restrict the routine forgiveness of copayments and deductibles for federal health care program beneficiaries. These authorities are subject to well-established exceptions, including for individualized, documented determinations of financial hardship made in good faith and not advertised or offered routinely.

1 AMA POLICY

2
3 The AMA has extensive, longstanding policy on physician balance billing, opposition to
4 inadequate reimbursement, private contracting, and freedom of choice. The Board of Trustees notes
5 six policies that are particularly relevant to the discussion:
6

7 Policy H-385.991, "Balance Billing"

8
9 Our AMA supports the right of the physician to balance bill a patient for any care given,
10 regardless of method of payment, where permissible by law or contractual agreement.
11

12 Policy D-380.996, "Balance Billing for All Physicians"

13
14 1. Our AMA will devote the necessary political and financial resources to introduce
15 national legislation at the appropriate time to bring about implementation of Medicare
16 balance billing and to introduce legislation to end the budget neutral restrictions inherent in
17 the current Medicare physician payment structure that interferes with patient access to care.
18

19 2. This national legislation will be designed to pre-empt state laws that prohibit balance
20 billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician
21 contracts.
22

23 3. Our AMA will develop model language for physicians to incorporate into any insurance
24 contracts that attempt to restrict a physician's right to balance bill any insured patient.
25

26 Policy D-390.985, "Medicare Balance Billing"

27
28 Our AMA will work on behalf of physicians to regain the right to balance bill Medicare
29 patients for the full reasonable fees as they determine appropriate.
30

31 Policy D-390.986, "Medicare Balance Billing"

32
33 Our American Medical Association advocates that physicians be allowed to balance bill
34 Medicare recipients to the full amount of their normal charge with the patient responsible
35 for the difference between the Medicare payment and the physician charges; our AMA
36 seeks introduction of national legislation to bring about implementation of balance billing
37 of Medicare recipients; and our AMA further advocates that such federal laws and
38 regulations pre-empt state laws that prohibit balance billing.
39

40 Policy H-390.854, "Freedom of Choice"

41
42 (1) The AMA will seek appropriate cases to challenge the legality and constitutionality of
43 Medicare restrictions on non-participating physicians' medical practice and on patient
44 freedom of choice by such mechanisms as limitations on balance billing and prohibitions
45 on private "opt out" arrangements between physicians and patients. (2) The AMA will
46 strongly resist such restrictions being extended to other payers in national health care
47 reform legislation.

Policy H-330.932, “Cuts in Medicare and Medicaid Reimbursement”

Our American Medical Association continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients... Our AMA aggressively encourages CMS to affirm the patient’s and the physician’s constitutional right to privately contract for medical services. If the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seeks immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee.

Additional policy reinforces this framework. Policy D-390.969, “Parity in Medicare Reimbursement,” expressly includes balance billing among the mechanisms our AMA supports to ensure adequate physician payment. Policy D-330.924, “Reform the Medicare System,” centers AMA Medicare reform efforts on pluralism, freedom of choice, and balance billing. Policy H-400.991, “Guidelines for the Resource-Based Relative Value Scale,” reaffirms physicians’ right to decide on a claim-by-claim basis whether to accept Medicare assignment and opposes the elimination of balance billing. Policy H-465.989, “Rural Health,” directs our AMA to monitor the impact of balance billing restrictions on reimbursement and access in rural areas.

Together, these policies establish a comprehensive advocacy foundation centered on physician autonomy in billing, opposition to artificial limits on reimbursement, preservation of private contracting and freedom of choice, and attention to the access consequences of balance billing restrictions. They provide the basis for our AMA’s ongoing regulatory and legislative efforts to secure fair payment for physician services in both the Medicare and commercial markets.

DISCUSSION

The Board of Trustees understands the concerns that prompted Resolution 205 and recognizes the financial pressures confronting independent physician practices. Decades of reimbursement erosion, combined with consolidation among health plans and the growth of narrow networks, have placed small and independent practices under sustained strain, and the Board agrees that our AMA should pursue a range of strategies to strengthen practice viability.

The environment in which balance billing operates has also changed substantially since our AMA’s foundational policies in this area were adopted. Those policies were developed principally in response to Medicare limiting charges and state laws restricting balance billing in the commercial market. The NSA introduced a comprehensive federal framework that now governs when balance billing is permitted, what patients owe, and how physicians contest inadequate payment. How our AMA’s existing policy operates within that framework is central to determining what additional policy, if any, is needed.

The Current Federal Framework and Its Limits

The NSA materially narrowed the circumstances in which a physician may balance bill a commercially insured patient. In the two settings the statute reaches, out-of-network emergency care and out-of-network care delivered at an in-network facility, balance billing is prohibited unless the physician satisfies notice and consent requirements, and for a substantial category of hospital-based and ancillary services the consent pathway is unavailable altogether. As a practical matter, this means that for many physicians in anesthesiology, pathology, radiology, emergency medicine, neonatology, and related fields, balance billing is not available at in-network facilities under any circumstance.

This is a matter of statute, not regulation. Changing it would require Congress to amend the “Consolidated Appropriations Act, 2021,” a framework enacted with bipartisan support following extended negotiation in which physician organizations, including our AMA, participated directly. Advocacy to restore balance billing authority in the settings the NSA reaches would therefore be a legislative undertaking of substantial scope, and one that would place our AMA in the position of seeking to reopen patient protections it helped to shape and continues to support.

The Board also observes that the constraint physicians most acutely experience in the commercial market is not a cap on what they may charge. Where balance billing remains permissible, no federal ceiling limits the amount. What determines physician revenue is the qualifying payment amount, the benchmark the health plan uses to calculate its payment obligation and one of the factors an IDR entity weighs, together with the accessibility and integrity of the dispute resolution process itself. A policy directed at billing caps would not reach the mechanism that actually governs payment. A policy directed at QPA methodology and IDR function would.

AMA Advocacy on Out-of-Network Payment

Our AMA has long opposed artificial limits on physician payment, and that opposition is reflected in its sustained work on the mechanisms that set out-of-network reimbursement. In the commercial market, the practical successor to the payment ceilings our AMA has historically resisted is not a statutory cap but the qualifying payment amount, which functions as the benchmark against which plans calculate what they owe. Our AMA's advocacy has therefore been directed at preventing the QPA from operating as a de facto cap.

Consistent with that assessment, our AMA has directed sustained advocacy at the methodologies and processes that determine out-of-network payment. In comments on the interim final rule implementing the NSA, our AMA raised detailed objections to the calculation of the QPA, including the breadth of the definitions of “market” and “geographic region,” the reliance on small data sets, and the exclusion of risk-sharing, bonus, penalty, and other incentive-based payments from the median contracted rate. Our AMA also emphasized the importance of transparency in how the QPA is derived and disclosed to physicians, and cautioned that the rule expanded certain administrative requirements in ways that burden practices without benefiting patients.

Our AMA also challenged, in coordination with other physician and hospital organizations, the federal rules that would have required arbitrators to presume the QPA as the appropriate payment amount, and the courts vacated those provisions. That outcome preserved the independent dispute resolution process as a genuine alternative to plan-set payment rather than a mechanism for ratifying it.

In comments on the Federal Independent Dispute Resolution Operations proposed rule (CMS-9897-P), our AMA advocated for changes designed to make the dispute resolution process accessible to independent practices. Among other positions, our AMA:

- Supported mandated use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes so that physicians can determine at the outset whether a claim is subject to the federal process or to a specified state law;
- Supported establishment of a centralized health plan registry accessible through the federal IDR portal, so that practices can identify the correct plan contact and determine whether a plan is fully or self-insured;
- Urged that health plans, rather than physicians, bear responsibility for submitting the QPA and the methodology used to calculate it;

- Supported expanded batching of claims and urged that the proposed line-item limitation be increased so that batching produces meaningful efficiency;
- Encouraged the Departments to exercise waiver authority to shorten the 90-calendar-day cooling off period, which can otherwise stack across successive disputes; and
- Supported reduced administrative fees for low-dollar disputes while urging further reductions, so that the dispute resolution process remains financially accessible to smaller, rural, and independent practices.

Our AMA has separately pressed the Departments on the administrative burdens associated with good faith estimate and advanced explanation of benefits requirements, urging phased implementation and cautioning against technology mandates that would fall disproportionately on small, rural, and under-resourced practices.

The Board recognizes the concern that our AMA has maintained balance billing policy without corresponding visibility in its advocacy. The record above reflects active and continuing engagement with the frameworks that most directly determine physician payment. The Board is satisfied that existing policy provides ample authority for this work, and that additional policy directed at balance billing authority and billing caps would duplicate positions our AMA already holds, and our AMA remains committed to defending physicians' billing autonomy and to securing fair payment through sustained advocacy on QPA methodology, dispute resolution accessibility, network adequacy, and plan accountability.

Patient Protections and Physician Payment

Protecting patients from balance billing in circumstances beyond their control and securing fair payment for physicians are complementary objectives, not competing ones. A patient who arrives at an emergency department does not select the treating physician, and a patient admitted through that department does not negotiate the network status of the hospitalist, the intensivist, or the pathologist who reads the specimen. In these circumstances the patient is not a party to the contracting failure that produced the out-of-network encounter. Our AMA has consistently maintained that the resulting payment dispute belongs between the physician and the health plan, and that our advocacy should be directed at making that dispute resolvable on fair terms rather than at transferring liability to patients.

Our AMA does not currently have freestanding policy supporting the continuation of these protections. Given the durability of the NSA framework and the likelihood that its patient protection provisions will be revisited in future legislative debate, the Board believes our AMA would benefit from an explicit position. Such a position would strengthen our AMA's standing when it presses the Departments and Congress on QPA methodology, dispute resolution reform, insurer accountability, and network adequacy, because it makes clear that our objection is to inadequate plan payment rather than to patient protection.

Such a position would not disturb our AMA's Medicare balance billing policy. Policies D-390.985 and D-390.986 address the Medicare limiting charge; the protections at issue here concern emergency care, Medicaid beneficiaries, and other vulnerable populations under existing state and federal law. The two operate in different contexts: our AMA supports patient protection where patients cannot exercise choice, and physician latitude in payment arrangements where they can.

Physician Discretion to Waive Patient Cost-Sharing

The Board turns finally to a subject on which our AMA has no policy at all: the ability of physicians to forgive copayments and deductibles for patients experiencing financial hardship. The Board regards this as a genuine gap warranting the House's attention.

Physicians in independent practice have historically exercised discretion to adjust or forgive patient obligations based on individual circumstances, a longstanding professional norm that serves patients directly. The growth of high-deductible health plans has increased the frequency with which patients face obligations they cannot meet, and practices in safety-net and high-volume settings encounter these circumstances routinely. Physicians should be able to respond without exposure to regulatory jeopardy.

It is important, however, to be precise about what current law provides, because the framing of an advocacy position determines whether it can succeed. Federal fraud and abuse authorities do not categorically prohibit waiver of cost-sharing for patients experiencing financial hardship. The anti-kickback statute and the beneficiary inducement civil monetary penalty provisions restrict the routine, advertised, or indiscriminate waiver of copayments and deductibles for federal health care program beneficiaries. Longstanding guidance permits waiver based on an individualized, good-faith determination of financial need.

The difficulty is therefore not prohibition but uncertainty and burden. The standards governing an adequate hardship determination are not clearly specified, documentation expectations are ill-defined, and the expectation that a practice demonstrate reasonable collection efforts before forgiving an obligation imposes administrative cost that can exceed the amount at issue. Because the consequences of a financial hardship determination that is later deemed to be insufficient are severe, many physicians decline to exercise discretion that federal law in fact, permits. Advocacy premised on removing a prohibition that does not exist would be unlikely to produce results. Advocacy directed at clarifying and simplifying the standards, while reducing the associated burdens, addresses the problem that physicians actually face and is something the responsible agencies could act upon through updated guidance, without statutory change.

Further, this subject involves two separable concerns. Federal fraud and abuse authorities are one. Private payer contracting provisions that restrict physician discretion over the collection of cost-sharing are another, requiring an advocacy approach directed at contracting practice rather than federal guidance. Policy addressing this subject should distinguish between those concerns.

CONCLUSION

The financial pressures confronting independent physician practices are significant and persistent, and the Board of Trustees shares the House's commitment to addressing them. Our AMA has longstanding and comprehensive policy supporting physicians' right to balance bill, opposing artificial limits on reimbursement, and defending private contracting and freedom of choice. That policy, when combined with sustained advocacy before the Departments on qualifying payment amount methodology, dispute resolution accessibility, plan accountability, and administrative burden, provides ample authority for our AMA's continuing work in this area, and reaffirmation renews that commitment without creating duplicative policy.

Two matters warrant new policy. First, our AMA lacks an explicit position supporting the continuation of balance billing protections for patients who cannot exercise meaningful choice over the network status of their treating physician; adopting one clarifies that our AMA's objection is to

1 inadequate plan payment rather than to patient protection. Second, our AMA lacks any policy
2 addressing physician discretion to waive cost-sharing for patients experiencing financial hardship,
3 an area where the practical obstacle is regulatory uncertainty and administrative burden rather than
4 outright prohibition. The Board will continue to pursue a coordinated legislative and regulatory
5 strategy consistent with Policies H-385.991, D-380.996, D-390.985, D-390.986, H-390.854, and
6 H-330.932.

7
8 RECOMMENDATIONS

9
10 The Board of Trustees recommends that the following be adopted and the remainder of the report
11 be filed.

- 12
13 1. That our American Medical Association reaffirm: Policy H-385.991, “Balance Billing;”
14 Policy D-380.996, “Balance Billing for All Physicians;” Policy D-390.985, “Medicare
15 Balance Billing;” Policy D-390.986, “Medicare Balance Billing;” Policy H-390.854,
16 “Freedom of Choice;” and Policy H-330.932, “Cuts in Medicare and Medicaid
17 Reimbursement.” (Reaffirm HOD Policy)
18
19 2. That our AMA support the continuation of protections from balance billing for emergency
20 care, Medicaid beneficiaries, and other vulnerable populations as currently required under
21 state and federal law. (New HOD Policy)
22
23 3. That our AMA advocate at the federal level for clarification of standards governing
24 physician waiver of patient cost-sharing obligations for patients experiencing documented
25 financial hardship, including reduction of the administrative, documentation, and collection-
26 effort burdens associated with existing hardship exceptions under federal fraud and abuse
27 authorities; and that our AMA oppose payer contracting provisions that restrict physicians
28 from exercising discretion permitted under those authorities. (New HOD Policy)

Fiscal Note: Minimal.

REPORT07 OF THE BOARD OF TRUSTEES (I-26)
Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
(Reference Committee B)

EXECUTIVE SUMMARY

Resolution 209-I-25, referred at the 2025 Interim Meeting, asks that our American Medical Association (AMA) advocate for federal legislation or regulatory changes that would allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other settings. This report responds to that referral.

Opt-out is presently structured as a complete and sustained exit from the program. Section 1802(b) of the “Social Security Act” permits a physician to contract privately with a Medicare beneficiary only on the condition that the physician file an affidavit forgoing all Medicare payment for all beneficiaries, in all settings, for at least two years. That status attaches to the physician’s National Provider Identifier and overrides the participation status of every entity through which the physician bills. The uniformity is not an artifact of drafting. Congress adopted it to prevent confusion among patients about whether a given visit would be covered and what they could expect to pay, and to give beneficiaries a stable basis on which to select their physicians.

The Board of Trustees shares the House of Delegates concern for physicians whose practices span multiple settings, but concludes that our AMA should not advocate for the mechanism the resolution proposes. The decisive consideration is that a setting-specific framework would transfer risk to beneficiaries in a form they cannot manage. Under current law, a beneficiary facing an opted-out physician confronts a large but knowable liability, disclosed in a written contract executed in advance and verifiable through a public file. Under the proposed framework, that same liability would arise contingently, in settings the beneficiary may not have chosen and on the basis of a distinction the beneficiary has no practical means of anticipating. Much of the flexibility the resolution seeks is moreover available today through membership and hybrid arrangements requiring no change in law, and the narrower restriction that remains follows from the mandatory claims submission requirement rather than from any rule about practice setting.

Our AMA has long supported private contracting that does not cost the patient their Medicare benefits, but the substantive principle underlying that position was rescinded from the text of current policy in 2020 when it was folded into our AMA’s advocacy for the Medicare Patient Empowerment Act. Restating it gives the House an explicit position rather than one carried by reference. Separately, physicians who practice through genuinely separate entities in geographically distinct locations present a circumstance in which the risk of beneficiary confusion is substantially reduced, and that circumstance warrants examination rather than a categorical answer.

Underlying all of this is inadequate Medicare physician payment, which has declined approximately 33 percent since 2001 when adjusted for practice cost inflation and remains the pressure that leads physicians to reconsider participation at all. Our AMA’s advocacy is directed at that cause.

The Board therefore recommends reaffirmation of five existing policies, explore options for physicians practicing in geographically distinct settings, and adoption of new policy supporting an additional payment option in Medicare fee-for-service, in lieu of Resolution 209-I-25.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 07-I-26

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

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 209-I-25, "Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians," was referred which asked the following:

RESOLVED, That our American Medical Association advocate for federal legislation or regulatory changes that would allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other settings, such as private practices, hospices, or hospitals. (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 is antiquated and needs to be remedied. Other testimony opposed the resolution, stating that the approach suggested in the resolution would fragment care and 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 existence of AMA policy on this topic, the Reference Committee recommended that Resolution 209 be referred, and the HOD concurred.

BACKGROUND

Section 1802(b) of the "Social Security Act," codified at 42 U.S.C. 1395a(b) and added by section 4507 of the "Balanced Budget Act of 1997," permits a physician to enter into a private contract with a Medicare beneficiary for items or services that would otherwise be covered by Medicare. To do so, the physician must file an affidavit with the Secretary of Health and Human Services affirming that the physician will not submit any claim to Medicare, and will not receive any Medicare reimbursement, for any item or service furnished to any Medicare beneficiary during the applicable opt-out period. Emergency and urgent care services are excepted. The opt-out period runs for two years and, following amendments enacted in the "Medicare Access and CHIP Reauthorization Act of 2015," renews automatically unless the physician cancels it.

The universal scope of opt-out was not incidental to the 1997 compromise. Congress authorized private contracting in response to concerns about physician participation, but conditioned that authority on a complete and sustained exit from the program. A physician may leave Medicare but may not hold both positions at once.

That principle is carried through the implementing framework. Opt-out is available only to individual practitioners; groups, clinics, and other organizations cannot opt out. Because the affidavit binds the practitioner, the resulting status applies to all items and services furnished to Medicare beneficiaries regardless of service location, and it applies across all of the physician's employment arrangements. Where a group employs a physician who has opted out, the group cannot bill Medicare for that physician's services even though the group itself is enrolled in Medicare. Opt-out status likewise extends across Medicare Administrative Contractor jurisdictions, so that a physician who opts out in one jurisdiction is opted out in all of them, and it extends to beneficiaries enrolled in Medicare Advantage as well as to those in traditional Medicare.

This uniformity is reflected in Medicare's administrative infrastructure. Claims are adjudicated against the rendering physician National Provider Identifier and opt-out status is applied at that level rather than at the level of a group, a location, or a particular enrollment record. Opt-out status overrides the participation status of any entity through which the physician bills. A physician therefore cannot presently opt-out for services furnished in a direct primary care practice while continuing to bill Medicare for services furnished in a hospital, hospice, or *locum tenens* assignment.

Opt-out should be distinguished from Medicare enrollment. Enrollment records are maintained at the level of the practice location and tax identification number, and a physician may be enrolled through more than one entity. Opt-out is a separate, practitioner-level election that applies to the physician regardless of how many enrollment records the physician holds. A physician who opts out remains enrolled but may not submit claims to Medicare for any covered service furnished to a beneficiary, in any setting.

Practice patterns have changed considerably since this framework was established. Physicians increasingly divide their professional time across multiple employment settings, and interest in direct primary care, concierge, and other cash-based practice models has grown. Resolution 209 reflects the concern that a framework designed for a period of more uniform practice arrangements now constrains physicians whose work spans several settings.

AMA POLICY

The AMA has existing policy addressing physician flexibility and voluntary participation in Medicare and other public programs. In addition to other extensive policy in the space, the AMA has several policies, noted below, that directly address the concerns raised by the resolution.

[Policy H-165.823](#), "Options to Maximize Coverage under the AMA Proposal for Reform," provides that physicians have the freedom to choose whether to participate in a public option, and that public option proposals should not require provider participation or tie physician participation in Medicare, Medicaid, or any commercial product to participation in the public option.

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

[Policy D-390.966](#), "Inappropriate Changes to Physician Medicare Participation Status by the Centers for Medicare & Medicaid Services," directs the AMA, among other things, to educate

physicians, through appropriate means, about the option of electing Medicare non-participating status, together with simple instructions for effecting such a change in status.

[Policy D-380.997](#), “Private Contracting by Medicare Patients,” establishes that any patient, regardless of age or healthcare insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and the right to personally pay for those services. It directs the AMA to pursue appropriate legislative and legal means to permanently preserve that right; to pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the patient-physician relationship; and to seek suitable cases to reverse the limitations on private contracting imposed by CMS or the private health insurance industry. The policy further reaffirms the AMA’s support for a pluralistic healthcare delivery system that includes fee-for-service medicine and commits the AMA to lobby for the elimination of any restrictions and physician penalties for the provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.

[Policy D-390.957](#), “A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act,” directs the AMA to initiate and sustain a well-funded grassroots campaign to secure public support for passage of the Medicare Patient Empowerment Act (MPEA), as directed by the House of Delegates at the 2010 Interim Meeting through Policy D-390.960.

Policy D-390.960, “Assuring Patients’ Continued Access to Physician Services,” was rescinded in the Council on Legislation’s 2020 sunset review on the ground that it had been implemented and superseded by D-390.957 and related policies.¹ As adopted, it directed the AMA to formulate legislation for an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. It further committed the AMA to a legislative and grassroots campaign to ensure that Medicare patients can keep their benefits when they privately contract with any physician of their choice, with the MPEA as the centerpiece legislation. Because D-390.957 incorporates D-390.960 by reference, the substantive principle underlying the AMA’s support for the MPEA is no longer set out in the text of current policy.

Taken together, these policies commit the AMA to advancing physician choice, flexibility, and reduced administrative burden in Medicare participation, to preserving the right of patients and physicians to contract privately without penalty, and to ensuring that physicians and patients alike understand the consequences of participation decisions.

DISCUSSION

Beneficiary financial exposure and the loss of advance notice

When a physician opts out, the beneficiary assumes the entire cost of care. An opted-out physician may bill any amount the physician determines is appropriate, without the limiting charge protections that cap what non-participating physicians may collect, and neither the physician nor the beneficiary may submit the claim to Medicare. Medigap and other supplemental coverage will not pay. The difference is substantial. In an illustration developed by the Kaiser Family Foundation, a colonoscopy with biopsy priced at approximately \$500 on the Medicare fee schedule leaves a beneficiary responsible for \$100 when furnished by a participating physician and approximately \$166 when furnished by a non-participating physician billing at the limiting charge. Furnished under a private contract, the beneficiary is responsible for whatever the physician

charges, which in that illustration was approximately \$1,200. There is no cap. Half of all Medicare beneficiaries live on yearly incomes of roughly \$24,000 or less.^{2 3}

Current law manages that exposure by making it knowable in advance, and Congress designed it to work that way. The requirement that physicians who opt out do so for all Medicare patients and for all services they furnish, rather than selecting among patients or services, was adopted to prevent confusion among patients about whether a given visit would be covered by Medicare and how much they could expect to pay out of pocket. The requirement was also intended to address concerns about the program's ability to protect beneficiaries from improper billing. The two-year minimum opt-out period was established for a related reason, which is to allow beneficiaries to make knowledgeable choices in selecting their physicians rather than be subject to frequent changes in status. Uniformity is therefore not an artifact of how the framework was drafted. It is the mechanism by which Congress made private contracting compatible with beneficiary protection.⁴

A beneficiary needs to know whether the physician has opted out, and that fact does not change from one visit to the next. It is verifiable through a public CMS file, and it must be disclosed in a written private contract executed before services are furnished, in which the beneficiary acknowledges responsibility for the full charge, the absence of limiting charge protection, the unavailability of supplemental coverage, and the right to obtain covered services from a physician who has not opted out. Congress further prohibited private contracting with beneficiaries who receive full Medicaid benefits or assistance through the Qualified Medicare Beneficiary program, and with beneficiaries in the midst of an urgent or emergent event.⁵

A setting-specific framework would reintroduce the confusion the statute was written to prevent. A beneficiary who has confirmed that a physician participates in Medicare would have confirmed nothing durable, because the answer would depend on where the encounter occurs. The written notice requirement would attach to each encounter rather than to the physician relationship, and the practical likelihood of a beneficiary receiving, reading, and understanding that disclosure at the moment it matters diminishes accordingly. Beneficiaries with cognitive impairment or limited health literacy, and those who present without having selected the setting in advance, would bear that risk most heavily.

The resolution does not specify the unit to which opt-out would attach. Whether that unit is an enrollment record, a practice location, a tax identification number, or a specialty designation carries substantial consequences for administrability, for the design of the notice requirement, and for the potential for arrangements that direct Medicare-payable work to one setting while reserving higher-margin work for private contracting. Congress would have to resolve that question before any such framework could function, and the answer would determine whether the change operates as the flexibility the resolution describes or as something considerably broader.

Flexibility is available under current law

A physician who wishes to build a direct primary care or membership-based practice while continuing to furnish hospital, emergency department, or urgent care services may remain a participating physician and do both. That physician may decline to accept Medicare beneficiaries into the membership practice, may see Medicare beneficiaries in that practice and bill Medicare in the ordinary fee-for-service manner, or may bill Medicare for covered services while charging a separate membership fee for services Medicare does not cover, an arrangement commonly described as the concierge or hybrid model. None of these requires the physician to give up Medicare billing in the hospital or emergency setting, and none exposes beneficiaries to unlimited charges.

1 What a participating physician cannot do is charge a Medicare beneficiary privately for a service
 2 Medicare covers. That restriction arises from the mandatory claims submission requirement rather
 3 than from any rule about practice setting. A setting-specific opt-out framework would be an
 4 indirect and consequential way to reach it and would carry effects well beyond the circumstance
 5 that prompted the resolution.

6
 7 Where the existing opt-out process is genuinely burdensome, Policy D-390.955 already directs
 8 AMA advocacy toward eliminating the reaffirmation requirement and establishing a safe harbor for
 9 physicians who fail to reaffirm inadvertently. That work addresses the administrative difficulty the
 10 resolution identifies without restructuring participation itself.

11 12 *Private contracting without forfeiture of benefits*

13
 14 The narrower restriction that remains, the inability of a physician who has not opted out to contract
 15 privately with a beneficiary for a covered service, is one the AMA has long sought to remove
 16 directly. Policy D-380.997 commits the AMA to eliminating restrictions and physician penalties
 17 for fee-for-service care furnished to consenting patients, including Medicare patients, and Policy
 18 D-390.957 directs sustained advocacy for the MPEA, which the AMA has supported in successive
 19 Congresses, including as H.R. 1650 in the 114th Congress. Under the MPEA, a beneficiary and a
 20 physician could agree, in a written contract signed before services are furnished and specifying the
 21 physician's fees, to a fee that differs from the Medicare fee schedule. The beneficiary would retain
 22 Medicare benefits and would receive the amount Medicare would pay a participating physician for
 23 the service, and the physician would be treated as having opted out only with respect to that patient,
 24 remaining a participating or non-participating physician for all others. Contracts could not be
 25 entered into while a beneficiary faces an emergency medical condition or urgent healthcare
 26 situation, and could not be entered into with beneficiaries dually eligible for Medicare and
 27 Medicaid.⁶

28
 29 That approach responds to the concerns underlying Resolution 209 more directly than a setting-
 30 specific opt-out framework would. It would allow physicians who wish to practice outside the fee
 31 schedule to do so for particular patients without leaving Medicare, reducing the pressure on
 32 physicians to opt out in order to sustain their practices and preserving beneficiary access to those
 33 physicians. It would do so while retaining the protections that make private contracting compatible
 34 with beneficiary interests: the beneficiary would know the physician's fee before receiving care,
 35 would agree to it in writing, and would not forfeit Medicare coverage for the service. Safeguards
 36 modeled on the "No Surprises Act," such as advance good faith estimates of expected charges and
 37 a notice-and-consent process that is unavailable in emergency situations, could further strengthen
 38 those protections. By supporting the viability of independent practices, the approach may also ease
 39 one of the pressures contributing to consolidation.

40 41 *Continuity of care and the concentration of withdrawal*

42
 43 Medicare beneficiaries are disproportionately likely to require care that moves across settings, and
 44 continuity depends on the ability of a physician who knows the patient to furnish that care
 45 wherever the patient presents. A framework in which participation is setting-dependent would
 46 divide those episodes along payment lines rather than clinical ones. The frequency of that problem
 47 would depend on design. A physician furnishing professional services to the same patient in an
 48 office and then in a hospital is not practicing in two settings in any sense Medicare presently
 49 recognizes, and the resolution is best understood as addressing physicians who maintain genuinely
 50 separate practices.

Even so, real difficulties arise. A beneficiary who belongs to a physician's cash-based practice and requires urgent evaluation would be directed to whichever physician is available rather than to the physician who knows the patient, and the beneficiary would face a different payment posture depending on which of those physicians provided the care. Referral and ordering authority presents a further complication. An opted-out physician may still order prescription drugs and have them covered by Medicare Part D as well as laboratory, imaging, and durable medical equipment services for which Medicare pays, and a setting-specific framework would require rules governing whether orders originating in an opted-out setting remain payable and how a beneficiary would know. These details would determine whether care furnished across settings holds together for the beneficiary or breaks into separately administered pieces.

A related concern is where selective withdrawal would concentrate. Physician exit from Medicare is associated with reduced access to care, particularly in nonmetropolitan areas and Health Professional Shortage Areas where beneficiaries already face limited physician availability. If opt-out could be exercised selectively, the incentive would run toward opting out in the settings with the lowest payment and the highest administrative burden, which are frequently the settings serving the most vulnerable beneficiaries. Selective withdrawal would therefore concentrate its effects rather than distribute them.⁷

Physicians practicing in geographically distinct settings

The concerns described above apply with the least force to one group of physicians whose circumstances merit separate consideration. A growing number of physicians hold multiple employment or contractor arrangements, whether as W-2 employees, 1099 independent contractors, or locum tenens physicians, either concurrently or in succession within a single two-year opt-out period. The pattern is common in anesthesiology, hospital medicine, and emergency medicine, and among locum tenens physicians of every specialty. Where those arrangements are with separate practice entities in locations far enough apart that a beneficiary would not reasonably be expected to see the physician in both, the risk of beneficiary confusion that underlies the uniform opt-out rule is substantially diminished. A beneficiary in either community would encounter the physician under a single, consistent payment status, and advance disclosure could attach to that practice relationship much as it now attaches to the physician.

Medicare already accommodates entity-level variation in participation. Participation status generally follows the billing entity, so a physician who bills through more than one entity may be participating in one and non-participating in another. Opt-out is the exception. Because it is a practitioner-level election that overrides the status of every entity through which the physician bills and runs for at least two years, a physician who opts out to practice privately in one community is foreclosed from Medicare-billed employment or locum tenens work in another, and a physician who accepts such work must forgo or cancel an opt-out elsewhere.

An accommodation limited to these circumstances would preserve flexibility for a workforce that increasingly practices across multiple arrangements, without reintroducing the encounter-level uncertainty discussed above. Its design would need to address how geographic separation is defined, how entity-specific status would be recorded and published so that beneficiaries and referring physicians can verify it, how orders and referrals would be treated, and how to prevent arrangements that direct Medicare-payable work to one entity while reserving other work for private contracting. These questions warrant examination rather than a categorical answer, and the Board recommends that the AMA explore options accordingly.

Scale of the constraint and the underlying payment problem

The constraint Resolution 209 identifies affects a narrow population. Approximately 98 percent of physicians and practitioners billing Medicare are participating providers, and formal opt-out remains rare. As of November 2024, roughly 1.2 percent of non-pediatric physicians had opted out of Medicare, a share consistent with prior analyses in 2013 and 2022, and opt-out is concentrated in a small number of specialties, with psychiatrists accounting for roughly 39 percent of all physicians who have opted out. In 47 states, fewer than two percent of physicians have opted out. CMS analysis of the first years of private contracting reached a similar conclusion, finding that few providers found opting out attractive and that the departure of that small group did not appear to create access problems for beneficiaries.^{8,9}

Inadequate Medicare physician reimbursement

The pressure giving rise to interest in opt-out flexibility is substantially a function of inadequate Medicare physician payment. Physicians are the only Medicare providers without an automatic annual inflation-based payment update. Medicare physician payment has declined approximately 33 percent since 2001 when adjusted for practice cost inflation, while the costs of operating a practice have risen sharply over the same period. Both the Medicare Trustees and the Medicare Payment Advisory Commission have warned about the consequences of that widening gap. MedPAC has cautioned that it could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, to stop participating in Medicare entirely, or to consolidate with hospitals, and has recommended that Congress replace current law updates with annual updates tied to the Medicare Economic Index.¹⁰

Understood in that context, the difficulty Resolution 209 identifies is a symptom. A setting-specific framework would not raise payment in any setting. It would permit withdrawal from the settings where payment is worst, relieving the individual physician while leaving the underlying problem intact and shifting its consequences onto beneficiaries. It would also provide an outlet that resolves the individual physician's circumstance without resolving the programs.

The AMA's advocacy is directed at that underlying problem. In July 2026, the AMA endorsed the "Patients First Act," (H.R. 9693), comprehensive and bipartisan legislation that would establish a permanent annual physician payment update tied to the Medicare Economic Index and built into the baseline. Under current law, the cumulative update for most physicians from 2026 to 2036 would be essentially flat, at 0.03 percent, while under the legislation it would grow by 7.7 percent. The bill pairs that update with a statutory floor for low-inflation years, an extended and increased work geographic practice cost index floor benefiting physicians in many rural areas and 34 states, and a five-year hybrid payment demonstration for independent primary care practices that is fully funded and exempt from budget neutrality. It incorporates the budget neutrality reforms of the "Provider Reimbursement Stability Act," raising the \$20 million threshold that has gone unchanged since it was established and requiring the Centers for Medicare & Medicaid Services to reconcile utilization misestimates so that physicians are not penalized indefinitely for estimation errors. It also replaces the Merit-based Incentive Payment System with a simplified quality-measurement system developed through a clinician-majority process. Enactment of a permanent inflationary update would address the circumstances that lead physicians to reconsider Medicare participation in every setting at once, which is what Resolution 209 seeks to achieve for one setting at a time.

1 CONCLUSION

2
3 The Board of Trustees appreciates the concerns that prompted Resolution 209. The current opt-out
4 framework was designed for practice arrangements that are no longer typical, and physicians who
5 divide their time across multiple settings encounter a rule that does not reflect how they work. That
6 frustration is legitimate, and the Board does not discount it.

7
8 The Board nevertheless concludes that the AMA should not advocate for the mechanism the
9 resolution proposes. The decisive consideration is that the framework would transfer risk to
10 beneficiaries in a form they cannot manage. Under current law, a beneficiary confronting an opted-
11 out physician faces a large but knowable liability, disclosed in advance and verifiable
12 independently. Under a setting-specific framework, that same liability would arise contingently, in
13 settings the beneficiary may not have chosen, on the basis of a distinction the beneficiary has no
14 practical means of anticipating. The AMA has consistently advocated for transparency in what
15 patients owe and for advance disclosure of financial responsibility. A framework that makes the
16 beneficiary's loss of Medicare coverage variable and encounter-dependent runs against that
17 commitment.

18
19 The Board is also persuaded that the flexibility sought is, for most physicians, already available
20 through membership and hybrid arrangements that require no change in law. The narrower
21 restriction that remains, the inability to charge a beneficiary privately for a covered service, follows
22 from the mandatory claims submission requirement rather than from any rule about setting.
23 Restructuring opt-out would be a substantial change to reach a problem both narrower and
24 differently situated than the resolution suggests.

25
26 The Board gives weight as well to the effect on continuity. A framework that divides a physician's
27 participation by setting introduces breaks in care along lines unrelated to clinical judgment, for a
28 population that moves across settings more often than any other, and the unresolved treatment of
29 referrals and orders originating in an opted-out setting compounds that concern.

30
31 Weighing these considerations, the Board finds that a setting-specific opt-out framework would
32 impose poorly bounded costs on beneficiaries in exchange for flexibility largely available already,
33 without addressing the payment inadequacy that drives physicians to consider leaving Medicare.
34 Existing AMA policy already commits the AMA to advancing physician choice, flexibility, and
35 reduced administrative burden in Medicare participation, including advocacy to simplify the opt-
36 out process itself, and to preserving the right of patients and physicians to contract privately
37 without penalty. The circumstance Resolution 209 describes is best addressed by resolving its
38 cause. The AMA is pursuing that remedy through its support for a permanent inflation-based
39 update tied to the Medicare Economic Index, which would relieve the pressure on physicians in
40 every practice setting. Advocating instead for selective withdrawal would divert effort from that
41 work while transferring its costs to beneficiaries.

42
43 The Board does, however, see two avenues that respond to the concerns underlying Resolution 209
44 without imposing those costs. The first is the private contracting approach embodied in the MPEA,
45 which would allow a physician and a patient to contract for a covered service without penalty to
46 either party and without the patient forfeiting Medicare benefits. Because the contract must be
47 executed in writing before services are furnished, may not be entered into during an emergency or
48 urgent situation, and may not be used with dually eligible beneficiaries, that approach preserves the
49 advance notice on which the Board's analysis rests while reducing the circumstances in which a
50 physician would need to opt out at all. The second is a narrowly drawn accommodation for
51 physicians who practice through separate entities in geographically distinct locations, where the

risk of beneficiary confusion is substantially reduced. The Board therefore recommends that existing policy supporting private contracting be reaffirmed, that the principle of rescinded Policy D-390.960 be restated as current policy, and that the AMA explore options to address the geographically distinct circumstance.

The remedy Resolution 209 proposes would make Medicare participation an attribute of the setting rather than of the physician. Beneficiaries would lose the ability to determine in advance whether Medicare will pay, and would face unlimited charges in settings they may not have selected and cannot readily identify. The Board of Trustees therefore recommends reaffirmation of existing policy, together with the targeted additions described above, in lieu of Resolution 209-I-25.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 209-I-25 and the remainder of this report be filed:

1. That Policies H-165.823, D-330.930, D-390.966, D-380.997, and D-390.957 be reaffirmed. (Reaffirm HOD Policy)
2. That our American Medical Association explore options to allow physicians who practice through separate practice entities in geographically distinct locations, where patients would not be likely to see the physician in more than one setting, to hold different Medicare participation or opt-out statuses with respect to those entities. (Directive to Take Action)
3. That our AMA support an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient, ensuring that Medicare patients can keep their benefits when they privately contract with any physician of their choice. (New HOD Policy)

Fiscal Note: Minimal.

REFERENCES

¹ American Medical Association, Board of Trustees Report 4-A-20, "Council on Legislation Sunset Review of 2008 and 2010 House Policies" (June 2020), app. 1, <https://www.ama-assn.org/system/files/2020-05/sm20-bot04.pdf>.

² Gretchen Jacobson et al., "Income and Assets of Medicare Beneficiaries, 2014-2030," Kaiser Family Foundation (September 2015), cited in Boccuti and Neuman, *supra*.

³ Cristina Boccuti and Tricia Neuman, "Private Contracts Between Doctors and Medicare Patients: Key Questions and Implications of Proposed Policy Changes," Kaiser Family Foundation (January 2017), <https://files.kff.org/attachment/Issue-Brief-Private-Contracts-Between-Doctors-and-Medicare-Patients>.

⁴ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4507; see also Boccuti and Neuman, *supra* (describing the all-patients, all-services requirement as intended to prevent confusion among patients as to whether a given visit would be covered and what they could expect to pay, and the two-year minimum period as intended to allow beneficiaries to make knowledgeable choices in selecting physicians).

⁵ 42 C.F.R. pt. 405, subpt. D; Medicare Benefit Policy Manual, ch. 15, § 40. Private contracting is prohibited with beneficiaries who have full Medicaid coverage or who receive assistance through the Qualified Medicare Beneficiary program.

⁶ American Medical Association, "Physicians FAQs: Medicare Patient Empowerment Act" (2015), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/medicare-patient-empowerment-act-physician-faqs.pdf>; see also H.R. 1650, 114th Cong. (2015).

⁷ Joanna Cantor et al., "US Physician Medicare Program Participation and Exit, 2013-2023," JAMA (published online October 20, 2025), doi:10.1001/jama.2025.15343.

⁸ William Buczko, “Provider Opt-Out Under Medicare Private Contracting,” Health Care Financing Review 26, no. 2 (Winter 2004-05), <https://www.cms.gov/files/document/hcfreview2004winterpg43pdf>.

⁹ Alex Cottrill, Nancy Ochieng, and Tricia Neuman, “How Many Physicians Have Opted Out of the Medicare Program?” Kaiser Family Foundation (January 2025), <https://www.kff.org/medicare/how-many-physicians-have-opted-out-of-the-medicare-program/> (analyzing CMS opt-out affidavit data as of November 2024). The 98 percent participation figure is drawn from MedPAC, Report to the Congress: Medicare Payment Policy (March 2024), ch. 4.

¹⁰ MedPAC, Report to the Congress: Medicare and the Health Care Delivery System (June 2025); see also American Medical Association, “AMA urges action on Medicare payment reform at House hearing” (May 20, 2026). The 33 percent figure reflects the change in Medicare physician payment from 2001 through 2025 adjusted for practice cost inflation.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 08-I-26

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

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 211-I-25, “Access to, and Retention of, Electronic Medical Records,” for report at the 2026 Interim Meeting. The resolution asks:

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; and be it further

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.

The Reference Committee heard mixed testimony 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. 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. Due to the complexity of the issue and in order to further address the complex overlap of federal and state regulations, vendor accountability, and data ownership issues before pursuing legislation, the HOD referred Resolution 211 for a report back at the 2026 Interim Meeting.

BACKGROUND

Objectives of Resolution 211

Resolution 211 appears to be directed at reducing the risk of loss of patient data and ensuring that patients and physicians have the ability to access patient records in a timely manner, particularly in scenarios where the EMR vendor's contract with a medical provider has terminated, or the EMR vendor becomes insolvent. Regulations supporting these goals were promulgated under the 2003 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule regulations, and made directly applicable to HIPAA business associates such as EMR vendors, under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

Ownership and Control of Medical Information

Protected Health Information (PHI) is generally collected from the individual by a medical provider, at which point it becomes subject to stringent privacy and security requirements under the HIPAA Privacy and Security Rules.

Medical providers, along with health plans and healthcare clearinghouses, comprise the definition of covered entities (CEs) under the HIPAA Rules and remain ultimately responsible to the individual and to regulators for as long as the individual's PHI that has been collected by the provider is used, disclosed, or maintained by them or on behalf of them. In order to facilitate the processing of PHI for claims payment, business analytics, and other purposes on behalf of the CE, each CE generally will contract with one or more entities that perform these services; HIPAA terms these entities "business associates" (BAs). The disclosure of PHI from the CE to the BA is strictly regulated and may only be done according to the terms of a business associate agreement. The required core terms of each business associate agreement (BA Agreement) are set forth in HIPAA regulations at [45 CFR §164.504\(e\)](#), and obligate the BA to adhere to the same Privacy and Security Rule requirements as the CE to ensure protection of the PHI. Entities that compile and maintain EMRs are a prime example of a HIPAA BA, and may only handle the PHI disclosed to them by a medical provider or health plan, according to the terms of the BA Agreement that the EMR vendor has in place with each CE.

Retention of PHI by EMR Vendor BAs

As noted, an EMR vendor's handling of PHI is governed by the terms of each BA Agreement, which includes among its required provisions, [45 CFR § 164.310\(d\)\(2\)](#), mandating that each CE and BA implement policies and procedures to address the final disposition of electronic protected health information. Of note, this means that the medical provider has a responsibility and an opportunity to specify and negotiate (within limits) the terms for return or destruction of the PHI they have disclosed to a BA, at the time of engaging them pursuant to a BA Agreement. Each physician should understand the terms that they have agreed upon with their EMR vendor, prior to disclosing PHI to them. For employed physicians, these terms are generally negotiated by the CE that employs them – often a hospital.

To assist physicians in ensuring that appropriate terms are in place, the AMA maintains [HIPAA Privacy & Security Resources](#), including a [Sample Business Associate Agreement](#), with terms at Article V. that govern contract term and termination; Section 5.04 of the linked document at pages 15 – 16, specifically governs the return or disposal of PHI by the business associate.

Patient Access to Records Held by an EMR Business Associate

Individuals have a right to access their PHI maintained by a BA. However, the HIPAA Privacy Rule¹ dictates that the CE (such as a health plan or healthcare provider) is primarily responsible for fulfilling this Right of Access. The Rule requires each CE to specify in their BA Agreement, that the BA must make such PHI available if and when needed by the CE so that it can provide individuals with access to their information. However, the Privacy Rule also allows the CE, when disclosing data to the BA, to agree in their BA Agreement that the BA will provide individuals with access to their data; this arrangement may be appropriate where the BA is the only holder of the data that is sought by the individual. BAs are generally not required to give individuals direct access to their PHI. Instead, if an individual requests PHI directly from a BA, the BA typically must forward the request to the CE, or handle it according to the terms of their BA Agreement. The CE then processes the request and provides the information to the requesting individual within 30 days.

The Information Blocking Rule (IBR) Impact on Patient Access to Records

The IBR regulations were promulgated in 2020 pursuant to the 21st Century Cures Act and require entities such as EMR vendors to provide each user² with the ability to “timely create an export file(s) with all of a single patient’s electronic health information.”

The electronic health information (EHI) export certification criteria requires that all EHI produced and electronically managed by a developer’s health IT be readily available to export for a single patient upon request for his or her health data, and for all patients when a physician seeks to change health IT systems. It further requires health IT developers to provide the format, such as a data dictionary or export support file, for the exported information to assist the receiving system in processing the EHI without loss of information or its meaning to the extent reasonably practicable using the developer’s existing technology. These regulations were promulgated to ensure that patients and physicians can timely access their EHI as a patient right, and for medical purposes of treatment and continuity of care.

AMA POLICY

Given this analysis’ focus on access and retention, the following policies are the highly relevant: Existing AMA policy supports the broader adoption of interoperable health IT and EHR systems when implementation improves care, protects patient safety, promotes usability and data portability, holds vendors accountable, and reduces, rather than increases, burdens on physicians ([D-478.995](#)). Additionally, AMA policy supports strong, practical privacy and security standards for electronic medical information while emphasizing that physicians should retain ownership and control of practice-generated data and receive support in meeting regulatory requirements ([H-315.979](#), [H-315.974](#)).

Policy [D-315.971](#) seeks to ensure that physicians have access to the medical and billing records necessary to protect their professional and legal interests. Key elements of this policy state that licensed physicians should have unrestricted access to their patients’ billing records and related medical records while employed or under contract to provide care; physicians should be able to access billing records submitted under their name, even if they did not personally provide the item or service; where state law does not already require physicians to possess billing records, contracts should specify that physicians are entitled to copies after employment or contract termination when needed for liability defense, administrative investigations, or other proceedings; and, that our AMA supports legislation or regulation to eliminate contract terms that limit or bar physicians’ access to

1 billing and associated medical records, including claims that such records are proprietary or trade
2 secrets.

3 4 DISCUSSION

5
6 The transition process to a new EMR vendor can be disruptive for both patients and their
7 physicians. Physicians are concerned by the potential for loss of critical patient data and the
8 possible costs of transitioning to a new system. For patients, this can result in delays in treatment,
9 gaps in medical history, and a breakdown in communication with their care team. However, in
10 addition to existing laws that create inherent protections for accessing and retaining patient health
11 records, the federal government has provided educational resources to help navigate contractual
12 language to include additional rights and obligations related to the scope of transition services that
13 could be provided, notice periods, and commitments to ongoing transition services.³

14 15 *Resolution 211-I-25 – first resolve*

16
17 The objective of the first resolve, to create a federal standard for medical record retention, is
18 incompatible with the body of law that regulates the practice of medicine at the state level.
19 Furthermore, as discussed above, such a federal standard is likely to impose conflicting compliance
20 obligations where related laws are implicated, such as statutes of limitations. The second part of the
21 first resolve targets “records of discharged patients,” which is unclear if it refers to patients
22 discharged from a facility or alternatively, patients discharged from a practice.” If the former,
23 creating a new time requirement for physicians at discharge does not help with record access and
24 causes additional administrative burden. If the latter, record access is already preserved by the rules
25 governing all other patient EMR records and thus it is unnecessary to call out this particular
26 instance. Finally, in regard to the first resolve, as it is written in passive voice, the wording is
27 unclear as to which entity would perform the compilation, review, and authentication within 30
28 days of discharge, that the resolution proposes. If the resolve intends to direct physicians to
29 complete these tasks, that would add significant burden to perform those activities routinely, rather
30 than providing the patient with access to their records upon request, as is the current practice. If,
31 however, the resolve intends to direct EMR vendors to perform these tasks, the compensation for
32 those services would be built into the business associate agreements that each EMR vendor has
33 with the physician practices it serves. The cost allocation and responsibility to perform these
34 services on a routine basis, as opposed to upon the request of a patient, would likely inflate the cost
35 of an EMR vendor’s services for the same duties that, as discussed above, they are already bound
36 by regulation to perform.

37 38 *Resolution 211-I-25 – second resolve*

39
40 With three subparagraphs, the second resolve advocates first, that EMR vendors comply with state
41 laws regardless of their contractual relationships, which is certainly unobjectionable, and is
42 understood to be the current practice.

43
44 Secondly, subparagraph (b) of the second resolve proposes that EMR vendors be required to
45 arrange for custodians of all electronic medical files in case of their insolvency. Such an extra step
46 appears inadvisable, as it would add to practice cost, as discussed above. Finally, as discussed
47 above, current federal regulations require that each medical provider enter into an agreement with
48 their EMR vendor, for the return or destruction of the provider’s PHI upon termination of the
49 contract. An EMR vendor’s insolvency, and the resulting impossibility of their performance, would
50 be one ground of contract termination, so that the transition of data held by an EMR vendor is
51 already provided for, by contract, statute, and regulation.

1 The third and final subparagraph of the second resolve, (c), aims to require EMR vendors to fulfill
2 patient requests for their records. As discussed above, HIPAA mandates that with certain
3 exceptions,⁴ the covered entity, such as a physician, remains responsible to the patient to provide
4 access to that patient's records. As further noted above, each medical provider may negotiate terms
5 in their agreement with their EMR vendor, for the vendor to provide an individual's PHI directly to
6 them. For these reasons, a mention of the "business associate agreement," should be inserted in the
7 subparagraph.

8 9 *State-Based Medical Record Retention Considerations and Federal Policy Outlook*

10
11 Establishing a single federal standard for medical record retention would be highly challenging
12 given the long-standing patchwork of state laws governing healthcare delivery, professional
13 licensure, and related liability issues. State law generally determines clinical record retention
14 periods, and requirements vary substantially by jurisdiction, patient age, and provider type. Statutes
15 of limitations for medical liability claims, particularly those involving pediatric patients, further
16 complicate any effort to impose a uniform national standard. Although federal law, including
17 HIPAA, establishes certain retention obligations for privacy and compliance documentation, it does
18 not prescribe comprehensive clinical record retention timelines, which remain largely a matter of
19 state law.

20
21 Creating a federal standard for medical record retention could create major challenges for
22 physicians by conflicting with existing state laws, increasing administrative and data storage costs,
23 and raising legal liability risks. Currently, retention rules are set mostly by individual states and
24 specific programs like Medicare, creating a complex landscape. Even if Congress created a federal
25 minimum or "floor," physicians would still have to account for longer state retention requirements,
26 state medical board rules, malpractice statutes of limitations, tolling rules for minors, and courts'
27 application of discovery rules in litigation. Because those state-law obligations and litigation risks
28 would remain, a physician who follows a shorter federal timeline could face exposure in liability
29 litigation. Conversely, if the federal standard imposed a longer retention period than required by
30 the state in which a physician practices, the storage of sensitive data whose retention is not
31 currently required, incurs heightened risks for the physician practice in the event of a breach or
32 unintentional, impermissible disclosure. In practice, a federal floor would add another layer of
33 compliance without eliminating the conflicting legal regimes, particularly those enumerated above,
34 that make medical record retention a complex compliance issue.

35
36 Congress has not recently demonstrated significant interest in adopting a universal federal medical
37 record retention mandate for healthcare providers. Recent federal activity has focused more on
38 patient access, affordability, privacy, and data security than on establishing nationwide storage and
39 retention timelines.⁵ As a result, retention obligations continue to be governed by a combination of
40 state law, Medicare and Medicaid requirements, and agency-specific rules. Any federal proposal in
41 this area would need to account for existing state frameworks and the practical implications of
42 creating requirements that are more prescriptive than many current state standards.

43 44 CONCLUSION

45
46 Clinical and medical record retention remains principally a matter of state law; imposing a uniform
47 federal standard would implicate numerous additional areas of state law with foreseeable, and
48 likely unforeseeable, negative consequences. Existing federal and state laws already provide
49 substantial protections for access, privacy, and related compliance obligations, while clinical
50 medical retention timelines are administered under state frameworks. Accordingly, a blanket
51 federal retention mandate would create friction with existing law and practice, and is unlikely to

provide the solution it appears to promise. Ensuring continued access to medical records is best addressed by enforcement of state and federal requirements, in addition to carefully drafted contract provisions clarifying physician ownership of records and uninterrupted rights of access to data.

RECOMMENDATIONS

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

1. That our American Medical Association support federal and state legislation, regulation, and certification standards requiring Electronic Medical Record (EMR) vendors and Health IT developers to retain, preserve, and provide complete export of patient data in an electronic, retrievable, interoperable, and transferable format for the period necessary to satisfy all applicable federal and state retention obligations, regardless of contract termination or vendor insolvency, without imposing unreasonable or punitive data extraction or archival fees on covered entities; (New HOD Policy) and
2. That our AMA support federal regulatory enforcement ensuring that EMR vendors fulfill their obligations as HIPAA Business Associates by promptly providing requested records to the covered entity that disclosed them, and where stipulated by contract or regulation, delivering records directly to patients or authorized third parties in a timely manner, at no more than the allowable cost-based fee, and in a standard, accessible, and usable format; (New HOD Policy) and
3. That our AMA advocate for federal health IT certification and bankruptcy reforms that establish clinical health records as protected custodial assets that cannot be withheld, deleted, or monetized during vendor insolvency, liquidation, or acquisition. (Directive to Take Action)

Fiscal Note: Minimal.

REFERENCES

¹ See [Does the HIPAA Privacy Rule require a business associate to provide individuals with access to their protected health information?](#) HHS Office for Civil Rights guidance published December, 2002. Note that this guidance precedes the 2009 HITECH Act, which made business associates directly subject to the Privacy Rule requirements and HHS-OCR enforcement, whereas business associates were previously made subject to the privacy and security requirements via the required terms of each business associate agreement.

² [CFR §170.315\(b\)\(10\)](#). The IBR does not place compliance burdens on a generalized "user," but instead regulates three distinct classes of entities known as Actors: Healthcare Providers, Health IT Developers, and Health Information Networks/Exchanges. While not labeled as regulatory "users" who must comply with the rule, patients and consumers are the intended beneficiaries whose rights to access, exchange, and use their electronic health information (EHI) are legally protected against blocking by the regulated Actors. See <https://hiteqcenter.org/Resources/HITEQ-Resources/ArtMID/718/ArticleID/2013/preview/true>.

³ [ONC Resource: EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print](#).

⁴ "[T]he Privacy Rule does not prevent the parties from agreeing through the business associate contract that the business associate will provide access to individuals, as may be appropriate where the business associate is the only holder of the designated record set, or part thereof." Footnote 1, *supra*.

⁵ E.g., [Foster Introduces Medical Records Access Fairness Act \(March 2026\)](#).

REPORT OF THE BOARD OF TRUSTEES

BOT Report 09-I-26

Subject: Medicare Should Not Unfairly Penalize Physicians

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim meeting of the American Medical Association (AMA) House of Delegates (HOD) Resolution 220-I-25, “Medicare Should Not Unfairly Penalize Physicians,” was referred. It states:

“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.”

The Reference Committee considered Resolution 220-I-25 together with Resolution 223-I-25, “Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity,” and it was also referred. It states:

“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.”

As the two resolutions were discussed together during the Reference Committee hearing, address the same topics, and were both referred, BOT Report 09-I-26 addresses both resolutions. The whereas clauses in Resolution 220-I-25 state that the administrative burdens created by value-based payment programs have fueled acquisition of independent practices by hospitals, insurance companies, and private equity firms. They also state that these programs present barriers to delivering better care at a lower cost by diminishing competition, and that value-based payment models inherently lead to conflicts of interest between physicians and patients. Whereas clauses in Resolution 223-I-25 cite studies finding that CMMI models have hurt quality of care, and whereas clauses in both resolutions cite a 2023 Congressional Budget Office report that found that CMMI payment models led to increased federal spending instead of savings in the agency’s first decade and projected that the models will continue to generate more instead of less Medicare spending.¹

Testimony on the resolutions acknowledged that CMMI payment models have imposed administrative burdens, financial penalties, and had negative impacts on care, but there was disagreement over how best to address these problems. Multiple people testified that current AMA policy should be reaffirmed in lieu of the resolutions due to the AMA’s longstanding support for voluntary, physician-developed payment reform. Other testimony advised that referral would provide an opportunity to evaluate how to strengthen the AMA’s advocacy so that future models reflect physician leadership, local flexibility, and data driven evaluation.

BACKGROUND

For more than 20 years, there has been bipartisan interest in implementing alternative payment models (APMs) for physician services as a means of improving the quality and coordination of patient care and reducing Medicare spending growth. The goal of creating APMs was to ensure payments reward physicians for delivering good quality and health outcomes at a lower cost, rather than basing payment solely on the number and types of services they deliver. Physicians supported the creation of APMs that would provide additional or different payments that enable physicians to deliver care in higher-quality and/or more cost-efficient ways for a clinical condition, a care episode, or a patient population. In addition, physicians were willing to take accountability for efficiently delivering high-quality care if they had the flexibility and adequate resources to do so.

Physicians supported the creation of multiple types of APMs, including accountable care organizations (ACOs), bundled episode payments, and primary care medical homes. The goal of ACOs was to enable medical practices, hospitals, and other organizations involved in patient care to work together to coordinate care for a defined patient population in ways that can improve quality and control total spending. If successful, ACOs would earn a share of the savings they generated for Medicare. Bundled payments were intended to provide a single payment or budget for all services related to an episode of care, such as a surgical procedure or management of a chronic condition. In primary care medical home models, practices would receive monthly payments for comprehensive management of patients' primary care services and coordination of other services that patients need in addition to, or instead of, payments for office visits.

The creation of CMMI in 2010 aimed to significantly boost the creation of Medicare APMs. The AMA developed educational materials and convened seminars all over the country to inform physicians about opportunities to improve patient care under well-designed payment models and how to design effective APMs. Although the AMA and many specialty societies proposed APMs to CMMI, the agency did not adopt them and instead developed its own models. One exception was a CMMI grant program, the Health Care Innovation Awards, that, starting in 2012, provided grants ranging from \$1 million to \$30 million for three years to test new models. Many physicians applied for these grants and used them to deliver services in ways that were not possible under existing payment systems. Although evaluation of the models found that more than 20 of them achieved significant savings, the projects generally could not be sustained or expanded because the grant funding only lasted for 3 years and CMMI did not create any APMs that would support the services that were delivered in the projects.

In 2015, there were still too few APMs for physician services available. To facilitate development of more APMs for physicians, Congress included an APM pathway and six years of incentive payments in the Medicare Access and CHIP Reauthorization Act (MACRA). Congress recognized that to be successful, APMs need to be designed by physicians working on the front lines of care, so MACRA also created the Physician-focused Payment Model Technical Advisory Committee (PTAC) to review and recommend physician-designed APM proposals. Physicians responded immediately to the opportunity to design APMs that would support better patient care. More than 30 patient-centered APM proposals were developed and submitted to PTAC, several of which had been successfully pilot tested under a Health Care Innovation Award. Nonetheless, although PTAC recommended 19 APM proposals for further development, testing, implementation or other action by Medicare, none were implemented by CMMI.

Currently, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. Moreover, most of the APMs that CMMI has created to date have not been designed in the ways that physicians expected or Congress intended. Most APMs

have provided “incentives” tied to higher quality or lower spending without providing physicians the resources or flexibility they need to deliver care in different ways. Many APMs have also placed physicians at financial risk for spending and outcomes that they cannot control. CMMI’s primary care models have only been available in a small number of states or regions. In addition, because they must demonstrate savings for Medicare within a short timeframe, many APMs that had desirable characteristics were terminated instead of being improved, and others were continued but modified in ways that made them less likely to support patient-centered care. In a report on physician practices in rural or underserved areas, the Government Accountability Office noted that many lacked the capital to finance the upfront costs of transitioning to the APMs created by CMMI and faced challenges acquiring or conducting data analysis necessary for participation.² Instead of fixing these problems to make the models more financially sustainable for practices and attract more participants, CMMI is increasingly turning to APMs that mandate participation and impose large penalties for failure to reduce spending by arbitrary amounts, most recently with the Ambulatory Specialty Model and Comprehensive Joint Replacement Expanded model.

AMA POLICY

Current AMA Policy [D-385.980](#), “CMMI Payment Reform Models,” has guided the AMA’s advocacy on mandatory APMs since 2021. It calls for the AMA to:

- continue to advocate against mandatory CMMI demonstration projects;
- advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide PTAC’s recommendations and CMMI’s work to propose demonstration projects that are voluntary and can be appropriately tested; and
- advocate that CMMI focus on the development of multiple voluntary pilot projects in many specialties, tailored to the needs of local communities and different specialties.

AMA Policy [H-160.915](#), “Accountable Care Organization Principles,” outlines AMA principles for ACOs and reinforces the need for them to be voluntary for both physicians and patients. It also states that any physician organization or other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO, and that physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid, a private payer, or being admitted to a hospital medical staff.

The AMA also has several policies addressing APMs beyond those that oppose mandatory models:

- Policy [H-385.901](#), “Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations,” calls for the AMA to extend ongoing payment reform advocacy to address the needs of specialties and patient populations not served by current CMMI models and work with national medical specialty societies that are developing APMs for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties, and continue to advocate that CMMI, state Medicaid agencies and other payers implement physician-developed APMs.
- Policy [H-450.931](#), “Moving to Alternative Payment Models,” asks that the AMA work with CMS to establish an appropriate timetable for APM implementation accounting for the physician community’s readiness to assume two-sided risk. It also asks that the AMA help practices optimize the quantity and content of physician work under APMs and address their concerns about operational details.

- Policy [H-385.913](#), “Physician-Focused Alternative Payment Models,” includes detailed lists of APM goals, guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members, and recommended technical assistance for CMS and private payers to provide to physician practices working to successfully implement APMs. The goals include avoiding placing practices at substantial financial risk and minimizing administrative burdens.

DISCUSSION

The AMA has often said that if CMMI would adopt the models that have been developed by the physician community, including those recommended by the PTAC, there would be many physicians willing to voluntarily participate in them. However, CMMI believes that voluntary APMs lead to selection bias that hurts its ability to fairly evaluate models; it thinks that only the participants who expect to succeed in the model will enroll, and those that do not succeed will drop out before the test has ended.³ CMMI also believes that it needs to impose steep financial risk requirements to generate a sufficiently large amount of savings for Medicare. However, placing physicians at high risk for costs that they cannot influence, or control, further discourages them from voluntarily participating in models. Rather than creating models in which physicians want to participate, CMMI is increasingly mandating physician participation in the APMs it has created to get an adequate number of participants.

APMs that focus primarily on reducing healthcare spending and utilization rather than on improving the delivery of care, particularly those involving significant financial risk, have the potential to harm patients as well as physicians. It is inappropriate for CMMI to require physicians and their patients to participate in a new APM before any testing on a voluntary basis, or evaluation of the impacts on patient care, has been completed.

CMMI has implemented several voluntary APMs that physicians have willingly joined and used to redesign services and reduce avoidable spending without harming patients. For example, CMMI has created a series of primary care focused models, including the Comprehensive Primary Care Initiative, Comprehensive Primary Care Plus, Primary Care First, and Making Care Primary that have provided important additional funding and other types of support to primary care practices to help them adopt advanced primary care models. Large numbers of practices voluntarily enrolled in these models and used the payments to improve the way they delivered patient care. As with the Health Care Innovation Awards, however, these APMs have either been allowed to lapse without being extended or have been terminated early. Some participants in the voluntary programs for bundled surgical payment, oncology care, kidney care, and the ACO models developed by CMMI have also had positive experiences with them, but in most cases, CMMI has revised the models in ways that reduced the resources available to physicians and increased their financial risk for costs they cannot control. CMMI has recently begun to focus more on the need to engage non-primary care specialists in APMs, but it has done so with limited input from specialists. The Long-Term Enhanced ACO Design model (LEAD ACO)—includes a component focused on specialist management of episodes for patients attributed to an ACO, but it is not yet clear exactly how this model will be implemented.

The Board of Trustees believes that the AMA should continue to support the creation of APMs that enable both primary care physicians and specialists to deliver care in higher-quality, lower-cost ways. The AMA should also continue to oppose mandating physician participation in payment models that place physicians at high levels of financial risk for costs and outcomes they cannot control and that fail to provide the flexibility and resources physicians need to improve care for

patients. Current AMA policy strikes an appropriate balance between these objectives, and the Board recommends that they be reaffirmed.

In addition, new policies are needed that would establish AMA support for legislation that could provide an effective pathway to CMMI's adoption of physician-developed APM proposals and establish some guardrails on mandatory testing of models. Title III of the bipartisan Patients First Act, H.R. 9693, which focuses on APM improvements, takes some initial steps in this direction. It would require the Secretary of Health and Human Services to use the notice-and-comment rulemaking process for mandatory models as well as for when the Secretary either terminates, expands, or modifies an APM. It would also require the Secretary to report to Congress on the barriers to specialty physicians' participation in APMs, including specific policy recommendations to reduce these barriers.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 220-I-25 and 223-I-25 and the remainder of the report be filed:

- 1) That our American Medical Association (AMA) support legislation to create a program funded by the existing Center for Medicare and Medicaid Innovation (CMMI) appropriation to test alternative payment models developed by physicians or medical societies while not placing physicians at financial risk for costs and outcomes they cannot control. (New HOD Policy)
- 2) That our AMA support legislation to require CMMI to test all new payment models on a voluntary basis. (New HOD Policy)
- 3) That our AMA reaffirm:
 - a. Policy D-385.980, "CMMI Payment Reform Models;"
 - b. Policy H-160.915, "Accountable Care Organization Principles;"
 - c. Policy H-385.901, "Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations;"
 - d. Policy H-450.931, "Moving to Alternative Payment Models;" and
 - e. Policy H-385.913, "Physician-Focused Alternative Payment Models. (Reaffirm HOD Policy)

Fiscal Note: Minimal.

REFERENCES

¹ Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation, Congressional Budget Office, September 23, 2023.

² Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas, Government Accountability Office, GAO-22-10468, Nov. 17, 2021.

³ Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program, Federal Register, Volume 90, Nov. 5, 2025, p. 49571.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 16-I-26

Subject: Ensuring Medical Liability Insurance Transparency and Continuity

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting of the American Medical Association (AMA), the House of Delegates (HOD) referred the second resolve of Resolution 235 “Ensuring Medical Liability Insurance Transparency and Continuity” to the Board of Trustees (Board) which reads:

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.

BACKGROUND

Physicians obtain medical liability coverage in many ways. To take just a few examples, a physician’s employer (e.g., a hospital, health system or large group practice) may purchase insurance from a carrier or it may self-insure. Here the physician may have little if any input concerning how his or her coverage is structured. Physicians in solo or smaller group practices frequently shop for and buy their own liability insurance. Physicians who are independent contractors also typically purchase their own policies, although sometimes they may be able to negotiate a deal where the other party pays or partially subsidizes the physician’s insurance premiums.

Regardless of how the physician is insured, a disturbing trend has emerged where physicians in all practice settings find themselves without insurance and need subsequent protection. For example, some hospitals, health systems, large group practices or other entities that may have funded the physician’s liability insurance have closed without giving physicians, patients, and communities any warning. Some of these closures have been disastrous and have drawn national attention.^{1,2} Physicians are particularly vulnerable in such situations because the coverage is abruptly cancelled and the physician is robbed of any opportunity to develop a transition plan.

One must be clear, however, that potential interruptions in medical liability protection extend to physicians in all kinds of circumstances, no matter how their coverage is provided. Because physicians are most often insured under claims-made policies, physicians may have to address a potential gap in coverage for a great many reasons, e.g., leaving the practice of medicine for another career or because of burnout, working for or with another organization, opening a practice, selling or merging a practice, retiring, suffering a disability, moving to another part of the country, etc.

AMA POLICIES

Policy [D-225.970](#), “Addressing Anti-Physician Contractual Provisions,” states that the AMA will develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts, and 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 [D-215.980](#), “Support Before, During, and After Hospital or Physician Group Closure or Reduction in Services,” states in part that the AMA 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 ensure financial reserves exist and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.

Policy [H-310.943](#), “Closing of Residency Programs,” states in part that the AMA will work with the Centers for Medicare & Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for the provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.

Also, Policy [D-435.978](#), “Loss of Medical Staff Privileges for Lack of ‘Tail Coverage,’” states in part that the AMA supports model medical staff bylaw language as follows, “Where continuous professional liability insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to ‘tail’ coverage) is not grounds for immediate termination of medical staff membership.”

DISCUSSION

As noted above, in some cases the cancellation of claims-made coverage, whether abrupt or otherwise, may bring about a gap in a physician’s medical liability protection. Physicians are typically insured under claims-made policies because they are less expensive than other alternatives such as occurrence policies or a tail coverage endorsement on a claims-made policy. Claims-made policies cover physicians if (1) the alleged harm occurs and (2) the associated medical liability claim is filed while the policy is in force. The cancellation of claims-made coverage may raise a couple issues. First, the physician may not be able to practice medicine until the physician can obtain coverage from another employer, carrier or any other means. Second, given the structure of claims-made coverage, the physician has no medical liability protection for claims filed after the coverage lapsed for alleged harm occurring while the prior claims-made policy was effective. For some specialties, particularly obstetrics and gynecology (OB/GYN) and emergency physicians providing OB/GYN services, claims may be filed decades after the alleged injury. While claims-made policies can provide adequate coverage during the policy, they offer less protection than occurrence policies and claims-made coverage with a pre-paid tail. Specifically, they offer no protection if the physician loses his or her medical liability insurance and the physician has no immediate prospect of obtaining a new policy that will insure the physician going forward and for claims filed for alleged harm(s) occurring during the policy period.

The interruption in coverage may be addressed generally in three ways, either by purchasing an occurrence policy, adding tail coverage to a claims-made policy, or through prior acts coverage. An

1 occurrence policy protects the physician for any incident that occurs during the policy period, and
 2 it makes no difference when any associated claim is filed, even decades later. In other words,
 3 occurrence policies offer life-time protection without the need to purchase a tail. The coverage also
 4 stays in place if the physician changes practice setting, practice status, or medical liability
 5 insurance carriers. As one would expect, occurrence policies are significantly more expensive than
 6 claims-made coverage. Not unexpectedly, many physicians may not be able to pay occurrence
 7 policy premiums so whether a physician has occurrence coverage will be up to another party.
 8 Notably, some medical liability insurers do not sell occurrence policies due to the unpredictable
 9 long-term risk of reserving funds for years or even decades to pay out claims filed long after a
 10 policy year ended, which increases financial exposure. Moreover, it must be noted that some
 11 insurers may not sell occurrence policies in particular markets or for certain specialties – again, due
 12 to increased financial exposure.

13
 14 Adding tail coverage to a claims-made policy can eliminate the gap in coverage. Tail coverage is a
 15 medical liability insurance endorsement that allows a physician to report medical liability claims
 16 after the claims-made policy has ended, for incidents that occurred while the claims-made policy
 17 was in force. The tail coverage must have a retroactive date that matches the prior claims-made
 18 policy's retroactive date to ensure there is no interruption in coverage. As in the case of occurrence
 19 coverage, tail insurance may be cost-prohibitive for many physicians since premiums may be 1.5 to
 20 3 times more than claims-made policies alone. For most physicians, the preferred way to obtain tail
 21 coverage protection is by having the tail purchased in advance, rather than attempting to do so after
 22 the fact. Importantly, it is possible that not all carriers will sell such coverage or limit such products
 23 to specific markets.

24
 25 A prior acts or “nose” policy is another strategy to coverage gaps, although an occurrence or
 26 claims-made policy with a pre-paid tail may be preferable, all things being equal. A prior acts
 27 policy is purchased from a new carrier to protect the physician from incidents that occurred before
 28 the new policy became effective. A prior acts policy may in some cases be more affordable than
 29 pre-paid tail or occurrence coverage, but it may have some downsides that the others do not. For
 30 example, since a prior acts policy are obtained from a new insurer, the physician's risk will be
 31 subject to the insurer's underwriting review, and there is no guarantee that the physician will
 32 qualify for coverage under the insurer's insurability criteria. Some carriers also do not sell prior
 33 acts medical liability insurance policies. And unlike an occurrence or a claims-made policy with a
 34 pre-paid tail, a prior acts policy does not protect a physician who retires or who decides to pursue a
 35 career outside the practice of medicine.

36
 37 The HOD has asked the Board to study whether occurrence policies or claims-made coverage with
 38 a pre-paid tail should be recognized as the gold standard in medical liability insurance coverage.
 39 Since many physicians in all practice settings may at some point have to confront the prospect of
 40 interruptions in coverage that may result from claims-made policies, the Board believes that it is
 41 not only appropriate, but also timely, for the AMA to adopt policy stating that occurrence policies
 42 or claims-made coverage with a pre-paid tale provide more protection and are therefore preferable,
 43 all things being equal, over other forms of coverage, including claims-made policies.

44
 45 Adopting new policy would also be consistent with existing AMA policy and directives cited in the
 46 previous section of this report. (Directive [D-215.980](#), “Support Before, During, and After Hospital
 47 or Physician Group Closure or Reduction in Services;” and Policy [H-310.943](#), “Closing of
 48 Residency Programs;” Directive [D-435.978](#), “Loss of Medical Staff Privileges for Lack of ‘Tail
 49 Coverage.’ ”)

1 The Board, however, wants to be clear that recommending adoption of a gold standard policy for
2 occurrence policies and claims-made policies with pre-paid tails does not in any way reflect
3 negatively on claims-made policies. For many physicians, claims-made policies are perfectly
4 adequate by themselves or in combination with prior acts coverage. The Board also understands
5 that in some markets only claims-made policies are sold and a prior acts add-on may not be an
6 option.

7
8 Nevertheless, physicians deserve to have the broadest medical liability coverage possible for
9 themselves and for the sake of the patients and communities they serve. When compared with
10 alternatives, occurrence or pre-paid tail coverage appears to offer physicians more comprehensive
11 protection across all settings. The proposed new policy will further express the AMA's ongoing
12 concern for the plight of so many physicians who have found themselves suddenly without medical
13 liability insurance with no prospects of obtaining subsequent coverage. This policy would also
14 make more physicians more aware of coverage limitations that may arise if their medical liability
15 insurance is no longer effective. Finally, the policy proposed in this report would encourage
16 physicians, where applicable, to explore the possibility of obtaining occurrence coverage or a
17 claims-made policy with a pre-paid tail whether through employment, contract, or any other means
18 that might be available.

19 20 CONCLUSION

21
22 After carefully examining the question of whether occurrence policies or claims-made coverage
23 with a pre-paid tail should be taken as a gold standard in medical liability insurance, the Board
24 recommends that the HOD adopt policy that recognizes that occurrence-based medical liability
25 insurance or claims-made medical liability insurance with a pre-paid tail is the gold standard for
26 medical liability coverage for physicians in all practice settings.

27 28 RECOMMENDATION

29
30 The Board of Trustees recommends that the second resolve of Resolution 235-1-25 be adopted and
31 that the remainder of the report be filed.

Fiscal Note: Minimal.

REFERENCES

¹ "Steward Health Care raided its own medical malpractice insurance company," The Boston Globe, Spotlight Investigations, September 2024, <https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-traco/>.

² Janis M. Orłowski, "Displaced Hahnemann Residents and Attending Physicians May Soon Lose Liability Insurance," AAMC News, January 7, 2020, <https://www.aamc.org/news/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance>.

REPORT 17 OF THE BOARD OF TRUSTEES (I-26)

Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform
BOT Report 04-I-25/RES 242-A-26

EXECUTIVE SUMMARY

At the 2024 Interim Meeting, the American Medical Association (AMA) AMA House of Delegates adopted Policy D-130.957, Addressing and Reducing Patient Boarding in Emergency Departments, calling for AMA to report at the 2025 Interim Meeting progress addressing and reducing patient boarding in emergency departments (EDs). BOT Report 04-I-25 provided a comprehensive review of the issue. At the 2025 Interim Meeting, Policy D-130.957 was amended to request a report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in EDs.

At the 2026 Annual Meeting of the House of Delegates, Res 242-A-26 (“Reducing Emergency Department Boarding through Payment Reform”) was introduced. Because the AMA was already actively engaged on this issue through its work on BOT Report 04-I-25, Res 242-A-26 was referred and both reports were combined. Accordingly, this report satisfies both items of business and provides an update of AMA advocacy on this issue since BOT Report 04-I-25 was written.

ED boarding, which occurs when patients remain in the ED after admission or placement in observation status, is a persistent national crisis, with more than 90 percent of EDs reporting crowded conditions. Boarding delays treatment, worsens patient outcomes, contributes to staff burnout, and increases violence against healthcare workers. Boarding is a result of systemic dysfunction throughout our healthcare system and can only be solved through a concerted, multi-pronged solution that addresses the myriad drivers of ED boarding.

Since the previous report, the AMA has continued to provide input on new quality measures relevant to ED boarding, continued its support of the advancement of the *Addressing Boarding and Crowding in the Emergency Department Act of 2025*, (ABC-ED Act), and continues its work to mitigate the root causes of ED boarding.

Looking ahead, the AMA will continue to support the ABC-ED Act and weigh in on ED boarding quality measure development efforts, which continue to be the two paths currently most active at the federal policy level. Meanwhile, we will continue our ongoing advocacy to address the many root causes contributing to ED boarding, including strengthening the physician workforce, reforming prior authorization, and improving the reliability of federal payers, among others.

In addition, the AMA is excited to collaborate with the American College of Emergency Physicians (ACEP), the American Academy of Emergency Medicine (AAEM), and other national medical specialty societies, state medical societies, and other interested parties that are leading on this issue to amplify their initiatives, reinvigorate national attention, and pursue action at the federal and state levels to address the multi-faceted causes of ED boarding and mitigate its harmful impact on physicians and patients. The AMA continues to believe that increased collaboration with and amplification of initiatives by ACEP, AAEM, and other national and state medical societies is the most effective way to meaningfully advance advocacy on this issue in the coming year.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 17-I-26

Subject: Addressing and Reducing Patients Boarding in the Emergency/Reducing
Emergency Department Boarding through Payment Reform

Presented by: Toluwalase A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2024 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-130.957, “Addressing and Reducing Patient Boarding in Emergency Departments,” which directed the AMA to report back to the House of Delegates at the 2025 Interim Meeting on progress addressing and reducing patient boarding in emergency departments (EDs). At the 2025 Interim Meeting, BOT Report 04-I-25 provided a comprehensive review of the issue. The sixth bullet of Policy D-130.957 was amended to request a report back to the HOD at the 2026 Interim Meeting on progress addressing and reducing patient boarding in EDs.

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.

Additionally, at the 2026 Annual Meeting of the House of Delegates, Res 242-A-26 (“Reducing Emergency Department Boarding through Payment Reform”) was introduced.

RESOLVED, that our American Medical Association advocates for the Centers for Medicare & Medicaid Services (CMS) and other payors to tie admitted patients’ hospital reimbursement to emergency department boarding performance, including payment reductions or creation of a lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to Take Action); and be it further

RESOLVED, that our AMA adopts policy and advocates for making emergency department boarding metrics and mandatory quality measures incorporated into value-based payment programs, rather than reporting-only requirements without financial consequences. (Directive to Take Action)

Because the AMA was already actively engaged on this issue through its work on BOT Report 04-I-25, Res 242-A-26 was referred and both reports were combined. Accordingly, this report satisfies both items of business and provides an update of AMA advocacy on this issue since BOT Report 04-I-25 was written.

BACKGROUND

A “boarded patient” is one who remains in the ED after being admitted or placed into observation status, which can contribute to ED crowding.¹ ED boarding is widely considered a system-wide crisis, with harmful impacts on patients, hospital staff, public safety, and healthcare costs. Over 90 percent of EDs routinely report crowded conditions.² Patients can wait days to weeks after a physician has decided to admit them for an inpatient bed to become available, which can exacerbate issues like delirium and contribute to worse outcomes for individual patients and create a ripple effect due to bed shortages, worsening community-level outcomes.

The COVID-19 Public Health Emergency shed more light on and exacerbated ED boarding, but the problem has persisted. Because EDs serve as the last line of defense for patient care in their communities and patients can end up in the ED for myriad reasons, the contributors to ED boarding are multifactorial and span the entire healthcare ecosystem. Contributing factors include federal coverage and reimbursement issues, misaligned financial incentives where hospitals are paid inpatient rates for patients who are admitted but remain boarded in the ED, workforce shortages, inefficient coordination and transitions across settings, limited staffing of hospital beds, and others, as summarized in this American College of Emergency Physicians (ACEP) [diagram](#). Accordingly, solving this problem will require a multifaceted approach.

It is important that efforts to address ED boarding, particularly data measurement efforts, do not take an overly punitive approach and penalize emergency physicians for factors outside of their control, such as availability of community resources, patients lacking access to reliable transportation for follow up medical appointments, or hospital decisions regarding staffing of inpatient beds. Instead, policy makers should look to adopt a range of policies aimed at enabling access to timely care in non-ED settings and improving efficiency and coordination throughout our healthcare system to keep patients healthy and prevent them from ending up in the ED in the first place. In addition, policies should aim to bolster ED resources to ensure patients are seen and treated in a timely fashion and eliminate barriers to transition those patients home or to alternative care settings when safe and appropriate to do so.

Summary of Recent Policy Developments

BOT Report 04-I-25 mentioned advocacy for Congress and the Administration to address ED boarding, including communications leading to a summit and report by the Agency for Healthcare Research and Quality (AHRQ), introduction and promotion of the *Addressing Boarding and Crowding in the Emergency Department Act of 2025* (ABC-ED Act), providing input on a new ED boarding measure as part of pre-rulemaking, and our advocacy on the myriad contributors to ED boarding. The following is a summary of developments since BOT Report 04-I-25 was written, several of which are expanded on in subsequent sections.

- September 2025: AMA [comments](#) on including the *Emergency Care Access and Timeliness* (ECAT) measure in the Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting Program (REHQR) Programs.
- November 2025: CMS finalizes the ECAT measure for inclusion in the OQR program for optional reporting in 2026 and mandatory reporting in 2027, and as an optional measure in the REHQR Program starting in 2027.
- March 2026: CMS hosts a [panel](#) on hospital boarding at its annual Quality Conference.
- April 2026: CMS released its 2027 Inpatient Prospective Payment System (IPPS) Proposed Rule. In the rule, the Agency included a Request for Information (RFI) on potentially including the ECAT measure in the Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs.
- June 2026: AMA [comments](#) on potentially including the ECAT measure in the IQR and Hospital VBP Programs.
- August 2026: AMA [comments](#) on the ECAT measure as part of its comments on the 2027 Outpatient Prospective Payment System proposed rule.

Current Policy Climate

Federal

Outside measure development, action has largely stalled at the federal regulatory level to address the ED boarding issue since the AHRQ issued its initial [report](#) on ED boarding in January 2025 following its October 2024 summit on the subject. Since January 2025, AHRQ has lost nearly 80 percent of its workforce as part of reductions across the federal workforce and restructuring of various agencies and sub-agencies by this administration. While in December 2024 AHRQ had issued a Special Emphasis Notice that describes its “strong and continued interest in receiving health services research grant applications for addressing ED boarding and hospital crowding,” in July 2026, AHRQ canceled every active grant in its portfolio.³ CMS hosted a [session](#) on ED boarding at its 2026 Quality Conference in March. However, the session focused on the experience of speakers from two health systems and did not provide insights into future plans for addressing this issue at a systemic level by this administration. The House and Senate introduced the ABC-ED Act in April and June 2025 respectively. See AMA’s relevant advocacy on these efforts below.

State

Several states have created policies to address ED boarding using a variety of tactics. Maryland integrated ED boarding into its Quality-Based Reimbursement Program,⁴ Connecticut established an ED Boarding and Crowding Working Group to develop targeted solutions⁵ and launched the nation’s first public-facing ED Boarding and Crowding [Dashboard](#), and California is pursuing mandatory hospital reporting on ED boarding times. Other states have initiated public-private partnerships to mitigate ED boarding through enhanced community resources, expanded outpatient services, and improved care coordination.⁶ Maine, Massachusetts, North Carolina, and Missouri have tackled pediatric behavioral health admissions, with specific approaches ranging from data tracking, to improving cross-sector coordination, to ED diversion and transition supports.⁷

RELEVANT 2025-2026 AMA EDUCATION AND ADVOCACY

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

In April 2025, the “ABC-ED Act of 2025” (H.R. 2936/S. 1974) was introduced in the House. Two months later it was introduced in the Senate. The bipartisan legislation leverages existing public health modernization federal grant funding for real-time hospital bed capacity tracking systems, establishes public-facing dashboards to promote accountability and transparency, directs the Government Accountability Office to evaluate capacity-tracking best practices, and promotes pilot programs through the Center for Medicare and Medicaid Innovation (CMMI) to ED redesign, improved infrastructure and staffing, and better transitions of care for patients who are older adults or experiencing psychiatric emergencies.

In August 2025, the AMA sent letters to the [House](#) and [Senate](#) in support of the bill. Since then, the AMA has remained in continuous contact with ACEP staff regarding efforts to further advance and secure additional support for the bill. As of the writing of this report, the bill had 29 cosponsors in the House and 13 cosponsors in the Senate. The AMA intends to remain supportive of future iterations of the bill that may be introduced in future Congresses, pending review of any substantive changes, and welcomes future opportunities to collaborate with ACEP and other interested parties on ongoing efforts to secure additional cosponsors.

New Emergency Care Access and Timeliness (ECAT) Quality Measure

Over the last several years, CMS has been working to develop a new composite measure on ED boarding called the *Emergency Care Access and Timeliness* (ECAT) measure, which attempts to quantify access to and timeliness of care in an ED setting based on performance against four thresholds:

1. The patient waited longer than one hour after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination;
2. The patient left the ED without being evaluated;
3. The patient boarded in the ED for longer than four hours; or
4. The patient had an ED length of stay longer than eight hours.

Based on previous feedback from ACEP, the AMA, and others, CMS established clear and meaningful boarding thresholds, including a four-hour maximum timeframe for the period between the admission order (or documented intent to admit) and the patient’s departure from the ED.

Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting Program (REHQR) Programs

On July 15, 2025, CMS released its 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center System (OPPS) [proposed rule](#). In that rule, CMS proposed the ECAT measure for use in the OQR and REHQR Programs.

In our [comments](#), the AMA expressed concern about the timeline for implementation due to the complexity of mapping the required data elements within Electronic Health Record (EHR) systems and time needed to evaluate the validity of the resulting data once mapped. We recommended CMS extend the voluntary reporting period from one to two years. Our letter raised concerns about applying the measure to rural emergency hospitals (REHs), noting that it was developed and tested for use in the hospital inpatient setting. REHs have key differences, including 50 or fewer beds, and they cannot have inpatient beds except those furnished in a distinct partial unit licensed as a skilled nursing facility. Furthermore, despite objections from the AMA, a physician is not required to provide or oversee the care delivered by non-physician practitioners in an REH, so an REH may

face external factors that contribute to extended wait times or boarding that are outside of its control. For example, REHs often struggle to find destination hospitals willing to accept patients with needs that exceed their capabilities, and additional time may be required to transfer the patient to the appropriate facility.

In the [final rule](#), released on November 21, 2025, CMS finalized the ECAT measure for inclusion in the OQR program for optional reporting in 2026 and mandatory reporting in 2027, and as an optional measure in the REH Program starting in 2027. Under the Hospital OQR Program, measures are scored on a pay-for-reporting basis and hospitals receive a two-percentage point reduction to their OPPS annual payment update if they fail to report on all mandatory measures.

In the 2027 OPPS [proposed rule](#), CMS does not propose any changes to the measure or implementation timeframe. Nonetheless, the AMA [reiterated](#) some of our chief concerns with the measure, including calls to delay mandatory reporting.

Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs

On April 10, 2026, CMS released its 2027 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) [Proposed Rule](#). In the rule, the Agency included an RFI on potentially including the same measure in the IQR and Hospital VBP Programs.

In our [comments](#), the AMA strongly emphasized that the time-based thresholds must be treated as a maximum limit, not a mean or median performance target, and that hospitals should be expected to meet these standards for every admitted patient. We recommended CMS weigh outcome #3 more heavily than the other components (40 versus 20 percent), signaling the importance that boarding times should never exceed four hours. In addition, the AMA made several recommendations to improve the measure's accuracy and warned against penalizing individual ED physicians for factors beyond their control, such as regional specialized bed availability. We noted that framing boarding as purely an ED operational failure risks misdirecting improvement efforts away from the inpatient capacity constraints that are the true drivers of prolonged boarding and warned about the potential adverse impact on rural hospitals, which continue to close at disproportionate rates. Specifically, we noted that the measure should take into consideration locality and other potential factors that may make it difficult to "smooth" demand. We also recommended several technical refinements, including broadening the patient population beyond solely admitted or boarded patients and suggesting that stratifying the data by patient type could help to distinguish between hospital-level dysfunction versus external or regional factors. The AMA also cautioned against possible perverse incentives, such as incentivizing inappropriate use of observation status to evade accountability and spoke to the importance of avoiding "wrong-facility" accountability for transfer-related delays and urged CMS to consider whether responsibility appropriately lies with the receiving facility when capacity or acceptance limitations drive prolonged boarding.

Due to our several outstanding concerns with the measure and possible unintended consequences including patient safety implications, and doubts over CMS' ability to resolve these concerns, the AMA cautioned against proposing the measure without further development and stakeholder input. Should CMS propose the measure at any point in the future, we recommended mirroring the implementation process used in the outpatient program: phasing in the measure first through optional reporting, then, implementing improvements to the measure based on learned experience before finalizing the measure. Since this was an RFI, the AMA does not anticipate inclusion of this measure in the final rule. The AMA will monitor and plan to comment should such a measure be proposed for inclusion in the IQR and/or Hospital VBP Programs in future rulemaking.

Physician Education Efforts

The AMA continues efforts to positively address the ED boarding issue at the system level through our various physician education channels. On June 30, 2025, a new interview was posted to AMA's Education Hub as part of our Journal of the AMA (JAMA) Internal Medicine Author Interview series entitled [National Trends in Prolonged ED Length of Stay Among Older Adults: 2017-2024](#). The interview with Adrian D. Haimovich, MD, PhD, Assistant Professor of Emergency Medicine at the Beth Israel Deaconess Medical Center, and Maura Kennedy, MD, MPH, Associate Professor of Emergency Medicine at Mass General Hospital, focuses on how often older adults remain for prolonged amounts of time boarded in EDs.

An AMA Steps Forward [Podcast](#) recorded in August 2025 discusses with Dr. Diana Savitzky, Chair of ACEP's Well-Being Section the unique stressors that emergency physicians face and how practical solutions to common problems can improve physician well-being and team operations. One example she noted was posting QR codes, which enabled ED staff to identify problems that slow down ED operations (e.g. a broken toilet) to senior management in real time. Also mentioned were "stoplight" reports, which categorize common issues into progress statuses.

Ongoing AMA Advocacy to Address the Root Causes of ED Boarding

Addressing the operational conditions that contribute to ED boarding is an important component of the AMA's commitment to ending the ED boarding crisis. As highlighted in the AMA's [2026 impact report](#), this work includes advocacy to reform Medicare physician payment, reduce administrative burdens and improve the conditions in which physicians deliver care, as detailed further below. Please note that this is not an exhaustive list of all ED boarding contributors and focuses on the areas where AMA's advocacy has been most active since BOT Report 04-I-25.

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

ED utilization for individuals with a mental illness or substance use disorder (SUD) has been a long-standing problem. Between 2019 and 2026, monthly use of the ED for a mental illness ranged between 4,600 to 7,000 visits per month per 100,000 total ED visits.⁸ Previous studies have found that more than 11 percent of patients who visit an ED have an SUD.⁹ Some of the causes behind this high utilization include a lack of inpatient and outpatient beds due in part to closure of inpatient psychiatric facilities around the country. Patients, particularly those uninsured or underinsured, are often unable to access a full continuum of care services, including ambulatory care options, crisis intervention services, and community programs to help maintain stability and avert declines and relapses, and turn to EDs as a last resort. This rise in mental health and SUD-related admissions has become a major contributor to the ED boarding crisis.

The AMA remains committed to strengthening access to mental health and SUD treatment. Our [2025 Report on Substance Use and Treatment: Progress, Policy and Future Directions](#) highlights several recent AMA advocacy actions to this end, including partnering with key medical societies to urge the U.S. Food and Drug Administration to clarify that higher doses of buprenorphine may be appropriate for patients with opioid use disorder (OUD), joining a physician-pharmacy coalition to urge the Drug Enforcement Administration to clarify policies that would reduce pharmacy and distributor reluctance in dispensing buprenorphine, and supporting new laws in several states to enhance mental health and substance use disorder parity. The AMA also joined with other partners to launch the [Mental Health Parity Index](#), which uses payer claims data to demonstrate national, state, and county-level disparities in network adequacy and reimbursement rates for outpatient mental health and SUD providers.

In a July 2026 [letter](#) responding to a Department of Health and Human Services (HHS) [Request for Comment](#) on addiction, the AMA called for increased enforcement of the Mental Health Parity and Addiction Equity Act, reduced prior authorization and other barriers to access to medications for OUD, and continued investment in drug overdose prevention strategies—particularly for youth, expanding the mental health and SUD workforce, sterile needle and syringe services programs, and naloxone and test strips distribution efforts. We also underscored our support for prescription drug monitoring programs, which can prevent ED admissions for medication-related complications.

The AMA actively supports numerous pieces of relevant federal legislation including the “SUPPORT for Patients and Communities Reauthorization Act of 2025” ([SUPPORT Act](#)), which would reauthorize several crucial OUD and SUD policy programs, the “Modernizing Opioid Treatment Access Act” ([MOTAA](#)) 2.0, which would increase access to addiction specialist physicians to prescribe methadone for OUD and allow community pharmacies to dispense it, and the “[Fatal Overdose Reduction Act](#),” which would establish a Health Hub Demonstration Program.

Addressing Physician Workforce Limitations

Hospitals and EDs regularly deal with staffing limitations that constrict their ability to see patients, which contributes to ED boarding. Further, hospital and EDs often serve as de facto safety net providers of healthcare services for communities that lack robust access to an adequate physician workforce to address their health needs. As a result, patients end up in the ED for services that do not necessarily require that level of care, or due to complications that could have been avoided with effective disease management. Strengthening local health care workforces to better manage chronic conditions and avoid unnecessary ED visits is one critical tactic to avoid ED boarding, particularly in rural and underserved areas where boarding issues may already be exacerbated. The AMA actively supports myriad efforts to alleviate physician workforce limitations, [particularly in rural communities](#), including but not limited to [increasing the number of residency slots](#), [fighting against recent caps on medical school loans](#), [supporting legislation](#) that would allow foreign-born physicians to stay in the U.S. if they work in a federally designated Health Professional Shortage Area or Medically Underserved Area, ensuring continued visa access for foreign born physicians, and [authorizing loans for specialty physicians in rural areas](#). To see more on our work in this space, please visit our graduate medical education initiatives and advocacy [webpage](#).

Telehealth and Remote Patient Monitoring

Telehealth and remote patient monitoring services can have the ability to help smooth demand and improve access to preventive services, improve management of chronic conditions, and prevent adverse events that land patients in EDs, particularly older Americans, who are also more likely to remain in EDs longer. Thus, expanding access to telehealth services can be another critical way to reduce ED boarding. The “Consolidated Appropriations Act of 2026” (CAA, 2026), extended flexibilities that allow Medicare telehealth services to be delivered nationwide and patients to receive services in their homes through 2027. Audio-only services were also extended, and in-person visit requirements for telehealth for mental health services were delayed through 2027. All these changes were strongly supported by the AMA. The AMA also continues to strongly support permanent access to Medicare telehealth services through the “CONNECT for Health Act.” In addition, the AMA continues to advocate for Medicare reimbursement for at-home blood pressure (BP) monitors to help patients better manage their BP, as well as for value-based payment models that support improved care coordination and patient self-management of BP, asthma, Crohn’s Disease, cancer, and other conditions. The more engaged patients are in managing their conditions at home, the more likely they are to be in a position to seek medical attention before it becomes an emergent situation, potentially avoiding the need to go to the ED.

Supporting Innovative Payment Arrangements that Address Root Causes of ED Boarding

The AMA supports innovative payment models designed to address the myriad root causes of ED boarding, including improved coordination and referral processes across settings, enhanced supports for patients to better manage their own health and have better access to non-acute care settings, and additional flexibilities and supports to emergency physicians to help get patients seen and treated in a timely fashion and transition them back to their home or an alternative care setting when safe to do so, with appropriate follow up care to help avoid repeat ED visits. Across our advocacy on Alternative Payment Models (APMs), the AMA frequently reiterates key themes which address ED boarding drivers, such as ensuring models include appropriate investment that allow physicians to make decisions based on best standards of care that keep patients healthy, as opposed to blunt short-term cost-cutting instruments; improving coordination across specialties and settings; rewarding physicians for improved care management and cost savings associated with reduced unnecessary ED visits; and reducing regulatory burden on physicians to get them back to treating patients. Some of our relevant advocacy is summarized below, though this is not an exhaustive list of our advocacy on all CMS value-based models or programs.

- The Acute Care Hospital at Home (HaH) Program: The AMA [strongly supported](#) extending the HaH program through 2030, which Congress included in CAA, 2026 (H.R. 7148), which became law in February 2026. The HaH Program waiver was originally created during the COVID-19 Public Health Emergency to help alleviate hospital capacity issues by allowing hospitals to provide acute care services in patients' homes. CMS has approved 365 hospital campuses across 137 health systems in 37 states to date. Numerous studies have found that patients and family caregivers prefer HaH, which delivers better clinical outcomes, decreased mortality rates, better patient and family experience, lower caregiver stress, high provider satisfaction, and lower costs of care.
- Long-term Enhanced ACO Design (LEAD) Model: The AMA issued a [positive statement](#) when the LEAD Model was announced as a better way for primary care physicians and specialists to work more closely together to deliver high-quality, coordinated care for patients—something the AMA has [recommended](#) for years. The LEAD ACO model focuses on better care coordination for patients with complex needs, including those who are dually eligible for Medicare and Medicaid and those who are homebound. Abe Sutton, the director of the CMMI and deputy administrator for CMS, and CMMI Chief Strategy Officer Gary Bacher spoke about LEAD with AMA CEO and Executive Vice President John Whyte, MD, MPH, on an [episode](#) of the “*AMA Moving Medicine*” podcast.
- Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model: In December 2025, the AMA issued a [statement](#) welcoming CMS' new ACCESS Model which aims to overcome Medicare coverage barriers for technology-based tools that could help patients more effectively manage chronic disease.

The AMA also continues to push for CMMI to solicit more input from the AMA and other stakeholders throughout model development and to adopt physician-designed payment models, such as ACEP's Acute Unscheduled Care Model, which would incentivize emergency physicians to safely discharge patients by taking on financial risk for managing care after an ED visit.

In addition, the AMA continues to advocate for an extension of APM incentives and modifications to APM Qualified Participant thresholds to encourage continued physician participation in APMs. Notably, the AMA-supported “[Patients First Act](#)” (H.R. 9693) would freeze current APM participation thresholds for three years, provide the Secretary with additional flexibility to further

reduce thresholds if necessary, require a formal notice and comment period for substantial model changes, and require a report to Congress on existing barriers to specialty participation in value-based models along with recommendation to reduce them.

Strengthening Federal Coverage and Reimbursement

Uninsured and under-insured patients are more likely to lack access to scheduled care when they need it, which can lead to exacerbated health issues, resulting in potentially avoidable ED admissions, which contributes to ED crowding and boarding. Furthermore, uninsured and underinsured patients can have difficulty affording care, particularly emergency services, which can contribute to uncompensated care costs, leaving EDs under resourced, another contributor to ED boarding.

The AMA believes healthcare is a fundamental right and fights every day for all Americans to be insured. We also fight to ensure reimbursement levels are sufficient for EDs as well as upstream providers to have the resources they need to appropriately maintain facilities, remain fully staffed, and invest in new technologies to improve care workflows and deliver care both more efficiently and effectively, all of which improve ED efficiency and prevent backups which lead to boarding.

- Medicaid: The AMA continues to vocally and vigorously oppose changes that would restrict patient access to or reduce federal funding for Medicaid coverage. We offered [detailed comments](#) in response to an interim final rule implementing new Medicaid community engagement requirements under Public Law 119-21. In our letter, we urged CMS to preserve the exceptions and patient protections Congress included in the statute, give states sufficient time to develop workable systems and processes, and streamline eligibility verification processes to minimize avoidable coverage losses. We urged CMS to reverse overly restrictive definitions of medical frailty requirements. When patients lose their health coverage, it reduces access to vital preventive care services, resulting in health complications and avoidable ED admissions, which contributes to crowding and boarding. On July 21, 2026, the AMA and the Massachusetts Medical Society filed an amicus brief in support of 26 plaintiff states that are challenging the medical frailty provisions of the interim final rule and seeking a preliminary injunction to block the provisions from taking effect in those states. On July 29, the U.S. District Court for the District of Massachusetts declined to issue a preliminary injunction blocking the rule. The court placed the litigation on an expedited schedule ahead of the January 1, 2027 compliance deadline for Medicaid changes. The AMA also [commented](#) on another proposed rule impacting Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments. In our letter, the AMA noted that the proposed rule limits funding sources beyond statutory requirements and hinders states' abilities to design workable reimbursement models that maintain sufficient beneficiary access.
- Medicare: When adjusted for inflation for rising practice costs, Medicare physician reimbursement [has declined](#) 33 percent from 2001 to 2026. Strengthening Medicare reimbursement remains one of the AMA's top advocacy priorities. Over the last year, the AMA has tirelessly pursued this through multiple avenues, culminating in an unprecedented number of relevant bills being introduced. The bipartisan "Strengthening Medicare for Patients and Providers Act" (H.R. 6160), introduced in November 2025, was strongly [endorsed](#) by the AMA and would permanently link Medicare payments to the real costs of running a physicians practice by tying them to the Medicare Economic Index (MEI). The "Provider Reimbursement Stability Act" (H.R. 8163), [AMA-supported](#) bipartisan legislation that was introduced in the House in March 2026, would raise the budget neutrality threshold for the first time in more than 35 years, require an inflation-based adjustment every five years thereafter, and would

require HHS to revise estimates that trigger cost-shifting redistributions in the Medicare Physician Fee Schedule (PFS) based on actual utilization, among other changes. The “Medicare Physician Data-Driven Performance Payment System Act of 2026” (H.R. 8622) would overhaul the flawed Merit-based Incentive Payment System. The AMA issued a [letter of support](#) when the legislation was introduced. On July 15, the three chairs of the GOP and Democratic Doctors Caucuses introduced the “Patients First Act” (H.R. 9693), comprehensive, bipartisan, [AMA-supported](#) MACRA reform legislation that includes an inflation-based update tied to MEI, budget neutrality reform, a MIPS replacement, APM reforms, and a new primary care payment pilot that would not impact budget neutrality. The AMA continues to lead Federation efforts to progress these legislative vehicles and enact meaningful, permanent Medicare payment reform for physicians. Strengthening Medicare reimbursement is critical to ensuring continued Medicare beneficiary access to a range of providers that appropriately manage patients’ physical and mental health and keep them out of EDs, as well as solidify a critical revenue stream for hospitals and EDs that ensures they retain the necessary resources to staff at appropriate levels, invest in technologies that can improve the speed and efficiency of billing and care delivery functions, and ensure facilities are up to date and have capacity to meet their patient needs, all of which help to avoid ED boarding issues for Medicare patients, which is particularly important as older patients tend to stay in the ED longer.

- Affordable Care Act Exchange Coverage: The AMA provided comprehensive [comments](#) on recent proposed changes to ACA marketplace coverage for plan year 2027 emphasizing the importance of maintaining coverage that is not only affordable, but comprehensive, particularly for older and medically complex Americans. We encouraged strong guardrails to preserve meaningful coverage, maintain patient access to care, stabilize risk pools and markets, and lower patient out of pocket costs. We also asked HHS to reconsider several changes including expanding catastrophic coverage and non-network plans as qualified health plans. In response to our advocacy, CMS reversed a proposal to revise the minimum percentage of essential community providers. In separate comments in response to a CMS RFI on essential health benefits (EHBs), the AMA [cautioned strongly](#) against changes that could increase patient costs and decrease patient access to care, pointing to the fact that comprehensive EHB requirements are critical to ensuring patient access to a range of services, which can lead to better maintenance of chronic conditions. Access to affordable, comprehensive coverage is directly tied to a patient’s ability to access preventive services, which reduces complications and preventable ED admissions, cutting down on ED crowding and boarding.
- Federal enforcement of *No Surprises Act* claims: The AMA continues to be vocal on the need to enforce *No Surprises Act* statutory timelines. This is critical for hospitals and physicians to avoid cash flow issues that can lead to under-resourcing and understaffing, which contribute to ED boarding. In April and May, the AMA led two sign-on efforts, [one letter](#) in support of the “No Surprises Act Enforcement Act,” which includes increased penalties for parties that fail to comply with such statutory timelines, and another [letter](#) alerting the administration to repeated acts of payer noncompliance with the law and urging increased federal enforcement including but not limited to penalties for payer noncompliance.
- Redesigning Primary Care RFI: As of the writing of this report, the AMA is drafting a response to an RFI on redesigning primary care as part of our comments in response to the 2027 Medicare Physician Fee Schedule proposed rule. The RFI reflects an important shift in CMS’ thinking about primary care payment signaling it may place greater emphasis on longitudinal patient outcomes, rather than reimbursement for discrete visits and services, which could improve patient access to a more robust fleet of preventive care and chronic disease management supports including those outside of discrete office visits. When patient care is

1 better managed, complications including ED admissions can be potentially avoided, reducing
2 strain on EDs which contributes to boarding.

3 4 Reforming Prior Authorization (PA)

5
6 PA requests can delay transfers to other external hospitals or facilities or inpatient units at the same
7 hospital, particularly psychiatric facilities. In addition, patients can arrive in the ED for tests or
8 treatments that they were waiting on from a non-emergency setting since there are fewer
9 requirements to obtain PAs for emergency services, which contributes to ED crowding and
10 boarding. The [results](#) of the most recent AMA PA physician survey released in May 2026 found
11 that 95 percent of physicians reported care delays, 22 percent reported that PA has led to a life-
12 threatening event or required intervention to prevent permanent impairment or damage, and 47
13 percent reported the PA process led to “immediate care/ER visits.”
14 H.R. 3514/S. 1816, the “Improving Seniors’ Timely Access to Care Act,” is legislation that would
15 standardize PA requirements and require greater transparency about utilization management usage
16 within the Medicare Advantage (MA) program. It has strong bipartisan support, passing out of the
17 House Energy and Commerce Subcommittee on Health and the full Ways and Means Committee in
18 June and July 2026. It was also added to a larger bill focused on health care transparency: H.R.
19 9393, “the Lower Costs, More Transparency Act,” which passed out of the full Ways and Means
20 Committee unanimously in July. The AMA sent a [letter](#) of support for H.R. 9393, which as of the
21 writing of this report, had nearly 300 cosponsors in the House and 70 cosponsors in the Senate and
22 is ripe for enactment either as a stand-alone bill or part of a larger healthcare package. AMA
23 President Willie Underwood III, MD, MSc, MPH also outlined AMA’s support for H.R. 9734, the
24 “Protecting Patients from Automated Denials Act” in a July 2026 [press release](#). This bipartisan
25 legislation would require MA plans that utilize augmented intelligence (AI) for PA decisions to
26 have an independent physician review the denial, as well as mandate MA plans to keep records to
27 facilitate HHS audits on the use of AI in PA.

28
29 As a result of sustained AMA advocacy over many years, CMS passed the landmark 2024
30 Interoperability and PA Final Rule, which among other provisions, requires affected health plans to
31 support electronic PA beginning January 1, 2027. In practical terms, the goal is that physicians
32 should be able to use their EHRs at the point-of-care to identify a plan’s documentation
33 requirements, submit PA requests, and receive decisions electronically. Following implementation
34 of this rule, the AMA audited PA plans’ compliance with the new public-reporting requirements
35 then summarized the findings in a [letter](#) to CMS identifying regulatory loopholes and
36 recommending ways to strengthen requirements. In response, in August 2026 CMS issued updated
37 [guidance](#) that strengthens enforcement of federal PA transparency requirements, addressing several
38 concerns raised by the AMA.

39
40 In the 2027 PFS proposed rule, CMS also proposes making its electronic PA measure optional,
41 delaying mandatory physician reporting until 2028. This proposal would reduce physician burden
42 and provide time for payers and EHR developers to demonstrate that their systems work before
43 physicians are held accountable.

44
45 In a separate February 2026 [letter](#), the AMA noted the importance of stakeholder input as the
46 National Standards Group continues discussions regarding technical standards, noting that the
47 industry remains at varying levels of FHIR readiness and alignment, and that additional time may
48 be needed.

49 In January 2026 [comments](#) responding to proposed 2027 changes to the MA program, the AMA
50 urged CMS to finalize PA protections that preserve continuity of care, while encouraging the

1 Agency to retain certain Utilization Management Committee requirements, including its ongoing
2 review and removal of unnecessary PA requirements. We also reiterated our [principles for PA](#)
3 [reform](#), including aligning MA with Medicare standards, and establishing clear oversight and
4 accountability mechanisms.

5
6 In a September 2025 [letter](#) to the Medicare Payment Advisory Commission (MedPAC), the AMA
7 highlighted the harms of unregulated AI automation and predictive tools in PA, and how it is
8 increasingly overriding clinical judgment and generating coverage denials.

9
10 In July 2025, the AMA wrote a [letter](#) to CMS expressing significant concerns with its Wasteful and
11 Inappropriate Service Reduction (WISeR) Model, a new voluntary model operating in six states
12 that expands pre-payment PA reviews to certain services in traditional Medicare for the first time,
13 leveraging AI and Machine Learning to expedite reviews. The AMA raised concerns over potential
14 care disruptions and patient harms, as well as administrative burdens on physicians, which could
15 exacerbate patient access issues. Since then, the AMA has been closely monitoring implementation
16 of the model and actively engaging CMS to try to secure robust guardrails on WISeR including
17 enhanced transparency, accountability, meaningful physician oversight, streamlined administrative
18 processes, patient access to timely care, and greater use of evidence-based clinical guidelines
19 consistent with AMA [policy](#) governing the use of AI in coverage determinations.

20
21 On June 9, 2026, the House Appropriations Committee unanimously adopted an amendment to the
22 FY 2027 Labor-HHS spending bill to block funding for the WISeR model. However, since
23 Congress is exceedingly likely to pass a temporary Continuing Resolution as opposed to a full
24 government appropriations bill by September 30th, the bill is unlikely to become law.

25
26 On July 16, 2026, the Senate separately voted 46–50 along party lines to block a Democratic-led
27 resolution to overturn the WISeR model. Of note, the resolution considered in the Senate is
28 completely separate from the actions taken by the House Appropriations Committee to defund the
29 WISeR Model. The Senate’s actions were an attempt to rescind the WISeR model via the
30 Congressional Review Act (CRA), which is a tool that allows federal lawmakers to vote on
31 “resolutions of disapproval” to overturn certain regulatory actions if reported to Congress. The
32 Government Accountability Office first had to issue a decision that the WISeR Model was, in fact,
33 a regulation that qualified for consideration under the CRA, [which it did on May 12](#). Once that
34 happens, Congress has 30 days to act. Since the resolution failed, and we are now beyond the 60-
35 day window, this effort to rescind the WISeR Model via the CRA is now considered “dead.”

36
37 Finally, the AMA is actively working to create technical standards to support electronic PA. In July
38 2026, we announced a new [initiative](#) to develop and deploy royalty free Systematized
39 Nomenclature of Medicine — Clinical Terms to Current Procedural Terminology (SNOMED CT-
40 to-CPT) maps specifically for PA. These maps will connect the clinical concepts documented in
41 EHRs using SNOMED CT with the CPT codes used to describe medical services, helping
42 physician and payer systems exchange information more accurately and efficiently. This work is
43 essential to ensuring that electronic PA reduces manual work, supports timely and consistent
44 decisions, and ultimately meets the needs of patients and physicians. Senior HHS leadership,
45 including CMS Administrator Mehmet C. Oz, MD, MBA has publicly recognized and supported
46 the AMA’s leadership in advancing these maps and broader PA reform.

47 Addressing the Negative Impacts of ED Boarding

48
49
50 ED boarding places sustained pressure on emergency physicians and other members of the care
51 team, compromising the care environment and the patient experience, and contributing to stress,

exhaustion and burnout. Since boarding causes longer wait times for initial assessments and leads to higher complications and poorer outcomes, this can translate to worse community health. The AMA advocates for policies that address the broader workforce consequences of prolonged operational strain caused in part by ED boarding to help reverse some of the effects, such as increased staff turnover and accelerated decisions to reduce clinical hours or leave practice that in turn exacerbate staffing shortages, which inhibit patient access, leading to more ED crowding and boarding, creating a dangerous loop wherein stress and burnout contribute to staffing issues, which cause more backups leading to ED boarding, which further exacerbates staff stress, and so on.

In March 2026, the AMA signed onto two letters to the [House](#) and [Senate](#) in support of the Dr. Lorna Breen Health Care Provider Protection Act (“Lorna Breen Act”). Congress reauthorized the Lorna Breen Act through FY 2030 as part of the CAA, 2026 (P.L. 119-75).

In addition, the AMA established a successful [national campaign](#) to help states enact confidentiality laws that protect physicians seeking help for mental health concerns, burnout and fatigue, and to remove inappropriate, stigmatizing questions from physician licensure and renewal applications. The campaign also helps health systems and academic medical institutions remove or revise questions on credentialing and other applications that might discourage physicians, residents, and medical students from seeking needed mental health care.

ED boarding increases stress on patients and physicians alike and has been shown to contribute to increased incidents of violence against physicians and other hospital staff.¹⁰ Workplace violence against physicians and other healthcare workers has increased in recent years, further compounding the risks associated with crowded and strained care environments. According to a January 2024 poll of ACEP members, 91 percent of emergency physicians said that they or a colleague had been a victim of violence in the previous year. The AMA continues to support a multipronged, “all-hands-on-deck” [strategy](#) to prevent and respond to violence against physicians, including support for continued research, stronger prevention policies and investments in enhanced security for hospital staff.

In June 2026, the AMA Advocacy Resource Center (ARC) updated its [issue brief](#), “Campaign to Support Medical Student, Resident and Physician Health and Well-Being,” to reflect recent legislative and policy developments and to provide state medical associations with current resources for advancing these protections.

Together, these efforts reflect the AMA’s multifaceted approach to the consequences of ED boarding: advocating for system-level improvements that reduce operational strain while also protecting the safety, mental health and long-term sustainability of the physician workforce.

AMA Cross-Sector Collaboration

As the leading specialty organization for emergency physicians [representing](#) more than 38,000 emergency physicians, emergency medicine residents, and medical students, ACEP has been [leading](#) national efforts to address ED crowding and boarding for several decades. Over the last year, AMA staff members have proactively reached out to ACEP staff several times to directly inquire about their advocacy efforts to address ED boarding and lend our support. As the nation’s largest physician organization representing virtually all major medical specialties and subspecialties, the AMA recognizes that we lend an important amplifying voice to this conversation. We continue to believe that the most effective path forward for physicians on this matter is leadership by ACEP, AAEM, and other specialties with specialized expertise on this issue. We look forward to continued collaboration in this regard and welcome future initiatives

from interested parties focused on addressing and reducing patient boarding in EDs. In particular, we believe efforts by relevant specialties such as ACEP and AAEM to collect updated data on the state of ED boarding in this country could help to underscore the magnitude of this concern and be leveraged to draw attention from a press or public relations level, and garner momentum for action from federal and state policymakers. The AMA commits our full ongoing support and willingness to help amplify these efforts, including through our capacity to engage the Federation and present a unified physician voice to help highlight the importance of addressing and reducing patient boarding in EDs, recognizing its cross-sectional nature across the healthcare industry and its impact on various specialties. The AMA's ARC team also remains committed to collaborating closely with state and national specialty societies to pass proposed state laws and regulations that address the hospital ED boarding issue.

CONCLUSION

The AMA will continue to work with relevant specialties, state medical associations, and other interested parties leading on this issue to advance federal and state efforts to address the multi-faceted causes of ED boarding and mitigate its harmful impact on physicians and patients.

Specifically, the AMA continues its support of the ABC-ED Act and continues to weigh in on ED boarding quality measure development efforts in various CMS value-based reimbursement programs, the two paths currently most active at the federal policy level. The AMA also will continue our ongoing advocacy to address the many root causes contributing to ED boarding, including advocating to strengthen the physician workforce and improve the reliability of federal and other funding for EDs.

The AMA understands this issue intersects with many areas of our healthcare system, recognizes the implications of addressing ED boarding on patient safety and the functioning of our healthcare system, and remains committed to continuing our advocacy on this important issue.

We understand the Federation is interested in staying abreast of the AMA's efforts to advance advocacy to address ED boarding and recognizes that there are alternative methods of communicating progress on this topic that would allow for more timely, concise and strategic updates than a formal report, while allowing staff time to be redirected toward direct advocacy on this important issue.

The AMA believes that increased collaboration with and amplification of initiatives by relevant national and state medical societies represents the most effective opportunity to draw renewed attention to this national problem and reinvigorate federal policymaking efforts in the coming year.

RECOMMENDATIONS

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

1. That our AMA continue to support federal legislative efforts to address ED boarding.
2. That our AMA continue to comment on CMS quality measure development efforts related to ED boarding, to ensure hospital payments are tied to ED boarding performance while ensuring emergency physicians are not penalized for factors that are beyond their control.
3. That our AMA continue to seek out opportunities to advance our policy and reduce ED boarding at the federal and state levels as appropriate.

- 1 4. That our AMA continue our advocacy on the myriad, system-wide causes of ED boarding,
2 including but not limited to misaligned financial incentives for hospitals, workforce
3 constraints, prior authorization reform, and strengthening federal coverage for care and
4 physician reimbursement.
- 5 5. That our AMA continue our advocacy to address the negative impacts of ED boarding on
6 physicians, health systems, and patients.
- 7 6. That our AMA continue to support initiatives led by state and specialty medical
8 associations to advance action on ED boarding at the federal and state levels as
9 appropriate.
- 10 7. That our AMA communicate updates on the AMA's ED boarding advocacy efforts through
11 organizational communications channels such as the weekly Advocacy Update. (Directive
12 to Take Action)
- 13 8. That the sixth bullet of policy D-120.957 be rescinded as it has been accomplished by this
14 report."
15

Fiscal Note: Minimal

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REPORT 21 OF THE BOARD OF TRUSTEES (I-26)

Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2026 Annual Meeting, the American Medical Association House of Delegates referred the second resolve clause of Resolution 236-A-26, which called for the AMA Task Force to develop and maintain a centralized digital resource hub for gender-affirming care, modeled on the Reproductive Health Resource Navigator.

The Board of Trustees shares the significant concerns expressed by members of the House regarding the rapidly evolving legal and regulatory environment surrounding gender-affirming care and appreciates the desire for our AMA to play a leading role in providing practical resources to physicians. As state and federal laws, regulations, and litigation continue to evolve, physicians increasingly face uncertainty regarding their legal risk. The Board agrees that our AMA should continue to identify meaningful ways to support physician practices, protect the patient-physician relationship, and support access to medically necessary, evidence-based gender-affirming care. In June 2026, the Board extended the Task Force through the 2026 Interim Meeting, and the AMA is already implementing the broader directives adopted by the House.

At the same time, the Board notes that developing a comprehensive digital resource hub of the breadth envisioned in Resolution 236-A-26 would require careful assessment. The experience of developing the Reproductive Health Resource Navigator demonstrated that such a project requires substantial planning, coordination, legal review, technical infrastructure, governance, and long-term maintenance. Additionally, the landscape of comparable resources in the gender-affirming care space is more limited than in the reproductive health space.

The Board further recognizes that this work must proceed thoughtfully. In the current climate, organizations, physicians, and communities involved in supporting or providing gender-affirming care may face heightened legal, political, professional, or personal risk if publicly identified. Accordingly, any AMA effort to identify, compile, or direct physicians to resources must account for potential unintended consequences in a dynamic legal and enforcement environment.

To support an informed decision, the AMA has already begun evaluating the feasibility of such a resource and has engaged outside legal counsel to assess the legal implications of developing and maintaining a comprehensive hub. This due diligence will help inform the appropriate scope, governance, resource needs, and long-term sustainability of any future centralized platform.

Accordingly, the Board recommends that the AMA continue identifying existing resources and support development of additional resources, as appropriate, to help physicians navigate the legal, regulatory, and practice issues surrounding evidence-based gender-affirming care, while continuing to evaluate the feasibility and implications of a centralized digital resource hub. The Board will report back to the House of Delegates at the 2027 Interim Meeting.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 21-I-26

Subject: Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2026 Annual Meeting, the American Medical Association House of Delegates (HOD) referred the second resolve clause of Resolution 236-A-26, “Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care,” which asked:

RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a comprehensive, centralized digital resource hub—modeled on the Reproductive Health Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026 Interim Meeting, including but not limited to:

1. State-specific legal summaries and regulatory guidance;
2. Shield law analyses and cross-state practice considerations;
3. Privacy and HIPAA compliance best practices;
4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
5. Documentation and informed consent templates consistent with evolving legal standards;
6. Coding, billing, and reimbursement guidance;
7. Institutional policy templates and sample protocols;
8. Educational and training resources for undergraduate and graduate medical education;
9. Telehealth and interstate licensure guidance; and
10. Information regarding legal assistance and physician defense resources.

BACKGROUND

Following the Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization*, the HOD established the Task Force to Preserve the Patient-Physician Relationship (Task Force) to help guide organized medicine’s response to the rapidly evolving reproductive health landscape. The Task Force’s original charge focused primarily on issues arising from abortion bans and other restrictions on reproductive healthcare. At the 2023 Interim Meeting, however, the HOD adopted policy directing the Task Force to consider payment and reimbursement issues related to gender-affirming care. In response, the Task Force devoted a full in-person meeting to examine the payment and reimbursement challenges facing physicians who provide gender-affirming care. Consistent with its original charge, much of the Task Force’s work to date has focused on the impact of state abortion bans.

Over the course of its two-year charge, the Task Force undertook numerous initiatives to support physicians practicing in states with abortion restrictions, including development of a resource hub, strategy and messaging development, state law guidance, legal assistance for physicians,

institution-level guidance, collaboration with concerned prosecutors, and support for medical students and residents. The Task Force's work has been described in a series of informational reports to the HOD (available as Board of Trustees Reports 9-I-23, 21-I-24, 12-A-25, and 33-A-26). Among its major initiatives, the Task Force identified the need for a central repository of legal and practice resources for physicians navigating abortion bans and oversaw the development of the Reproductive Health Resource Navigator (available at www.rhrnavigator.org). The Reproductive Health Resource Navigator required extensive planning, collaboration across multiple AMA departments and external vendors, and significant organizational resources to develop and launch, and it has become an important resource in the reproductive health space. Further, the experience gained through developing the Reproductive Health Resource Navigator provided valuable insight into the substantial planning, governance, legal review, technological infrastructure, and long-term maintenance required to create and sustain a centralized resource of this nature.

As the Task Force concluded the work for its initial charge, it developed recommendations for the Board of Trustees (the Board) regarding future AMA activities to support physicians practicing in evolving legal and regulatory environments. The Board has received those recommendations and is considering possible actions. Additionally, in June 2026, the Board extended the Task Force until the 2026 Interim Meeting. Similarly, new policy adopted at the 2026 Annual Meeting directed the AMA to extend and expand the work of the Task Force to focus on gender-affirming care.

AMA POLICY

Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA HOD. Policy G-605.009 instructs that:

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
 - a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
 - b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
 - c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
 - d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.

- 1 e. Patient triage and care coordination, including identifying and publicizing
2 resources for physicians and patients to connect with referrals, practical support,
3 and legal assistance.
- 4 f. Coordinating implementation of pertinent AMA policies, including any actions to
5 protect against civil, criminal, and professional liability and retaliation, including
6 criminalizing and penalizing physicians for referring patients to the care they need.
- 7 g. Anticipation and preparation, including assessing information and resource gaps
8 and creating a blueprint for preventing or mitigating bans on other appropriate
9 health care, such as gender affirming care, contraceptive care, sterilization,
10 infertility care, and management of ectopic pregnancy and spontaneous pregnancy
11 loss and pregnancy complications.
- 12 h. Work with interested parties to encourage the development of institution-level
13 guidance and protection for physicians practicing in states with restrictions
14 potentially interfering with the patient-physician relationship.
- 15 3. Our American Medical Association will appoint an ad hoc committee or task force,
16 composed of physicians from specialties who routinely provide gender-affirming care,
17 payers, community advocates, and state Medicaid directors and/or insurance
18 commissioners, to identify issues with physician payment and reimbursement for gender-
19 affirming care and recommend solutions to address these barriers to care.

20
21 At the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, “Accountability for
22 G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force
23 Update and Guidance,” which states:

- 24
25 1. Our American Medical Association’s Task Force, to Preserve the Patient-Physician
26 Relationship, will present annual updates on their findings at AMA Annual Meetings until
27 the objectives have been completed.

28
29 Adopted as policy at the AMA’s Annual Meeting of the HOD in June 2026, Policy D-605.981,
30 “Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to
31 Ensure Access and Regulatory Clarity in Gender-Affirming Care,” states that:

- 32
33 1. Our American Medical Association extend and expand the work of the Task Force to
34 Preserve the Patient-Physician Relationship When Evidence- Based, Appropriate Care Is
35 Banned or Restricted to include a formalized and sustained focus on legislative and
36 regulatory actions to protect access to and education in gender-affirming care.
- 37 2. Our AMA strengthen its advocacy efforts at the federal and state levels to oppose
38 criminalization and punitive actions against physicians providing evidence-based gender-
39 affirming care and to support legal protections safeguarding the patient physician
40 relationship, with guidance by the Task Force.
- 41 3. Our AMA identify gaps in information and resources and develop a comprehensive
42 advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe,
43 evidence-based, and medically appropriate health care.
- 44 4. Our AMA report annually to the HOD regarding progress on these deliverables, including
45 metrics on resource utilization, physician engagement, and identified advocacy outcomes.

46
47 AMA Policy D-5.995, “Protecting Access to Emergency Abortion Care Under EMTALA,” states
48 that:

- 49 1. Our AMA will advocate for the reinstatement of federal guidance affirming hospitals’
50 obligation under EMTALA to provide necessary emergency pregnancy care, including, but
51 not limited to, abortion care, to stabilize patients irrespective of state-level abortion

- 1 restrictions. Our AMA will collaborate with relevant stakeholders, including federal
2 agencies, Congress, medical societies, and patient advocacy groups, to educate
3 policymakers and healthcare providers on EMTALA obligations concerning emergency
4 pregnancy care, including, but not limited to, necessary abortion care.
- 5 2. Our AMA task force established under AMA Policy G-605.009, "Establishing A Task
6 Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate
7 Care Is Banned or Restricted," will provide ongoing recommendations and updates on
8 navigating conflicting state and federal regulations on emergency pregnancy care.

9
10 AMA Policy H-185.927, "Clarification of Evidence-Based Gender-Affirming Care," states that:
11

- 12 1. Our American Medical Association recognizes that medical and surgical treatments for
13 gender dysphoria and gender incongruence, as determined by shared decision making
14 between the patient and physician, are medically necessary as outlined by generally-
15 accepted standards of medical and surgical practice.
- 16 2. Our AMA will work with state and specialty societies and other interested stakeholders to:
17 advocate for federal, state, and local laws and policies to protect access to evidence-based
18 care for gender dysphoria and gender incongruence; oppose laws and policies that
19 criminalize, prohibit or otherwise impede the provision of evidence-based, gender-
20 affirming care, including laws and policies that penalize parents and guardians who support
21 minors seeking and/or receiving gender-affirming care; support protections against
22 violence and criminal, civil, and professional liability for physicians and institutions that
23 provide evidence-based, gender affirming care and patients who seek and/or receive such
24 care, as well as their parents and guardians; and communicate with stakeholders and
25 regulatory bodies about the importance of gender-affirming care for patients with gender
26 dysphoria and gender incongruence.
- 27 3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care
28 by health insurance providers, including public and private insurers.

29
30 AMA Policy H-185.905, "Advocating for the Informed Consent for Access to Transgender
31 Health," states that:
32

- 33 1. Our American Medical Association unambiguously supports access to and insurance
34 coverage of medically necessary gender-affirming care but does not identify a preferred
35 model of care for determining medical necessity. The AMA vigorously advocates for
36 equitable payment policies, relying on the evidence-based professional guidelines and
37 recommendations set by professional medical associations, as well as individual physician
38 clinical judgment, on questions of appropriate clinical criteria.

39
40 AMA Policy D-275.942, "Ensuring Equitable and Timely Medical Licensure for Physicians
41 Providing Abortion and Gender-Affirming Care," states that:
42

- 43 1. Our American Medical Association advocates that no physician be disqualified from
44 medical licensure or subject to unnecessary delay in the licensure process solely due to
45 having provided abortion care or gender-affirming care in accordance with then-current
46 standards of medical practice and/or while such care was legal in their jurisdiction.
- 47 2. Our AMA supports policies, legislation, and state medical society initiatives that prohibit
48 discrimination by state medical boards or licensing authorities against applicants based on
49 their provision of abortion or gender-affirming care.
- 50 3. Our AMA will work with relevant interested parties, including state medical boards and
51 specialty societies, to support the development of guidance ensuring that physicians

1 seeking licensure are evaluated in a timely manner, equitably and without bias relating to
2 reproductive or gender-affirming.

3
4 AMA Policy H-295.847, “Increasing Access to Gender-Affirming Care Through Expanded
5 Training and Equitable Coverage,” states that:

- 6
7 1. Our American Medical Association will advocate for expanded structured training for
8 gender-affirming procedures by working with relevant stakeholders including but not
9 limited to the Accreditation Council for Graduate Medical Education.

10
11 AMA Policy H-140.824, “Healthcare Equity Through Informed Consent and a Collaborative
12 Healthcare Model for the Gender Diverse Population,” states that:

- 13
14 1. Our American Medical Association supports shared decision making between gender
15 diverse individuals, their health care team, and, where applicable, their families and
16 caregivers.
17 2. Our AMA supports treatment models for gender diverse people that promotes informed
18 consent, personal autonomy, increased access for gender affirming treatments and
19 eliminates unnecessary third party involvement outside of the physician-patient
20 relationship in the decision making process.

21
22 AMA Policy H-185.950, “Removing Financial Barriers to Care for Transgender Patients,” states
23 that:

- 24
25 1. Our American Medical Association supports public and private health insurance coverage
26 for evidence-based gender-affirming care as recommended by the patient's physician.

27
28 DISCUSSION

29
30 The Board shares the significant concerns expressed by members of the HOD regarding the rapidly
31 evolving legal and regulatory environment surrounding gender-affirming care and appreciates the
32 desire for our AMA to play a leading role in providing practical resources to physicians. As state
33 and federal laws and litigation continue to evolve, physicians increasingly face uncertainty
34 regarding their legal risk. The Board agrees that our AMA should continue to identify meaningful
35 ways to support physician practices in this increasingly complex environment.

36
37 The HOD has already adopted four of the five directives in Resolution 236-A-26 as Policy
38 D-605.981, and the AMA is actively implementing them. In particular, AMA policy now directs
39 the AMA to extend and expand the work of the Task Force to include a formalized and sustained
40 focus on legislative and regulatory actions; strengthen federal and state advocacy efforts to oppose
41 criminalization and punitive actions against physicians providing evidence-based care and to
42 support legal protections safeguarding the patient-physician relationship; identify gaps in
43 information and resources and develop a comprehensive advocacy and policy blueprint to ensure
44 the provision of safe, evidence-based, and medically appropriate healthcare; and report annually to
45 the HOD regarding progress on these deliverables, including metrics on resource utilization,
46 physician engagement, and identified advocacy outcomes. The Board supports these directives, is
47 actively implementing them, and views them as the operating framework for the AMA’s ongoing
48 work in this area. Progress for each will be reported to the HOD annually, as part of the charge
49 from the fourth resolve clause.

1 The Board also notes that, as part of its charge, the Task Force has submitted recommendations to
2 the Board regarding future AMA activities in this area. The Board is currently considering those
3 recommendations. Because the issues raised by Resolution 236 intersect directly with those
4 recommendations, the Board is considering them together so that the AMA's response is coherent
5 and durable, rather than fragmented. Should any actions be taken before the Interim Meeting, the
6 Board will provide the HOD with an update. Looking ahead, and as appropriate following further
7 assessment, the extended Task Force will address these additional charges, and the Board looks
8 forward to reporting on that work to the HOD.

9
10 The Board is committed to exploring how our AMA can best support physicians navigating
11 challenges related to gender-affirming care and the patient-physician relationship. The work
12 remaining, pending further assessment, is to define the scope, structure, implementation, and long-
13 term maintenance of a resource of this breadth, so that any resource the AMA launches is accurate,
14 sustainable, and genuinely useful to physicians.

15
16 The Board also recognizes the value of identifying resources that may already exist that could help
17 inform or support physicians navigating the legal, regulatory, and practice issues related to gender-
18 affirming care. AMA staff have been monitoring and identifying potentially responsive resources
19 since the inception of the Task Force. That work has included ongoing assessment of the legal,
20 policy, practice, educational, and advocacy landscape to better understand where useful materials
21 may already exist and where substantial gaps remain. As the legal landscape evolves and the
22 associated risks become better understood, AMA staff will continue to identify existing resources
23 to support physicians navigating this environment.

24
25 While some general legal, policy, clinical, educational, and practice resources exist, few—if any—
26 are specifically tailored to the provision of care in the manner contemplated by this resolution.
27 Unlike the reproductive health space, where a more developed ecosystem of practice support and
28 legal navigation resources has emerged in response to rapidly changing abortion laws, comparable
29 resources for gender-affirming care remain limited. This underscores the challenge to determine
30 what information can appropriately, safely, and sustainably be identified, maintained, and made
31 available.

32
33 The resource envisioned by the resolution would encompass numerous complex subject areas—
34 including state-specific legal summaries, regulatory guidance, privacy considerations, liability
35 issues, institutional policies, educational resources, reimbursement information, and physician
36 support resources—many of which, as noted above, do not currently exist in publicly accessible
37 forums. Developing and maintaining such content would require substantial legal, policy,
38 operational, and technical expertise, and ongoing processes to ensure that information
39 remains accurate as laws, regulations, and litigation evolve.

40
41 The Board also notes that the Reproductive Health Resource Navigator, which serves as the
42 model identified in the resolution, required extensive planning, cross-departmental collaboration,
43 external expertise, vendor contracting, and significant time to develop. Establishing a comparable
44 resource for gender-affirming care would similarly require careful assessment of staffing,
45 technological needs, financial resources, governance, long-term maintenance, and sustainable
46 processes for keeping content current. In addition, the AMA must conduct appropriate
47 due diligence regarding the feasibility of the project, the resources required to develop and sustain
48 it, and the legal and operational considerations associated with creating and maintaining content of
49 this nature.

The Board further believes that any effort to identify, compile, or direct physicians to responsive resources must be undertaken with caution. In the current environment, organizations, physicians, other individuals, and communities involved in supporting or providing gender-affirming care—including LGBTQ populations—may face heightened legal, political, professional, or personal risk when publicly identified or highlighted. Accordingly, the AMA must carefully consider whether and how referencing particular entities, individuals, or resources could inadvertently increase scrutiny or expose them to harm.

These concerns arise within a broader legal, regulatory, and enforcement environment that remains highly dynamic. Organizations involved in developing, disseminating, or supporting clinical resources related to gender-affirming care have increasingly become the subject of governmental investigations, subpoenas, litigation, and other forms of legal scrutiny. At the same time, the legal landscape continues to change through executive actions and court decisions. Our AMA can develop resources to support physicians in this environment; however, these considerations shape how that could be done: they require the AMA to evaluate and appropriately manage the legal, operational, and organizational issues associated with building and maintaining such a resource.

The AMA has already begun this evaluation. As part of its due diligence, the AMA has engaged outside legal counsel to assess the legal considerations associated with developing and maintaining a comprehensive resource of this nature. That assessment will help inform the Board's evaluation of the resource's feasibility, appropriate scope, governance, and long-term sustainability.

RECOMMENDATION

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

That our American Medical Association continue to identify existing resources and support the development of additional resources, as appropriate, to assist physicians in navigating the legal, regulatory, and practice issues surrounding the provision of evidence-based gender-affirming care, while evaluating the feasibility, scope, governance, resource requirements, and legal and operational considerations associated with developing and maintaining a centralized digital resource hub, and report back to the House of Delegates at the 2027 Interim Meeting. (New HOD Policy)

Fiscal Note: Minimal.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-26)

Introduced by: American Association of Clinical Urologists, Utah, Resident and Fellow
Section

Subject: Artificial Intelligence Having Prescriptive Authority

Referred to: Reference Committee B

1 Whereas, Utah is the first state to allow patients to renew their medications online through a
2 commercial Artificial Intelligence (AI) platform without needing a physician or other health care
3 professional's prescription; and
4

5 Whereas, Utah has partnered with *Doctronic* for this pilot program which started December
6 2025; and
7

8 Whereas, the pilot allows 30-, 60-, and 90-day refills for 190 commonly prescribed drugs; and
9

10 Whereas, currently the program only covers refills, initial prescriptions still require a physician or
11 health care professional's authorization; and
12

13 Whereas, delegating prescriptive authority to AI presents new concerns for patient safety and
14 harm; therefore be it
15

16 RESOLVED, that our American Medical Association oppose the use of Artificial Intelligence (AI)
17 without a physician or other health care professional's direct supervision to prescribe either new
18 or refill prescriptions (New HOD Policy); and be it further
19

20 RESOLVED, that our AMA develops model state legislation regulating AI prescriptive authority
21 so that both new and refill prescriptions are under the direct supervision and control of a
22 physician or other licensed healthcare professional. (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 8/24/26

References

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2. [Artificial intelligence begins prescribing medications in Utah - POLITICO](#)
3. [NEWS RELEASE: Utah and Doctronic Announce Groundbreaking Partnership for AI Prescription Medication Renewals - commerce.utah.gov](#)

RELEVANT AMA POLICY

Prohibiting the Independent Practice of Medicine by Artificial Intelligence D-480.947

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-26)

Introduced by: Medical Student Section, American Association of Public Health Physicians,
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island,
Vermont

Subject: Rapid Response Framework for Unsupported Medical Claims by Public
Officials

Referred to: Reference Committee B

Whereas, public statements by elected or appointed government officials regarding medical or public health matters can significantly influence patient behavior, health care decision-making, and public trust in scientific institutions^{1,2}; and

Whereas, dissemination of medical claims that are inconsistent with established scientific evidence may contribute to confusion, erosion of public trust, and increased burden on physicians to address misinformation during clinical encounters^{3,4}; and

Whereas, research in risk and health communication demonstrates that transparent acknowledgment of uncertainty and alignment with scientific evidence can strengthen public trust, even when recommendations evolve over time⁵⁻⁹; and

Whereas, while existing AMA policy supports the dissemination of accurate medical and public health information and urges organizations publicizing health guidelines to include supporting evidence, none of these policies establish a defined, transparent, or time-bound process by which the AMA itself evaluates and publicly responds to government officials' medical or public health claims that conflict with established scientific consensus or misrepresent the strength or certainty of available evidence^{10,11,12}; therefore be it

RESOLVED, that our American Medical Association study and develop a transparent, time-bound evidence review and response framework for evaluating and publicly responding to medical or public health claims made by elected or appointed government officials outside formal regulatory rulemaking that materially conflict with established scientific consensus or misrepresent the strength or certainty of available evidence, including consideration of: criteria for identifying high-impact claims warranting review, the responsible organizational entity, and associated timelines and processes for evidence assessment and public communication.
(Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Date Received: 9/3/26

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10. American Medical Association. D-440.915 Medical and Public Health Misinformation Online
11. American Medical Association. Policy H-373.995 Government Interference in Patient Counseling
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RELEVANT AMA POLICY**Evidence-Based Standard Requirement for Governmental Regulation H-270.956**

Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded.

[BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

Health Care Standards H-450.935

Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-governmental organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines.

[Res. 205, A-10; Reaffirmation I-10; Reaffirmed: Res. 105, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Set-Aside Federal Funding for Tribal Health Programs

Referred to: Reference Committee B

1 Whereas, The U.S. Indian Health Service (IHS) remains chronically underfunded relative to
2 demonstrated need, limiting access to comprehensive and culturally grounded medical and
3 behavioral health services¹; and
4

5 Whereas, federal health funding that is distributed primarily through state governments can limit
6 Tribal access to resources due to inconsistent consultation with tribal governments, differing
7 state priorities, and state legislatures who oppose tribal sovereignty and block the dispersion of
8 funding to tribal governments²⁻⁶; and
9

10 Whereas, the IHS, the U.S. Substance Abuse and Mental Health Services Administration
11 (SAMHSA), and other federal health agencies use set-aside funding, federal appropriations
12 reserved specifically for Tribal governments and Tribal health organizations within broader
13 federal grant programs, to advance American Indian and Alaska Native health and wellness,
14 ensuring that Tribal communities have dedicated access to funding without competing against
15 states and other municipalities²; and
16

17 Whereas, Tribal set-aside programs have demonstrated measurable success in improving
18 health outcomes through culturally tailored interventions, including the Special Diabetes
19 Program for Indians, which contributed to a 54% reduction in end-stage renal disease and an
20 84% reduction in hospitalizations for uncontrolled diabetes among AI/AN populations³; and
21

22 Whereas, Tribal set-asides in federal appropriations are inconsistently used due to the
23 discretionary nature of appropriations for the Indian Health Service, unlike other federal health
24 programs, including Medicare and Medicaid, which receive mandatory appropriations, leading to
25 uncertainty in long-term planning, staffing, and service delivery⁷; and
26

27 Whereas, transitioning the Indian Health Service and American Indian and Alaska Native health
28 programs administered by related federal agencies to mandatory appropriations is supported by
29 a majority consensus of tribal leaders and their health advocacy organizations, including the
30 National Congress of American Indians and the National Indian Health Board⁸⁻¹⁰; and
31

32 Whereas, adoption of new, specific, internal AMA advocacy targets will best position the AMA
33 Board of Trustees and staff to advocate for the unmet health needs of American Indian patients
34 and communities in concert with guidance provided by the AMA Advisory Committee on
35 American Indian Affairs^{4,11,12}; therefore be it
36

37 RESOLVED, that our American Medical Association supports dedicated set-aside
38 appropriations for American Indian, Native Hawaiian, and Alaska Native governments and their
39 associated healthcare entities that do not compete with states and other municipalities (New
40 HOD Policy); and be it further

- 1 RESOLVED, that our AMA supports that the Indian Health Service, the Native Hawaiian Health
2 Care Systems, and related federal agencies administering American Indian, Native Hawaiian,
3 and Alaska Native health programs be transitioned from discretionary to mandatory
4 appropriations. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Health Care Access for American Indians and Alaska Natives H-350.939

Our American Medical Association supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.(2)Our AMA supports collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement.(3)Our AMA encourages studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care.(4)Our AMA supports federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices.[Res. 242, A-24]

Indian Health Service H-350.977

The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends: Indian Population: (1)In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (a)Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (b)Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (c)Improvement in transportation to make access to existing private care easier for the American Indian population. (2)Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3)will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [Reaffirmed: CMS Rep. 03, A-24Reaffirmed: Res. 244, A-24Reaffirmed: BOT Rep. 31, A-24Modified: CMS Res. 305, A-24]

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987

Our American Medical Association will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers. (2) will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service. (3) adopts a new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction. (4)In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.[Res. 233, A-13Appended: Res. 229, A-14Appended: Res. 812, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Federal Framework for Social Media Access by Minors Under Age 16

Referred to: Reference Committee B

1 Whereas, social media use among American youth has reached epidemic proportions, with
2 approximately 95 percent of teenagers aged 13-17 reporting use of at least one social media
3 platform and more than one-third reporting using social media “almost constantly;” and
4

5 Whereas, the average American adolescent spends 4.8 hours per day on social media
6 platforms with some studies reporting even higher usage among girls and economically
7 disadvantaged youth; and
8

9 Whereas, children as young as eight and nine years old are accessing social media platforms
10 despite minimum age requirements of 13 and the majority of platforms employ algorithms
11 specifically designed to maximize engagement and time on app, often at the expense of user
12 wellbeing; and
13

14 Whereas, the United States Surgeon General issues an advisory in 2023 stating that social
15 media poses a “profound risk of harm” to the mental health and wellbeing of children and
16 adolescents and calling on Congress to enact age-appropriate health and safety standards; and
17

18 Whereas, multiple peer-reviewed studies have established statistically significant associations
19 between heavy social media use and increased rates of depression, anxiety, loneliness, and
20 suicidal ideation in adolescents, particularly among girls aged 10-14; and
21

22 Whereas, a 2022 study published in JAMA Psychiatry found that adolescents who spent more
23 than three hours per day on social media had double the risk of experiencing poor mental health
24 outcomes, including symptoms of depression and anxiety; and
25

26 Whereas, Dr. Jean Twenge’s longitudinal research published in Clinical Psychological Science
27 documented sharp increases in adolescent depression and loneliness beginning around 2012
28 and coinciding closely with widespread adoption of smartphones and social media; and
29

30 Whereas, social media platforms expose minors to cyberbullying, harassment, sexual predation,
31 and exploitation, the National Center for Missing and Exploited Children’s reported a 39 percent
32 increase in online enticement of children between 2020 and 2022; and
33

34 Whereas, the adolescent brain is neurologically immature, with the prefrontal cortex—
35 responsible for impulse control, risk assessment, and emotional regulation—not fully developed
36 until the mid-twenties, making children and teenagers particularly vulnerable to the addictive
37 design features and dopaminergic reward cycles embedded in social media platforms; and
38

39 Whereas, the American Psychological Association’s Health Advisory on Social Media Use in
40 Adolescence in 2023 concluded that adolescents who use social media frequently are more

likely to be exposed to potentially harmful content and to experience negative social comparisons that damage self-esteem and body image; and

Whereas, exposure to eating disorder content, self-harm imagery, and extremist ideologies on platforms such as Instagram, TikTok, and others had been documented to have direct, measurable, harmful effects on vulnerable youth; and

Whereas, internal documents from Meta disclosed through litigation and congressional testimony revealed that company researchers were aware of Instagram's harmful effects on teenage girls' body image and mental health as early as 2019 and suppressed findings rather than remediate product design; and

Whereas, despite voluntary self-regulatory commitments, social media companies have consistently failed to meaningfully enforce minimum age requirements, implement effective parental controls, or redesign algorithmic systems to reduce harm to minor users; and

Whereas, excessive social media use has been linked to disrupted sleep patterns, with a majority of teens reporting that they check their phones within the last hour before bedtime, resulting in reduced sleep quality and duration that impairs learning, memory consolidation, and emotional regulation; and

Whereas, the Children's Online Privacy Protection Act (COPPA), enacted in 1998 and last updated in 2013, has proven wholly inadequate to address the modern social media landscape and provides no meaningful health protections for minors aged 13-15; and

Whereas, Australia enacted the Online Safety Amendment (Social Media Minimum Age) Act in November 2024, establishing a minimum age of 16 for social media use—making it the first country in the world to impose such a restriction—with platforms subject to significant financial penalties for non-compliance; and

Whereas, Norway enacted legislation in 2021 requiring parental consent for children under 15 to create social media accounts and in 2024 proposed raising the minimum age to 15 without exceptions; and

Whereas, France passed a law in 2023 requiring parental consent for minors under 15 to access social media platforms with platforms required to obtain verifiable consent; and

Whereas, the United Kingdom's Online Safety Act of 2023 imposed strict duties of care on platforms likely to be accessed by children, requiring age verification and risk assessments to protect minors from harmful content; and

Whereas, the European Union's Digital Services Act of 2023 prohibits platforms from using personal data to serve targeted advertising to minors and requires enhanced protections for users under 18; and

Whereas, Florida, Texas, Arkansas, and Montana have passed state-level legislation restricting social media access for minors under 16, though these laws face ongoing legal challenges, underscoring the need for uniform federal legislation; and

Whereas, the American Academy of Pediatrics (AAP) has published clinical guidance recommending that pediatricians counsel families on the risks of social media and advise against unrestricted access for adolescents; and

Whereas, the AMA has historically played a decisive role in shaping public health policy on issues ranging from tobacco to seat belt safety to firearm violence, setting a clear precedent for legislative advocacy when the scientific evidence of harm to children is substantial; and

Whereas, pediatricians and child psychiatrists in clinical practice are witnessing firsthand an unprecedented surge in anxiety, depression, eating disorders, and self-harm in patients aged 10-17 with many physicians identifying heavy social media use as a significant contributing factor; therefore be it

RESOLVED, that our American Medical Association will call upon Congress and the President to enact federal legislation establishing a minimum age of 16 for independent social media account creation with limited supervised access permitted for younger minors only through verifiable parental consent and platform-implemented safeguards (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation requiring social media platforms to deploy privacy-preserving, minimally intrusive age assurance technologies consistent with applicable law, subject to Federal Trade Commission oversight and meaningful penalties for non-compliance (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage platforms to (a) disable addictive design features (infinite scroll, autoplay) by default for minors, (b) limit daily usage, and (c) conduct transparent health impact assessments prior to algorithmic changes affecting youth (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for robust federal funding for longitudinal research into the effects of social media, including equity impacts on rural and underserved youth, to be administered through the National Institutes of Health and the Centers for Diseases Control and Prevention (Directive to Take Action); and be it further

RESOLVED, that our AMA support the development of clinical screening guidelines for harmful social media use and public education campaigns (New HOD Policy); and be it further

RESOLVED, that our AMA communicate its positions to the U.S. Congress, the White House Office of Science and Technology Policy, the Federal Trade Commission, the Federal Communications Commission, and all relevant state medical associations with policy reassessment required after five years based on outcomes data. (Directive to take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 8/19/26

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RELEVANT AMA POLICY

Teens and Social Media H-478.976

1. Our American Medical Association will study and make recommendations for teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting.
2. Our American Medical Association urges physicians to:
 - a. educate themselves about social media;
 - b. be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and
 - c. consider expanding clinical interviews to inquire about social media use.
3. Our AMA encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health.
4. Our AMA supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media.
5. Our AMA recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment).
6. Our AMA supports legislative, regulatory, and associated initiatives that, at a minimum, provide youth with strong data privacy protections, require platforms to be designed to align with child development, and provide transparency into the potential harms posed by platforms to young people and any steps taken to mitigate those harms.
7. Our AMA will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment.

Citation: Res. 430, A-23; Appended: CSAPH Rep. 05, I-24

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965

1. Our American Medical Association will collaborate with relevant professional organizations to:
 - a. support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and
 - b. support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage.
2. Our AMA advocates for schools to provide safe and effective, evidence-based educational programs so that:
 - a. all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; and
 - b. all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media).
3. Our AMA affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions.

4. Our AMA advocates for and support media and social networking services addressing and developing safeguards tailored to youth users, including ensuring robust protections for youth online privacy, providing effective tools to manage screentime content and access, considering special circumstances for certain youth populations (such as LGBTQ+ youth and youth with disabilities), and promoting the development and dissemination of age-appropriate digital literacy training.
5. Our AMA advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.

Citation: Res. 905, I-17; Modified: Res. 420, A-21; Reaffirmed: A-23; Modified: CSAPH Rep. 05, I-24

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

1. Our American Medical Association recognizes the positive role of the Internet in providing health information to children and youth.
2. Our AMA recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
3. Our AMA supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
4. Our AMA encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
5. Our AMA supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
6. Our AMA actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Res. 926, I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs

Referred to: Reference Committee B

1 Whereas, health insurers, including Medicare Advantage organizations and commercial health
2 plans, increasingly attribute patients to physicians and physician practices for purposes of
3 quality measurement, star ratings, and value-based payment programs; and
4

5 Whereas, many attribution methodologies rely on administrative enrollment data, patient self-
6 selection, or claims algorithms that may assign patients to physicians with whom they have no
7 active clinical relationship; and
8

9 Whereas, physicians and practices are frequently held accountable for quality metrics,
10 preventive care measures, and performance ratings for patients who have never been seen in
11 their practice or who have not received care from the attributed physician during the
12 measurement period; and
13

14 Whereas, inaccurate patient attribution may negatively affect physician performance scores,
15 payer star ratings, public reporting metrics, and financial incentives tied to value-based care
16 programs; and
17

18 Whereas, physicians often face a significant administrative burden when attempting to correct
19 inaccurate patient attribution, and many health plans lack transparent processes, timely dispute
20 mechanisms, or clear criteria for removing patients who are incorrectly assigned; and
21

22 Whereas, inaccurate attribution increases administrative burden and diverts physician resources
23 from patient care; and
24

25 Whereas, inaccurate attribution undermines the integrity of quality measurement programs and
26 may misrepresent the quality of care delivered by physicians and physician practices; and
27

28 Whereas, accurate attribution should reflect a meaningful clinical relationship between a patient
29 and a physician, such as documented visits or a confirmed patient designation of a primary care
30 physician; therefore be it
31

32 RESOLVED, that our American Medical Association advocate for federal and state legislation
33 and regulation that ensures accurate patient attribution and prevent physicians from being
34 evaluated on patients with whom they have no established care relationship, including
35 enforcement mechanisms for payers who fail to maintain accurate attribution lists (Directive to
36 Take Action); and be it further
37

38 RESOLVED, that our AMA develop model state legislation and regulatory policy addressing
39 accurate patient attribution in health plan quality measurement and value-based payment

1 programs, based on the Universal Standards for Patient Attribution, with modular components
2 adaptable to varying state legislative and regulatory environments (Directive to Take Action);
3 and be it further
4

5 RESOLVED, that our AMA adopt as policy the following Universal Standards for Patient
6 Attribution:

- 7 1. Clinical Relationship: Attribution must be based on a documented clinical relationship,
8 defined by recent clinical encounter(s) within an appropriate timeframe or a verified
9 patient designation of the physician as their primary care provider (PCP);
- 10 2. Prospective Notification: Payers must provide physicians with an option for retrospective
11 or prospective attribution methodology and, if opting for prospective attribution, they
12 should provide physicians with a list of attributed patients at least 30 days before the
13 start of a measurement period;
- 14 3. Transparency: Payers must disclose the attribution algorithms, claims thresholds, and
15 patient designation processes used to assign patients to physicians;
- 16 4. Mandatory Exclusion: Patients subject to an active attribution dispute must be excluded
17 from all quality scoring and financial performance calculations until the dispute is
18 resolved;
- 19 5. Dispute Resolution: Payers must provide a standardized, timely mechanism for
20 physicians to correct or suppress inaccurate attributions, with a determination required
21 within 30 days of submission;

22 (New HOD Policy); and be it further
23

24 RESOLVED, that our AMA Board of Trustees report back at the 2027 Annual Meeting with
25 recommendations to align and consolidate existing AMA policies related to patient attribution to
26 ensure a streamlined advocacy strategy. (Directive to take Action)
27

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 8/19/26

RELEVANT AMA POLICY

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance;
 - b. Develop IT systems that support and streamline clinical participation;
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:

- a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
 - c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
- a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
 - b. Distinguish between services ordered by a physician and those delivered by a physician;
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
- a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.
- Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
 - a. Promote improved patient access to high-quality, cost-effective care.
 - b. Be designed with input from the physician community.
 - c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
 - d. Not require budget neutrality within Medicare Part B.
 - e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
 - f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
 - g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
 - h. Use adequate risk adjustment methodologies.
 - i. Incorporate incentives large enough to merit additional investments by physicians.
 - j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
 - k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
 - l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
 - m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmed: A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmed: I-15; Reaffirmed: A-16; Reaffirmed in lieu of Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmed: A-19; Reaffirmed: BOT Action in response to referred for decision: Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision: Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmed: A-22; Modified: CMS Rep. 04, A-23; Reaffirmed: Res. 214; A-23; Reaffirmed in lieu of Res. 225, A-25; Reaffirmed: Res. 226, A-25

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

Citation: BOT Rep. 6, A-15; Reaffirmed: I-18; Reaffirmed: CSAPH Rep. 2, I-19

Work of the Task Force on the Release of Physician Data H-406.990

Release of Claims and Payment Data from Governmental Programs

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they

have provided;

3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
 4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
 5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
 6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
 - (a) the publication or release of this information is deemed imperative to safeguard the public welfare;
 - (b) the raw data regarding physician claims from governmental healthcare programs is:
 - (i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
 - (ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
 - (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
 - (i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
 - (ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
 - (iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
 - (d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.
- Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19

Work of the Task Force on the Release of Physician Data H-406.991

Principles for the Public Release and Accurate Use of Physician Data

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:

1. Patient Privacy Safeguards

- All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
- Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).

2. Data Accuracy and Security Safeguards

- Effective safeguards are established to protect against the dissemination of inconsistent, incomplete,

invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).

- Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).

- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).

3. Transparency Requirements

- When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).

- The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).

- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).

- Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).

4. Review and Appeal Requirements

- Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).

- When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).

5. Physician Profiling Requirements

- The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).

- Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (H-450.951).

- When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used.

- Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services.

- Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes.

6. Quality Measurement Requirements

- The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).

- Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).

- These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data.

7. Patient Satisfaction Measurement Requirements

- Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).

- Because of the difficulty in determining whether responses to patient satisfaction surveys are a

result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms.

- As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication.

Citation: BOT Rep. 19, A-09; Reaffirmed: A-10; Reaffirmed: BOT action in response to referred for decision: Res. 709, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed: I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of res. 824, I-10; Reaffirmed: A-11; Reaffirmed: BOT Rep. 17, A-13; Reaffirmed: Res. 806, I-13; Reaffirmed: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-26)

Introduced by: Kansas

Subject: Third-Party Litigation Funding in Medical Liability Claims

Referred to: Reference Committee B

1 Whereas, a fair, transparent, and stable medical liability system is essential to preserving
2 patient access to physicians and a full range of health care services; and
3

4 Whereas, third-party litigation funding provides money for litigation fees, costs, or expenses in
5 exchange for repayment or other consideration contingent on the outcome, giving a funder a
6 financial interest in litigation that may be unknown to the court, parties, and insurers; and
7

8 Whereas, North Carolina's 2026 Prohibit Litigation Investments Act prohibits outcome-
9 contingent litigation investment while preserving traditional contingency-fee representation,
10 attorney advancement of litigation costs, insurer defense and indemnity obligations, qualifying
11 nonprofit legal services, personal and household support not used for litigation expenses,
12 immediate-family support, and financing not contingent on the outcome; and
13

14 Whereas, Montana and Wisconsin require disclosure of litigation funding agreements without
15 awaiting a discovery request, and Montana requires continuing disclosure to the court, parties,
16 and known insurers and prohibits funder influence over litigation strategy, expert selection, and
17 settlement decisions; and
18

19 Whereas, AMA policies D-435.996 and H-265.994 support effective medical liability reform and
20 oppose contingent fees for medicolegal consulting firms, respectively, but do not establish policy
21 governing third-party litigation funding in medical liability claims; therefore be it
22

23 RESOLVED, that our American Medical Association support state legislation prohibiting
24 outcome-contingent third-party litigation funding for the fees, costs, or expenses of a pending or
25 potential medical liability claim or proceeding, while preserving traditional contingency-fee
26 representation, attorney advancement of litigation costs, contractual defense or indemnity
27 obligations, qualifying nonprofit legal services, personal and household support not used for
28 litigation expenses, immediate-family support, and financing not contingent on the outcome
29 (New HOD Policy); and be it further
30

31 RESOLVED, that our AMA support state laws requiring, in any medical liability claim or
32 proceeding involving third-party litigation funding, automatic and continuing disclosure without
33 awaiting a discovery request of the funding agreement and the identity of each funder and any
34 person or entity with a direct or indirect right to receive payment contingent on the outcome to
35 the court, all parties, and any known insurer with a duty to defend or indemnify, with appropriate
36 protection of attorney-client privilege and attorney work product (New HOD Policy); and be it
37 further
38

39 RESOLVED, that our AMA develop and advocate for model state legislation consistent with
40 these principles, including provisions prohibiting a litigation funder from controlling or influencing

1 litigation strategy, expert selection, or settlement decisions and providing effective enforcement
 2 through voiding prohibited agreements and authorizing civil remedies or penalties, to promote a
 3 fair, transparent, and stable medical liability environment for patients and physicians. (Directive
 4 to Take Action)
 5

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/11/26

REFERENCES

1. American Medical Association. *State Medical Liability Reform*. Updated January 23, 2026.
2. North Carolina Session Law 2026-14, House Bill 315, *Prohibit Litigation Investments Act*, N.C. Gen. Stat. §§ 66-511 through 66-515. Approved June 22, 2026.
3. Montana Code Annotated §§ 31-4-104 and 31-4-108 (2025).
4. Wisconsin Statutes § 804.01(2)(bg) (2025).
5. American Medical Association Policy D-435.996, Model State Legislation Incorporating Medical Malpractice Tort Reform.
6. American Medical Association Policy H-265.994, Expert Witness Testimony.

RELEVANT AMA POLICY

D-435.996, Model State Legislation Incorporating Medical Malpractice Tort Reform

Our American Medical Association will 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.
5. Expand circumstances where physicians are entitled to attorney fees.

[Res.205,I-25]

H-265.994, Expert Witness Testimony

(1) Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses.

(2) Our AMA is on record that it will not tolerate false testimony by physicians and will assist state, county and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority.

(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows:

(a) The AMA believes that the minimum statutory requirements for qualification as an expert witness in medical liability issues should reflect the following: (i) that the witness be required to have comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim; and (iv) that the witness be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or by a board with equivalent standards.

(b) The AMA opposes payment of contingent fees for all types of medicolegal consultations, including management services provided by firms engaged in locating physician consultants. Where necessary, the AMA supports state legislation making it illegal for medicolegal consulting firms to take a contingent fee in personal injury litigation. Such arrangements threaten the integrity and the compensation goals of the civil justice system. Like the individual expert witness, the role of the medicolegal consulting firm which locates

and supplies experts should be one of limited service to the judicial process. Contingent fee arrangements are plainly inconsistent with the scope of this responsibility.

(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which they testified for either plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony. [Sub. Res. 223, A-92; Appended: Sub. Res. 211, I-97; Reaffirmation A-99; Modified: BOT Rep. 8, I-04; Reaffirmed: Res. 2, I-05; Reaffirmed: BOT Rep. 10, A-15; Modified: Speakers Rep. 02, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-26)

Introduced by: Kentucky Delegation

Subject: Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety

Referred to: Reference Committee B

1 Whereas, interventional pain medicine is a physician specialty requiring completion of
2 medical school, residency, and a dedicated fellowship year devoted specifically to the diagnosis,
3 risk stratification, image-guided procedural technique, and longitudinal management of chronic
4 pain, training that no nonphysician pathway currently requires or replicates; and
5

6 Whereas, chronic interventional pain management is fundamentally distinct from
7 perioperative anesthesia-related pain care, and involves independent medical decision-making
8 including differential diagnosis, patient selection, procedural planning, interpretation of
9 advanced imaging, rehabilitation planning, complex medication management, and longitudinal
10 follow-up that exceeds the scope of nurse anesthesia training; and
11

12 Whereas, certified registered nurse anesthetists are trained in the management of acute,
13 procedural, and obstetric pain occurring in the intraoperative and immediate perioperative
14 period, a skill set that is valuable and appropriate within its intended context, but is categorically
15 distinct from, and does not include, the fellowship-level training required to independently
16 diagnose, select, and perform invasive image-guided procedures for the longitudinal
17 management of chronic pain; and
18

19 Whereas, interventional pain procedures are invasive, image-guided interventions
20 performed in close proximity to the spinal cord, nerve roots, and major vascular structures,
21 carrying serious risks including epidural hematoma, infection, nerve injury, and paralysis, and
22 demand the judgment and complication-management expertise obtained only through physician
23 residency and fellowship training; and
24

25 Whereas, certified registered nurse anesthetists (CRNAs) and other nonphysician
26 practitioners in Kentucky and surrounding states are increasingly establishing and operating so-
27 called "pain institutes" or freestanding pain clinics that independently diagnose, select, and
28 perform complex interventional pain procedures without onsite physician supervision, in direct
29 conflict with the training, credentialing, and safety standards required of physicians practicing in
30 this specialty; and
31

32 Whereas, this unsupervised expansion of practice creates a two-tiered system of pain care
33 in which patients may unknowingly receive physician-level diagnostic and procedural decisions
34 from practitioners who have not completed physician residency or pain medicine fellowship
35 training, thereby endangering patient safety and undermining public trust; and
36

37 Whereas, patients are frequently unable to determine, from clinic names, advertising, or

1 signage alone, whether the professional diagnosing their pain condition, recommending a
2 procedure, performing an invasive intervention, or managing their follow-up care is a physician,
3 and deserve clear and enforceable transparency in this regard; and
4

5 Whereas, physician-led, team-based care remains fundamental to the safe and effective
6 practice of interventional pain medicine, and this resolution affirms the valuable and appropriate
7 contributions of certified registered nurse anesthetists, physician assistants, nurse practitioners,
8 anesthesia assistants, and other nonphysician clinicians when practicing within, and under the
9 active supervision of, a physician-led team; and
10

11 Whereas, payer, credentialing, and institutional policies too often fail to reflect meaningful
12 differences in education, training, and demonstrated competency between physicians and
13 nonphysician practitioners, resulting in reimbursement, privileging, and authorization structures
14 that incentivize and enable unsupervised nonphysician practice in interventional pain medicine;
15 and
16

17 Whereas, the unchecked proliferation of nonphysician-operated pain institutes, if left
18 unaddressed by statute, regulation, and payer policy, threatens to establish independent
19 nonphysician scope of practice in chronic pain management as a de facto standard, to the
20 detriment of patients across the Commonwealth; therefore be it
21

22 RESOLVED, that our American Medical Association oppose the independent, unsupervised
23 establishment and operation of pain clinics, pain institutes, or similar practices by certified
24 registered nurse anesthetists or other nonphysician clinicians, and oppose any expansion of
25 scope of practice permitting the independent performance of complex interventional pain
26 procedures absent active, onsite physician supervision (New HOD Policy); and be it further
27

28 RESOLVED, that our AMA call upon relevant regulatory bodies to investigate pain practices
29 reasonably suspected of operating outside applicable licensure scope-of-practice, or physician-
30 oversight requirements and to enforce, where applicable, the physician ownership, on-site
31 physician (Directive to Take Action); and be it further
32

33 RESOLVED, that our AMA advocate for enforceable transparency standards in advertising,
34 clinic naming, informed consent, and other patient-facing communications that clearly identify
35 the credentials and roles of the clinicians responsible for diagnosis, procedural selection,
36 procedural performance, and longitudinal management. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

RELEVANT AMA POLICY

Pain Management H-410.950

Our American Medical Association adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

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

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

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

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

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

Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers H-410.958

1. Our American Medical Association encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that **interventional pain** management of patients suffering from chronic **pain** constitutes the practice of **medicine**.
2. Our AMA will work to ensure that **interventional pain** management is the practice of **medicine** and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in **pain** management and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in **pain** management.

Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy D-35.984

1. Our American Medical Association will
 - a. advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians.
 - b. develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.
2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.

Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings H-405.967

The AMA opposes US West Yellow Pages or any other corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory.

Clarification of Healthcare Physician Identification: Consumer Truth & Transparency D-405.974

1. Our American Medical Association will advocate for legislation that would establish clear legal definitions for use of words or terms "physician," "surgeon," "medical doctor," "doctor of osteopathy," "M.D.," "D.O.," or any other allopathic or osteopathic medical specialist.
2. Our AMA will advocate for "Truth & Transparency" legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and board licensure in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. -ologist) that can mislead the public.

Definition and Use of the Term Physician H-405.951

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-26)

Introduced by: American College of Surgeons

Subject: Facilitating Short-Term Supervised Clinical Training for International Physicians

Referred to: Reference Committee B

1 Whereas, surgeons from low- and middle-income countries frequently seek short-term,
2 procedure-specific training in areas such as trauma systems, minimally invasive surgery,
3 oncology, transplantation, endoscopy, and critical care that cannot feasibly be obtained through
4 multi-year residency or fellowship programs in their home countries; and
5

6 Whereas, current U.S. visa regulations limit such exchanges to observation without supervised
7 participation in clinical care, which is not sufficient to train surgeons hoping to return to their
8 home country with new skills to treat local populations; and
9

10 Whereas, AMA Policy H-255.989 supports exchange visitor physician programs that permit
11 noncitizen physicians to participate in education, training, and research in the United States
12 followed by return to their home countries to improve health care delivery; and
13

14 Whereas, AMA Policy H-255.969 encourages physician preceptors, medical associations, and
15 medical organizations to establish observership programs utilizing the AMA International
16 Medical Graduate Observership Guidelines and Evaluation Tools; and
17

18 Whereas, AMA Opinion E-8.14 recognizes that ethical global health partnerships should foster
19 reciprocal learning, strengthen health systems, promote sustainable capacity building, and
20 benefit patients and physicians in both host and partner countries; and
21

22 Whereas, existing *Exchange Visitor Program* regulations governing physicians generally permit
23 graduate medical education under Educational Commission for Foreign Medical Graduates
24 (ECFMG) sponsorship or observation, consultation, teaching, and research activities, but
25 provide no practical mechanism for international physicians to participate in structured, short-
26 term supervised hands-on clinical training as continuing medical education (CME) outside
27 formal residency or fellowship programs¹; and
28

29 Whereas, academic medical centers, teaching hospitals, and specialty societies throughout the
30 United States maintain longstanding educational partnerships with physicians from around the
31 world and frequently receive requests for brief supervised procedural and clinical skills training
32 that cannot be accommodated under existing visa structures; and
33

34 Whereas, several states, including Tennessee and Ohio, have established limited licensure
35 pathways for the purpose of allowing international physicians to participate in short- term,
36 supervised, hands-on clinical training without meeting all requirements for unrestricted medical
37 licensures. Yet, existing federal immigration and exchange visitor requirements may prevent
38 otherwise eligible international physicians from entering the United States for the purpose of
39 participating in such clinical training; and

Whereas, time-limited supervised clinical training conducted under the direct supervision of licensed U.S. physicians, pursuant to a defined educational curriculum and without authorization for independent clinical practice, would promote ethical international collaboration, strengthen global health systems, and improve patient care while maintaining appropriate safeguards; therefore be it

RESOLVED, that our American Medical Association amend Policy H-255.989, Exchange Programs for Visitor Physicians, by adding the following new directive:

“3. Our AMA supports modifications to the federal Exchange Visitor Program regulations governing J-1 physicians to establish a short-term supervised clinical training category that would permit qualified international physicians to participate in structured educational clinical experiences at accredited U.S. teaching hospitals and medical schools without enrollment in an ACGME-accredited residency or fellowship program or completion of USMLEs, provided that such training:

- (a) is limited in duration and has an educational purpose;
 - (b) occurs pursuant to a structured curriculum established in advance that includes defined educational objectives, appropriate instruction and supervision, and a mechanism for evaluating whether those objectives have been achieved;
 - (c) is conducted under the direct supervision of appropriately licensed and certified U.S. physicians;
 - (d) complies with all applicable federal and state laws and institutional policies;
 - (e) does not authorize independent clinical practice or unrestricted patient care;
 - (f) is intended to facilitate the transfer of medical knowledge and procedural skills to improve health care delivery in participants' home countries;
 - (g) does not interfere with or diminish the clinical learning opportunities of residents, fellows, medical students, or other trainees at the hosting institution;
 - (h) does not substitute for physicians, residents, fellows, advanced practice professionals, or other health care professionals or personnel who would otherwise be employed or engaged to provide patient care, and is not used to address staffing shortages or increase the clinical or procedural capacity of the hosting institution or supervising physician;
 - (i) includes appropriate institutional oversight and safeguards to protect participating international physicians from exploitation and ensure that clinical activities are undertaken solely to advance the program's defined educational objectives”
- (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate before the U.S. Department of State, Department of Homeland Security, Educational Commission for Foreign Medical Graduates, and other appropriate federal agencies for modifications to the Exchange Visitor Program regulations consistent with this policy (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with specialty societies, academic medical centers, the ACGME, ECFMG, and other stakeholders to develop recommendations regarding appropriate program eligibility, supervision, duration, institutional sponsorship, patient safety safeguards, and educational standards for such a short-term clinical training category. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

REFERENCES

1. 22 CFR § 62.27, Exchange Visitor Program—Alien Physicians; see also 22 CFR Part 62. <https://www.ecfr.gov/current/title-22/chapter-I/subchapter-G/part-62/section-62.27>

RELEVANT AMA POLICY

H-255.989 Exchange Programs for Visitor Physicians

1. Our AMA supports non-citizen physicians participating in exchange visitor physician programs for purposes of education, training, and/or research followed by return to their home country. This is separate from the issues involving U.S. citizens who are graduates of foreign medical schools and non-citizen physician graduates of foreign medical schools who seek permanent residence in the U.S.
2. Our AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land.

H-255.969 Create Local Observership Programs

Our AMA encourages physician preceptors, medical associations, and medical organizations to establish local observership programs by utilizing the IMG Observership Guidelines and Evaluation Tools.

AMA Code of Medical Ethics Opinion 8.14 Short-Term Global Health Clinical Encounters

Short-term global health clinical encounters, which send physicians and physicians in training from wealthier communities to provide care in under-resourced settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such encounters also provide training and educational opportunities, they may offer benefit both to the host communities and the medical professionals and trainees who volunteer their time and clinical skills.

Short-term global health clinical encounters typically take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term global health clinical encounters requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term global health clinical encounters should ensure that the trips with which they are associated:

1. Focus prominently on promoting justice and sustainability by collaborating with the host community to define project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the visiting medical team or the sponsoring organization.

2. Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting participants, but also possible adverse effects the presence of participants could have for beneficial local practices and local practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.
3. Provide resources that help them become broadly knowledgeable about the communities in which they will work and to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the visiting medical team are expected to uphold the ethics standards of their profession and participants should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect that will have on the patient, the medical team, and the project overall, in keeping with ethics guidance on the exercise of conscience. Participants should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.
4. Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer guidance regarding the evaluation process of the experience, in an effort to enhance and improve the outcomes of future encounters.

Sponsors of short-term global health clinical encounters should:

5. Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and participants' personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.
6. Proactively define appropriate roles and permissible range of practice for members of the visiting medical team, so that they can provide safe, high-quality care in the host community. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable in their ordinary clinical practice, even if the host community's standards are more flexible or less rigorously enforced.
7. Ensure appropriate supervision of trainees, consistent with their training in their home communities, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in under-resourced settings.
8. Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-26)

Introduced by: American College of Preventive Medicine

Subject: Protecting GME Subject to Funding Uncertainty

Referred to: Reference Committee B

1 Whereas, Graduate Medical Education (GME) is essential to developing a physician workforce
2 capable of meeting the nation's current and future health care needs;¹ and
3

4 Whereas, Medicare is the single largest federal source of GME funding, providing over \$21
5 billion dollars of mandatory funding for physician training, but statutes define that reimbursement
6 for services tied to Medicare services, resident-to-bed ratios, and additional statutory
7 requirements that are prohibitive of certain GME training environments;² and
8

9 Whereas, in addition to Medicare-supported residency positions, a variety of GME programs are
10 administered by federal agencies such as the Health Resources and Services Administration
11 and Centers for Disease Control and Prevention to support physician training through grants
12 supported by discretionary appropriations such as the Children's Hospital GME program, the
13 Teaching Health Centers GME program, and more;¹ and
14

15 Whereas, such GME programs subject to dependence on the annual discretionary
16 appropriations process are subject to instability and uncertainty, which the AMA is opposed to;³
17 and
18

19 Whereas, the American Medical Association has supported legislation fully authorizing
20 discretionary GME programs, such as the Teaching Health Centers GME program;⁴ and
21

22 Whereas, in the cases of disruption to discretionary funding, i.e. government shutdowns and
23 delays in disbursement of funds due to inadequate staffing of federal agencies, incoming
24 resident physicians having been unable to start their desired GME program, either being turned
25 away from residency programs after having been matched or programs removing themselves
26 from participating in the standardized recruitment process for resident physicians in fear of
27 having to turn away matched physicians; and
28

29 Whereas, the passage of a continuing resolution or government shutdown extending into the
30 beginning of the academic year would threaten progress and disbursement of funding for
31 discretionary GME programs; and
32

33 Whereas, the AMA's Council on Legislation and Council on Medical Education publish a GME
34 Compendium report to focus on viable ways to improve GME and ensure medical students have
35 the opportunity to fulfill training requirements and become practicing doctors;⁵ and
36

37 Whereas, the AMA's GME Compendium includes limited information surrounding discretionary
38 GME programs;⁵ therefore be it

1 RESOLVED, that our American Medical Association advocate for continuation of GME
2 programs primarily supported by discretionary funding during government shutdowns and
3 delayed appropriation timelines (Directive to Take Action); and be it further
4

5 RESOLVED, that our AMA advocate for legislation that would convert funding for discretionary
6 GME programs to mandatory funding (Directive to Take Action); and be it further
7

8 RESOLVED, that our AMA elevate the issue of threats to the physician workforce from
9 interruptions to discretionary GME programs in the United States by including information and
10 advocacy actions in the annual GME Compendium report (Directive to Take Action); and be it
11 further
12

13 RESOLVED, that our AMA publish a report on discretionary GME programs and
14 recommendations to strengthen physician training to the House of Delegates at the 2027 Interim
15 Meeting. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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RELEVANT AMA POLICY

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

Our AMA:

- recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.

- will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.

- will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

Our AMA will:

- encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.

- strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.

- encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how

Direct GME funds are allocated on a per resident or fellow basis, for the previous year. [Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmation A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep. 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmation A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18 Reaffirmed in lieu of: Res. 960, I-18 Modified: Res. 233, A-19 Modified: BOT Rep. 25, A-19 Reaffirmed: CME Rep. 3, A-21 Appended: Res. 202, I-22 Reaffirmed: Res. 244, A-24 Modified: Res. 310, A-24 Reaffirmed: Res. 227, A-26]

H-310.916 Funding to Support Training of the Health Care Workforce

Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.

Our AMA strongly advocates that:

There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions.

There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs. [Sub. Res. 913, I-09 Appended: Res. 917, I-15 Appended: Res. 309, I-20 Reaffirmed: Res. 305, A-21]

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

It is AMA policy that:

Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

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

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

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

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

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

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

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

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

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

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

D-305.955 Funding for Teaching Health Center Graduate Medical Education Program

Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations. [Res. 214, A-15 Reaffirmed: BOT Rep. 09, A-25]

H-310.943 Closing of Residency Programs

Our American Medical Association:

encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.

reminds all institutions involved in educating residents of their contractual responsibilities to the resident.

encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.

will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.

urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on

remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.

opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.

will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.

Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.

Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.

Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;

Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents. [Sub. Res. 328, A-94 Appended by CME Rep. 11, A-98 Reaffirmed: CME Rep. 7, A-06 Appended: Res. 926, I-12 Modified: CME Rep. 1, A-15 Appended: Res. 310, I-19 Modified: CME Rep. 3, I-20 Reaffirmed: CME Rep. 01, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-26)

Introduced by: Indiana

Subject: Requiring Physician Oversight for Artificial Intelligence Tools

Referred to: Reference Committee B

1 Whereas, artificial intelligence (AI) diagnostic tools are increasingly integrated into clinical
2 practice with the aim of improving accuracy and efficiency; and
3

4 Whereas, current AMA policies support physician oversight but do not specifically address
5 mandated physician review of AI-driven diagnostic outputs or therapeutic decisions before
6 patient communication or implementation; and
7

8 Whereas, research indicates AI tools can produce errors or perpetuate bias if not adequately
9 supervised by physicians; and
10

11 Whereas, ensuring final diagnostic responsibility and treatment decision-making remain with a
12 licensed physician protects patient safety and maintains public trust in medical care; therefore
13 be it
14

15 RESOLVED, that our American Medical Association support federal and state policies requiring
16 that any artificial intelligence-generated diagnostic or treatment recommendations be reviewed,
17 interpreted, and communicated by a licensed physician. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

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RELEVANT AMA POLICY

Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software D-478.955

Our American Medical Association will pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy.

Citation: Res. 007, A-26

Artificial Intelligence to Bolster Physician-Led Team-Based Care H-478.971

1. Our American Medical Association will make efforts to educate physicians on evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-physician clinicians through improved interdisciplinary communication, decision support, and workflow integration.
2. Our AMA supports the development and dissemination of best practices for AI integration into physician-led care teams, with emphasis on safety monitoring, transparency, cyber hygiene, and preserving physician leadership in clinical decision-making.
3. Our AMA encourages further research on AI interventions that demonstrate how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk perception, and improve coordination of care.

Citation: Res. 003, A-26

Prohibiting the Independent Practice of Medicine by Artificial Intelligence D-480.947

Our American Medical Association advocates for legislation and regulation related to the use of augmented and/or artificial intelligence (AI) in autonomous or semiautonomous circumstances in healthcare (including diagnostics, prescriptions, care management, or other functions) requiring that such tools must:

- a. integrate with the physician-led team and be used at the direction of the treating physician,
 - b. respect the continuity of care and best practices related to transitions of care,
 - c. have transparent, auditable data demonstrating safety and efficacy,
 - d. be subject to relevant and appropriate regulations (including but not limited to those related to liability and documentation), and
 - e. adhere to our AMA policy on Augmented Intelligence in Health Care; and be it further
1. Our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, and their potential impact on the profession and the physician-patient relationship.

Citation: Res. 238, A-26

Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making D-480.950

1. Our American Medical Association recognizes and promotes the importance of transparency and explainability so physicians have sufficient information to make sound clinical decisions when using AI clinical decision support tools, which depending on the tool, may include information such as the grading of medical evidence including the data sources.
2. Our AMA will collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems.
3. Our AMA encourages medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision-making.
4. Our AMA will monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care.
5. Our AMA supports that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document.

Citation: CSAPH Rep. 07, A-26; Res. 505, A-26;

Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence D-480.952

1. Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care, in order to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings.
2. Our AMA advocates that entities developing or deploying artificial-intelligence systems—including, but not limited to, generative AI, foundation models, neural networks, and other machine-learning approaches—in healthcare:
 - a. establish and maintain a risk-based governance approach proportionate to the system's intended use and potential harm;
 - b. implement relevant security measures and privacy protections;
 - c. provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs; and
 - d. implement risk management approaches throughout the AI lifecycle with particular emphasis on appropriate monitoring of the system for safety, clinical effectiveness, accuracy, and reliability, to help ensure ethical and regulatory alignment across all deployment contexts.

Citation: Res. 507, A-25

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 505, A-26;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Fair and Clinically Appropriate EMTALA Investigations

Referred to: Reference Committee B

1 Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) protects
2 nondiscriminatory access to emergency medical screening and stabilizing treatment regardless
3 of ability to pay; and
4

5 Whereas, EMTALA investigations are increasingly extending beyond questions of access,
6 screening, stabilization, and appropriate transfer to retrospective review of the correctness of a
7 physician's diagnosis or treatment, creating particular concern when reviewers lack sufficient
8 EMTALA-specific training or emergency medicine expertise; and
9

10 Whereas, AMA policies support EMTALA's original patient-protection purpose, recognize that
11 an EMTALA medical screening examination is the process necessary to determine with
12 reasonable clinical confidence whether an emergency medical condition exists, and support due
13 process for physicians subject to EMTALA enforcement; and
14

15 Whereas, an appropriate EMTALA medical screening examination does not require a correct
16 final diagnosis, and retrospective quality-of-care concerns are appropriately addressed through
17 established peer review, accreditation, licensure, and medical liability processes; and
18

19 Whereas, accurate and consistent EMTALA enforcement requires reviewers with appropriate
20 EMTALA-specific training and clinical understanding and must distinguish physician conduct
21 from institutional responsibilities outside a physician's control; therefore be it
22

23 RESOLVED, that our American Medical Association advocate for implementation and
24 enforcement of EMTALA that preserves its guarantee of nondiscriminatory access to
25 emergency care and:

- 26 1. distinguishes EMTALA compliance from retrospective quality-of-care review and
27 evaluates clinical decisions based on information and resources reasonably available at
28 the time;
- 29 2. requires standardized EMTALA-specific training and demonstrated competency for
30 individuals conducting EMTALA investigations, including appropriate clinical expertise;
- 31 3. ensures that physicians are not held responsible for institutional administrative, staffing,
32 on-call coverage, or resource deficiencies outside their control; and
- 33 4. requires corrective actions and sanctions to be related and proportionate to the nature
34 and severity of the EMTALA deficiency identified, distinguishing administrative and
35 documentation deficiencies from failures to screen, stabilize, or appropriately transfer.

36 (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/16/26

RELEVANT AMA POLICY

Definitions of "Screening" and "Medical Necessity" H-320.953

1. Our American Medical Association defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
2. Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."
3. Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
4. in accordance with generally accepted standards of medical practice;
5. clinically appropriate in terms of type, frequency, extent, site, and duration; and
6. not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
7. Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".
8. Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
9. Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
10. Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.
11. Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.

[CMS Rep. 13, I-98Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99Modified: Res. 703, A-03Reaffirmation I-06Reaffirmed: CMS Rep. 01, A-16Reaffirmed: CMS Rep. 05, A-23]

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950 Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA);

(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations;

(3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and.

(4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.

[Sub. Res. 214, A-97Reaffirmation I-98Reaffirmation A-99Appended: Sub. Res. 235 and Reaffirmation A-00Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17]

EMTALA -- Major Regulatory and Legislative Developments D-130.982 Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA

regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.

[BOT Rep. 17, I-02Reaffirmation A-07Modified: BOT Rep. 22, A-17]

Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule D-130.976

Our AMA will: (1) ask the (EMTALA) Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the (EMTALA) regulations; (2) work with the (EMTALA) TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing (EMTALA) mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by (EMTALA) for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing (EMTALA)-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. [CME Rep. 3, A-05Reaffirmation A-07Reaffirmed in lieu of Res. 605, I-08Modified: CCB/CLRPD Rep. 2, A-14Reaffirmed: BOT Rep. 09, A-25]

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975

Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status. [BOT Rep. 2, I-05Reaffirmation A-07Reaffirmed: CMS Rep. 01, A-17]

The Future of Emergency and Trauma Care D-130.971 Our American Medical Association will expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care. Our AMA, with the advice of specific specialty societies, will advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties. Our AMA will continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care. Our AMA will disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation. Our AMA supports demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care. Our AMA supports the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension. If an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

[BOT Rep. 14, I-06Reaffirmation A-07Reaffirmation A-08BOT action in response to referred for decision Res. 204, A-11Appended: Res. 221, I-11Modified: CCB/CLRPD Rep. 2, A-14Reaffirmed: BOT Rep. 09, A-24]

Protecting Access to Emergency Abortion Care Under EMTALA D-5.995 Our AMA will advocate for the reinstatement of federal guidance affirming hospitals' obligation under EMTALA to provide necessary emergency pregnancy care, including, but not limited to, abortion care, to stabilize patients irrespective of state-level abortion restrictions. Our AMA will collaborate with relevant stakeholders, including federal agencies, Congress, medical societies, and patient advocacy groups, to educate policymakers and healthcare providers on EMTALA obligations concerning emergency pregnancy care, including, but not limited to, necessary abortion care. Our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will provide ongoing recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care.
[Res. 014, A-25]

Confidentiality of Physician Peer Review D-130.993 (1) Our AMA will continue to assess the threat to the physician peer review process created by health care related federal regulation or statute, i.e. the Emergency Medical Treatment and Active Labor Act (EMTALA); and (2) If our AMA determines that Federal regulations or laws (including EMTALA) undermine state protections for the confidentiality of the peer review process, our AMA will take urgent action to establish protections for covering all Federal programs and related regulations for physician peer review.
[Res. 219. I-00Reaffirmed: BOT Rep. 6, A-10Modified: BOT Rep. 04, A-20]

On-Call Physicians H-130.948 Our AMA: (1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients. (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients. (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance. (d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services. (e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. (f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage. (g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care. (h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained. (i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff; (3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and (4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.

[CMS Rep. 3, I-99Reaffirmation A-00Modified: Sub. Res. 217, I-00Reaffirmation I-01Reaffirmation A-07Appended and Reaffirmed: CMS Rep. 1, I-09Modified: Res. 818, I-17Reaffirmed: Res. 824, I-24]

Offsetting the Costs of Providing Uncompensated Care H-160.923 Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

[CMS Rep. 8, A-05Reaffirmation A-07Modified: CMS Rep. 01, A-17]

Medicare's Appropriate Use Criteria Program H-320.940 Our American Medical Association will advocate to Congress and the Centers for Medicare & Medicaid Services (CMS) to delay implementation of and advance modifications to the Medicare Appropriate Use Criteria (AUC) Program in such a manner that exempts care mandated by EMTALA, adequately addresses technical and workflow challenges that add to clinician's administrative burden and practice expenses, maximizes alignment with the Quality Payment Program (QPP), and creates provider flexibility for the consultation of physician-developed, evidence-based and transparent AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. [Res. 229, A-17Reaffirmed - BOT Action in response to referred for decision: Res. 245, A-19 and Res. 247, A-19Reaffirmation: A-22Modified: Res. 211, A-22]

Interpreter Services and Payment Responsibilities H-385.917 Our American Medical Association supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. [CMS Rep. 5, A-11Reaffirmed: CMS Rep. 1, A-21Reaffirmed in lieu of: Res. 231, A-23]

Coverage of Emergency Services D-130.989 Our American Medical Association will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition". Our AMA will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy. Our AMA will in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules. [Res. 229, A-01Reaffirmed: BOT Rep. 22, A-11Reaffirmed: BOT Rep. 7, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-26)

Introduced by: American Academy of Emergency Medicine, Florida Medical Association

Subject: Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract

Referred to: Reference Committee B

1 Whereas, federal regulations require hospitals to maintain an organized medical staff
2 responsible for the quality of medical care provided to hospital patients, and require the
3 governing body to ensure that contracted hospital services are provided safely and effectively
4 [1,2]; and

5
6 Whereas, hospital accreditation standards similarly recognize the organized medical staff's
7 responsibility for quality of care and its role in medical staff governance and accountability [3,4];
8 and

9
10 Whereas, exclusive contracts for physician services determine who may provide care within
11 hospital departments and can directly affect physician staffing, continuity of care, medical staff
12 privileges, and the quality and delivery of patient care; and

13
14 Whereas, AMA Policy H-225.985 supports medical staff review and recommendations before
15 decisions to execute, renew, modify, or terminate exclusive contracts, and AMA Policy H-
16 225.957 supports medical staff involvement in exclusive contracting and other hospital-based
17 physician contracts [5,6]; and

18
19 Whereas, existing federal requirements and AMA policy provide for medical staff responsibility,
20 involvement, and recommendations but do not require formal medical staff approval before a
21 hospital establishes, replaces, renews, materially modifies, or terminates an exclusive physician
22 services contract [1,2,5,6]; and

23
24 Whereas, recent disputes involving replacement of established emergency physician groups at
25 PeaceHealth in Oregon and Valley Health in Virginia demonstrate the significant effects that
26 changes in exclusive physician staffing contracts can have on physicians, medical staffs,
27 patients, and the communities they serve; [7,8]; therefore be it

28
29 RESOLVED, that our American Medical Association amend current policy H-225.985 by
30 addition and deletion to read:

31
32 Our American Medical Association believes that the medical staff should review, ~~and~~ make
33 recommendations to the governing body, and ultimately approve arrangements related to
34 exclusive contract ~~arrangements~~, prior to any decision being made, in the following situations:

- 35 1. ~~the any~~ decision to execute an exclusive contract in a previously open department or
36 service;
- 37 2. ~~the any~~ decision to renew or otherwise modify an exclusive contract in a particular
38 department or service;
- 39 3. ~~the any~~ decision to terminate an exclusive contract in a particular department or service;
40 and

- 1 4. ~~prior to termination of the contract the medical staff should hold a hearing, as defined by~~
 2 ~~the medical staff and hospital to permit interested parties to express their views on the~~
 3 ~~hospital's proposed action. (Modify Current HOD Policy); and be it further~~

5 RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and
 6 hospital accrediting organizations to require the above recommendations (Directive to Take
 7 Action); and be it further

9 RESOLVED, that our AMA seek federal legislation requiring organized medical staff approval in
 10 the above listed situations, and develop model state legislation incorporating the same
 11 protections. (Directive to Take Action)

12 Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

REFERENCES

1. Centers for Medicare & Medicaid Services. 42 CFR § 482.22, Condition of Participation: Medical Staff.
2. Centers for Medicare & Medicaid Services. 42 CFR § 482.12, Condition of Participation: Governing Body.
3. The Joint Commission. Standard MS.01.01.01, Medical Staff Bylaws.
4. DNV. NIAHO Accreditation Requirements for Hospitals, MS.1, Organization, Accountability, and Responsibility.
5. American Medical Association. Policy H-225.985, Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract.
6. American Medical Association. Policy H-225.957, Principles for Strengthening the Physician-Hospital Relationship.
7. Office of Oregon Governor Tina Kotek. Governor Kotek and Speaker Fahey Applaud PeaceHealth for Changing Direction on Staffing Contract. May 6, 2026.
8. American College of Emergency Physicians and Virginia College of Emergency Physicians. Joint Statement on Due Process, Transparency, and Due Diligence in Emergency Medicine Contracting. April 14, 2026.

RELEVANT AMA POLICY

Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract H225.985

Our American Medical Association believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations:

the decision to execute an exclusive contract in a previously open department or service;
 the decision to renew or otherwise modify an exclusive contract in a particular department or service;
 the decision to terminate an exclusive contract in a particular department or service; and
 prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.

Principles for Strengthening the Physician-Hospital Relationship H-225.957

The following twelve principles are our American Medical Association policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary

responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws:

1. The qualifications for holding office.

2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.

3. The qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff

activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-26)

Introduced by: American Academy of Emergency Medicine, Florida

Subject: Clear Identification and Differentiation of Physicians and Nonphysicians in
Clinical Rosters, Signage, and Listings

Referred to: Reference Committee B

1 Whereas, patients should be able to clearly identify and understand the professional
2 qualifications and credentials of the individuals involved in their care; and
3

4 Whereas, studies have demonstrated that in clinical settings where physicians and non-
5 physician practitioners, including nurse practitioners and physician assistants, provide care,
6 patients may be unable to accurately determine whether they were evaluated or treated by a
7 physician, a non-physician practitioner, or both [2]; and
8

9 Whereas, American Medical Association Policy H-405.951, Definition and Use of the Term
10 Physician, defines the term “physician” and calls for references to physicians by health care
11 entities to clearly distinguish physicians from nonphysicians; and
12

13 Whereas, AMA Policy H-405.968, Clarification of the Term “Provider” in Advertising, Contracts
14 and Other Communications, supports requiring health care entities to identify health
15 professionals by their recognized professional titles, so that their education, training, and
16 licensure are clearly and unambiguously stated; and
17

18 Whereas, the AMA Truth in Advertising Campaign similarly supports clear and accurate
19 identification of health professionals so that patients can easily understand the qualifications of
20 the individuals providing their care; and
21

22 Whereas, signage, directories, websites, printed materials, and other clinician listings in some
23 hospitals and clinical departments list physicians and nonphysician clinicians together, without
24 clearly differentiating their professional roles; and
25

26 Whereas, listing physicians and nonphysicians separately would provide patients with greater
27 transparency regarding the education, training, and professional qualifications of the individuals
28 involved in their care and reduce the potential for confusion; therefore be it
29

30 RESOLVED, that our American Medical Association amend Policy H-405.951, Definition and
31 Use of the Term Physician, by addition to read as follows:
32

33 Our AMA will advocate that, in all printed and electronic materials, signage, directories, and
34 listings in clinical departments, hospitals, health care facilities, and similar settings, physicians
35 be listed separately from nonphysicians and that this distinction be clear and unambiguous.
36 (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

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6. American Medical Association. Opinion 9.6.1: Advertising & publicity. AMA Code of Medical Ethics. Accessed August 27, 2026. <https://code-medical-ethics.ama-assn.org/ethics-opinions/advertising-publicity>

RELEVANT AMA POLICY

H-405.951 – Definition and Use of the Term Physician

H-405.968 – Clarification of the Term "Provider" in Advertising, Contracts and Other Communications

D-405.991 – Clarification of the Title "Doctor" in the Hospital Environment

H-35.984 – Proper Visual Identification of Nonphysicians Who See Patients

H-405.969 – Definition of a Physician

AMA Code of Medical Ethics Opinion 10.8 – Collaborative Care

AMA Code of Medical Ethics Opinion 9.6.1 – Advertising & Publicity

Definition and Use of the Term Physician H-405.951

1. Our American Medical Association Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician.
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician.
 - c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Our AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Our AMA ensures that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.

6. Our AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-26)

Introduced by: American Academy of Emergency Medicine, Florida Medical Association

Subject: Prohibiting Health Care Sale-Leaseback Transactions

Referred to: Reference Committee B

1 Whereas, AMA Policy H-160.891, as updated in 2025, lists various cautions for physicians
2 contemplating sales of their practices to corporate investors, including concerns that are
3 especially relevant when the investors are “Private Equity” (PE) firms; and
4

5 Whereas, when a PE firm purchases a corporation, the PE firm also typically imposes “Sale-
6 Leaseback” terms, which obligate the PE-acquired entity to pay “rents” to the PE firm for the
7 continued use of the same facilities that had been utilized without any “rent” obligation before
8 the PE purchase, for the production goods and services [4]; and
9

10 Whereas, these Sale-Leaseback terms impose new debt for the acquired firm, via adding a new
11 rent obligation payable to the PE owner. This new debt obligation causes a new negative impact
12 upon the acquired corporation’s financial balance sheet, while also extracting capital from the
13 acquired entity to the PE owner [4], as the PE firm seeks to further monetize its purchase; and
14

15 Whereas, this negative impact on the acquired corporation’s financial balance sheet typically
16 leads to staffing or service cuts, increased patient charges, and other negative effects upon
17 physicians, other health care workers, and the patients whom they serve; and
18

19 Whereas, this set of financial circumstances imposed by these rents lead to severe constraints
20 on physician autonomy and authority, a topic addressed by AMA Policy HD-160.891; and
21

22 Whereas, nothing about this Resolution is to be construed as addressing the establishment of
23 fair market rents that would be charged to clinical entities that did not ever own or partially own
24 the physical facilities in which medical care is delivered, toward avoiding “Stark Law” penalties;
25 therefore be it
26

27 RESOLVED, that our American Medical Association advocate for laws and regulations
28 prohibiting purchasers or acquirers of hospitals, health systems, physician practices, and other
29 health care entities, or their affiliates, from requiring or causing the acquired health care entity to
30 enter into a sale-leaseback transaction involving its real property or other material assets
31 (Directive to Take Action); and be it further
32

33 RESOLVED, that our AMA develops model federal and state legislation prohibiting the
34 imposition of sale-leaseback provisions related to the purchase of health care entities as above.
35 (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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RELEVANT AMA POLICY

Corporate Investors and Other Corporate Entities H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under “friendly” physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
 - a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor/entity.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity’s business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
 - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
 - h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
 - j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
 - i. Determining which diagnostic tests are appropriate;
 - ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
 - iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
 - iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
 - v. Determining the content of patient medical records;
 - vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
 - vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
 - viii. Making decisions regarding coding and billing procedures for patient care services; and
 - ix. Approving the selection of medical equipment and medical supplies.
 - k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
 - l. Clear protection and dispute resolution processes for physicians advocating on patient

care and quality issues should be incorporated into an agreement between physicians and corporate entities.

m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.

3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.

4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.

5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship. (Rationale: AMA Policy and Advocacy is needed to specify that the Private Equity practice of the charging of "rents" must be constrained, because this PE business practice adds new expenses to health care enterprises' corporate "bottom lines", precipitates service cutbacks, drives increases in patient charges, and threatens physician autonomy).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-26)

Introduced by: Washington

Subject: Establishing Product Liability for Clinical Augmented Intelligence Failures

Referred to: Reference Committee B

1 Whereas, the U.S. Food and Drug Administration (FDA) has authorized over 1,450 AI-enabled
2 medical devices for marketing in the United States (US) as of December 2025, with
3 approximately 76 percent concentrated in radiology alone (1); and
4

5 Whereas, the FDA cleared 295 new AI-enabled medical devices in 2025, the highest single-year
6 total for AI/ML-enabled device authorizations in the agency's history, reflecting an accelerating
7 pace of AI deployment into clinical practice that outstrips the development of corresponding
8 legal and liability frameworks; and
9

10 Whereas, a systematic review published in JAMA found that of 717 FDA-authorized radiology
11 augmented intelligence and machine learning (AI/ML) devices with available documentation,
12 only 5 percent underwent prospective testing, only 8 percent included human-in-the-loop
13 evaluation, and only 29 percent incorporated any clinical testing, meaning the vast majority of
14 AI/ML tools now used in clinical settings were cleared without rigorous real-world validation (2);
15 and
16

17 Whereas, ninety-seven percent of all FDA-authorized AI/ML medical devices were cleared
18 through the 510(k) pathway, which requires only a demonstration of "substantial equivalence" to
19 a previously cleared device and does not require the clinical trial data demonstrating safety and
20 effectiveness that the more rigorous Premarket Approval (PMA) pathway demands; and
21

22 Whereas, clinical AI tools are now used across nearly every medical specialty, from reading
23 imaging scans to screening for cancer to recommending treatments, and when these tools get it
24 wrong, patients are directly harmed; and
25

26 Whereas, the journal Radiology has documented a case in which an FDA-cleared AI algorithm
27 misdiagnosed a finding as an intracranial hemorrhage in a patient who was ultimately diagnosed
28 with an ischemic stroke, illustrating the real-world consequences of AI tool failures in clinical
29 settings (3); and
30

31 Whereas, in *Dickson v. Dexcom Inc.* (4), a federal court considered product liability claims
32 arising from an FDA-authorized continuous glucose monitor that allegedly malfunctioned,
33 contributing to a dangerous hypoglycemic episode that caused a motor vehicle crash; although
34 the Dexcom G6 is not itself an AI/ML-enabled device, as analyzed by Gerke and Simon in
35 *Science* (2025), the case is directly relevant to AI/ML-enabled medical device manufacturers
36 because many similar monitoring and diagnostic tools are now being developed using AI/ML,
37 and the court's ruling addresses the critical question of whether manufacturers can use the
38 FDA's De Novo authorization pathway to block product liability claims; and

1 Whereas, the Dickson decision is significant because, as more AI-enabled medical devices
2 enter the market through the FDA's 510(k) and De Novo pathways, manufacturers may attempt
3 to invoke federal preemption to shield themselves from state product liability claims, and the
4 court's analysis of the boundaries of that preemption defense will shape the liability landscape
5 for AI/ML-enabled devices for years to come; and
6

7 Whereas, established product liability law holds that when a medical device fails due to a defect
8 in design, manufacturing, or warnings, the manufacturer bears liability for the resulting patient
9 harm, not the physician who used the device, as demonstrated by the DePuy ASR hip implant
10 litigation in which Johnson & Johnson paid over \$2.5 billion in settlements for design defects
11 while no liability was imposed on the orthopedic surgeons who implanted the devices, the
12 Philips Respironics CPAP recall in which Philips paid \$1.1 billion for device defects while no
13 liability was imposed on the sleep medicine physicians who prescribed the devices, and the
14 Medtronic SynchroMed implantable infusion pump Class I recall in which liability was directed at
15 the manufacturer, not the physicians who implanted the pumps; and
16

17 Whereas, in each of these cases, the physician used the device as intended, had no ability to
18 detect or correct the underlying defect, and was not held liable. Physicians who rely on AI tools
19 that produce erroneous outputs due to defects in the algorithm, training data, or software design
20 are in the identical position; and
21

22 Whereas, the FDA regulates AI-enabled clinical software as a medical device, yet unlike hip
23 implants, pacemakers, and infusion pumps, AI software is not consistently treated under product
24 liability law, meaning manufacturers of physical devices bear liability for defects while
25 manufacturers of AI software performing equivalent clinical functions do not; and
26

27 Whereas, under current law, physicians face malpractice liability when they appropriately rely on
28 an FDA-cleared AI tool that produces a defective output, bearing the legal risk for a product
29 defect they had no ability to detect, control, or correct; and
30

31 Whereas, the Restatement (Third) of Torts: Products Liability already holds manufacturers
32 strictly liable for defective products, including medical devices, and this framework should
33 logically extend to AI-enabled medical software; and
34

35 Whereas, in May 2024, the American Law Institute approved a new Restatement of Torts:
36 Medical Malpractice that shifts the standard of care toward evidence-based "reasonableness,"
37 meaning physicians may now face liability both for failing to use AI tools and for relying on AI
38 tools that fail; and
39

40 Whereas, the European Union's revised Product Liability Directive (EU 2024/2853), in force
41 since December 2024, explicitly defines software including AI systems as a "product" subject to
42 strict manufacturer liability, with full Member State implementation required by December 2026,
43 while the United States has no equivalent framework, leaving American physicians exposed to
44 liability for AI product failures that EU law assigns to the manufacturer; and
45

46 Whereas, existing AMA Policy H-480.939 already states that "developers of autonomous AI
47 systems with clinical applications are in the best position to manage issues of liability arising
48 directly from system failure or misdiagnosis and must accept this liability," yet no legal
49 framework enforces this principle; and
50

51 Whereas, physicians cannot inspect, audit, modify, or independently verify the algorithms
52 underlying AI tools they are required or encouraged to use, and are frequently bound by vendor

1 licensing agreements that prohibit reverse engineering or independent testing of the software;
2 and
3

4 Whereas, malpractice insurers are already responding to AI-related risk by introducing policy
5 riders and exclusions for AI-assisted clinical decisions, which threatens to shift financial
6 exposure onto individual physicians for product failures outside their control; and
7

8 Whereas, physicians are increasingly required by their employers or hospital systems to use
9 specific AI tools as part of their clinical workflow, often with no ability to opt out, choose an
10 alternative, or participate in the selection or validation of the system, yet under current law these
11 same physicians bear the full malpractice liability when a mandated AI tool produces a defective
12 output; and
13

14 Whereas, no physician is held liable when an MRI machine malfunctions, a lab analyzer returns
15 an erroneous result, or an infusion pump delivers a wrong dose, because the defect originates
16 in the equipment, not the physician's judgment, and the same principle should apply when an AI
17 tool produces a defective clinical output; and
18

19 Whereas, at least one AI manufacturer has already demonstrated that vendor-assumed liability
20 works: Digital Diagnostics, maker of IDx-DR, the first FDA-authorized autonomous AI diagnostic
21 device, carries its own medical malpractice insurance and assumes liability for injuries arising
22 from the system's decisions (Price, Gerke, and Cohen, 2024), proving this is not theoretical but
23 already in practice; and
24

25 Whereas, physicians who use AI tools as intended, within the scope of the tool's marketed and
26 cleared indications, and who exercise appropriate clinical judgment in conjunction with those
27 tools, should not bear liability for errors that originate in the AI product itself; therefor be it
28

29 RESOLVED, that our American Medical Association advocate for federal and state legislation
30 establishing that when a clinical AI product produces an erroneous output and a physician has
31 used the product as intended while exercising appropriate clinical judgment, the liability for
32 resulting patient harm constitutes a product liability claim against the AI vendor, manufacturer,
33 or distributor, not a medical malpractice claim against the physician (Directive to Take Action);
34 and be it further
35

36 RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same
37 product liability standards as manufacturers of other medical devices under the Restatement
38 (Third) of Torts: Products Liability, including strict liability for manufacturing defects, and liability
39 for design defects and failure to provide adequate instructions or warnings (Directive to Take
40 Action); and be it further
41

42 RESOLVED, that our AMA advocate for legislation requiring that AI vendors and manufacturers
43 maintain product liability insurance adequate to cover claims arising from AI product failures in
44 clinical settings, and that such insurance obligations be a condition of FDA marketing
45 authorization (Directive to Take Action); and be it further
46

47 RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions, including
48 end-user license agreements and vendor contracts, that attempt to shift product liability for AI
49 tool failures from the manufacturer to the physician or health system end user (Directive to Take
50 Action); and be it further

1 RESOLVED, that our AMA advocate for federal legislation requiring AI vendors and
 2 manufacturers to disclose known failure rates, limitations, and performance data for their clinical
 3 AI products, including performance across different patient populations, so that physicians can
 4 make informed decisions about the clinical appropriateness of AI tool outputs (Directive to Take
 5 Action); and be it further

7 RESOLVED, that our AMA advocate that when a health system, hospital, payer, or other entity
 8 mandates the use of a specific AI tool and that tool produces an error resulting in patient harm,
 9 the mandating entity and the AI vendor bear the liability, and the physician who was required to
 10 use the tool and exercised appropriate clinical judgment is not liable for errors originating in the
 11 mandated product. (Directive to Take Action)

12 Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-26)

Introduced by: American Society of Plastic Surgeons; Michigan State Medical Society

Subject: Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process

Referred to: Reference Committee B

1 Whereas, the No Surprises Act (NSA) was enacted to protect patients from unexpected out-of-
2 network medical bills while establishing an Independent Dispute Resolution (IDR) process for
3 resolving certain payment disputes between health plans and physicians and other health care
4 providers;¹ and

5
6 Whereas, since its launch in April 2022, the federal IDR process has received millions of
7 disputes, substantially exceeding initial expectations and contributing to administrative burden,
8 delays, and increased costs;² and

9
10 Whereas, eligibility determinations have been a significant source of IDR delay and
11 administrative burden, and more than one million disputes were closed as ineligible between
12 implementation of the federal IDR process and May 31, 2026;³ and

13
14 Whereas, the 2026 Federal IDR Operations Final Rule established important reforms to improve
15 eligibility determinations, communication between parties, and IDR efficiency, but additional
16 safeguards are needed to discourage both submission of ineligible disputes and inappropriate
17 payer eligibility challenges to otherwise valid disputes;^{2, 4} and

18
19 Whereas, final IDR determinations are binding under federal law, yet physicians continue to
20 report late, incomplete, or unpaid IDR awards, as well as inappropriate patient cost-shifting
21 following IDR determinations;^{5, 6} and

22
23 Whereas, the bipartisan No Surprises Act Enforcement Act (H.R. 4710/S. 2420), supported by
24 the American Medical Association and numerous state and national medical organizations,
25 would strengthen enforcement of statutory payment requirements and impose consequences for
26 failure to comply with final and binding IDR determinations;^{5, 7, 8} and

27
28 Whereas, the NSA's notice-and-consent provisions were intended to provide a limited
29 mechanism through which eligible patients may voluntarily waive certain protections, and
30 practices that condition scheduling, preauthorization, coverage, or access to care upon
31 surrender of NSA protections may undermine the law's fundamental patient-protection purpose;¹
32 and

33
34 Whereas, health plan practices that shift financial responsibility to patients following IDR
35 determinations or penalize or pressure facilities because of lawful out-of-network physician
36 participation may undermine patient protections, physician contracting, and access to care;⁶ and

Whereas, the integrity and long-term sustainability of the IDR process also requires accountability for systematic submission of ineligible disputes, appropriate oversight of high-volume filing entities and third-party IDR intermediaries, and reasonable, carefully designed safeguards against extreme outlier provider offers; and

Whereas, concerns remain regarding the accuracy, transparency, and consistency of Qualifying Payment Amount (QPA) calculations, making appropriate disclosure, auditing, and enforcement important to ensuring that QPAs comply with applicable federal requirements;⁴ therefore be it

RESOLVED, that our American Medical Association advocate for comprehensive reform of the No Surprises Act Independent Dispute Resolution process, with particular emphasis on improving eligibility determinations, including appropriate pre-submission eligibility verification and attestation, timely and specific standards for payer eligibility challenges, meaningful accountability for patterns of ineligible filings or inappropriate eligibility challenges, and a consistent mechanism for resolving complex eligibility determinations before they unnecessarily burden the IDR process (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to support passage and implementation of the No Surprises Act Enforcement Act and advocate for additional mechanisms necessary to ensure timely compliance with final and binding IDR determinations, meaningful enforcement and recovery of unpaid or underpaid awards, appropriate remedies for noncompliance, and transparent reporting of health plan compliance with federal IDR payment requirements (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for preservation and strengthening of the patient protections underlying the No Surprises Act, including prohibiting practices that improperly increase patient financial responsibility following an IDR determination; condition scheduling, preauthorization, coverage, or access to care upon waiver of NSA protections; or penalize or coerce facilities or physicians solely because of lawful out-of-network physician participation in patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA support balanced safeguards to promote the integrity and sustainability of the federal IDR process, including accountability for systematic ineligible filings; appropriate oversight, registration, and transparency of high-volume filing entities and third-party IDR intermediaries; establishment of a reasonable, transparent, geographically adjusted cap on provider bids submitted through the federal IDR process, based upon an independent and credible benchmark, to prevent extreme outlier offers while preserving meaningful access to independent dispute resolution and appropriate reimbursement for complex, high-acuity care, and other out-of-network services; and accurate calculation, appropriate disclosure, auditing, and enforcement of Qualifying Payment Amount requirements. (New HOD Policy)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-26)

Introduced by: American Society of Plastic Surgeons; Michigan State Medical Society

Subject: Strengthening the Patients First Act and Medicare Physician Payment Reform

Referred to: Reference Committee B

1 Whereas, the continued instability of the Medicare physician payment system threatens the
2 financial sustainability of physician practices and patients' access to care; and
3

4 Whereas, years of inadequate Medicare physician payment updates and payment reductions
5 have occurred while the costs of operating physician practices have continued to rise, creating
6 an increasing disconnect between Medicare reimbursement and the cost of providing patient
7 care;^{1, 2} and
8

9 Whereas, H.R. 9693, the *Patients First Act of 2026*, represents a significant congressional effort
10 to reform Medicare physician payment, including reforms to the Medicare Physician Fee
11 Schedule intended to improve payment stability, such as changes addressing budget neutrality,
12 utilization estimates, conversion factor volatility, and physician practice expense inputs, as well
13 as provisions to modernize quality reporting, reduce administrative burden, and strengthen
14 physician participation in value-based care;³ and
15

16 Whereas, these payment stability reforms represent meaningful improvements to the Medicare
17 Physician Fee Schedule but must be accompanied by an adequate annual physician payment
18 update to achieve long-term payment stability; and
19

20 Whereas, the *Patients First Act* proposes an annual physician payment update based on the
21 Medicare Economic Index (MEI), which is a measure of inflation in the costs of maintaining a
22 physician practice, minus one percentage point, which would not fully account for increases in
23 the costs measured by the MEI;³ and
24

25 Whereas, the American Medical Association has advocated for an inflation-based Medicare
26 physician payment update tied to the MEI to better reflect rising physician practice costs;⁵ and
27 Whereas, the *Patients First Act* proposes the Patient Outcome Improvement National
28 Tabulation System (POINTS) as a successor framework to the Merit-based Incentive Payment
29 System (MIPS), while retaining a performance-based physician payment structure;³ and
30 Whereas, meaningful reform of physician quality and performance measurement should reduce
31 administrative burden, utilize clinically relevant measures, meaningfully engage the specialties
32 and physicians it affects;^{5, 6} therefore be it
33

34 RESOLVED, that our American Medical Association advocate that Medicare physician payment
35 reform proposals, including the *Patients First Act of 2026*, provide annual physician payment
36 updates no less than the full MEI (Directive to Take Action); and be it further

1 RESOLVED, that our AMA advocate for preservation and advancement of Medicare Physician
2 Fee Schedule reforms that improve payment stability, including appropriate reforms to budget
3 neutrality, utilization estimates, conversion factor volatility, and regular updating of physician
4 practice expense inputs (Directive to Take Action); and be it further

5
6 RESOLVED, that our AMA advocate that any replacement or reform of the Merit-based
7 Incentive Payment System, including the proposed Patient Outcome Improvement National
8 Tabulation System (POINTS), meaningfully reduce administrative burden; utilize clinically
9 relevant measures that appropriately account for differences among medical specialties,
10 practice settings, and patient populations; provide meaningful representation and input from
11 affected specialties and practicing physicians in the development and review of such measures;
12 and provide appropriate transition protections for existing clinically valid MIPS and Qualified
13 Clinical Data Registry (QCDR) measures. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION

Resolution: 218
(I-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island,
Vermont

Subject: Firearm Manufacturer Accountability for the Cost of Gun Violence

Referred to: Reference Committee B

1 Whereas, firearm injury is the number one cause of death for children, teens, and pregnant
2 women;^{1,2} and
3

4 Whereas, firearm injury is the most lethal and common method for suicide;³ and
5

6 Whereas, the estimated total cost of firearm injury to American society, when including lost
7 productivity and statistical value of lives lost, is approaching half a trillion dollars per year;⁴ and
8

9 Whereas, the cost of firearm injury is disproportionately borne by Black communities and
10 Medicaid and self-pay patients;⁵ and
11

12 Whereas, despite this staggering financial and human toll, firearm manufacturers have been
13 largely exempt, with few exceptions, from indirect regulation through tort liability since the 2005
14 federal law the Protection in Lawful Commerce in Arms Act;⁶ and
15

16 Whereas, for over a century, no-fault systems like Workers' Compensation have successfully
17 served as a proof-of-concept that legislation can work to balance economic responsibility with
18 public welfare, demonstrating that these frameworks can protect communities and build trust in
19 industries; and
20

21 Whereas, the tobacco, opioid, and other comparable industries have been held financially
22 accountable for their for-profit activities' exorbitant societal costs;^{7,8} and
23

24 Whereas, several types of state gun laws have been shown to be associated with a significant
25 reduction in firearm-related violence and suicide, averting thousands of deaths and decreasing
26 firearm suicide rates by up to 25%;⁹⁻¹² and
27

28 Whereas, there are several manufacturer-led gun modifications that can reduce the risk of
29 firearm-related injury, misuse and theft, including user-authorization, automatic locking
30 mechanisms, chamber/load-status indicators, magazine-disconnect safety mechanisms,
31 tamper-resistant designs, theft-resistant features, and built-in forensic identifiers;^{13,14} and
32

33 Whereas, gun manufacturers have been resistant to universally including these features in their
34 firearms and have consistently lobbied heavily against federal and state legislation that seeks to
35 regulate firearms or increase industry accountability;¹⁵ and
36

37 Whereas, government-imposed financial disincentives have historically proved to be effective in
38 motivating change across industries, including but not limited to carbon tax to reduce
39 emissions,¹⁶ excise taxes to phase out chlorofluorocarbons,¹⁷ and significant HIPAA violation
40 fines to improve hospital security and confidentiality measures;¹⁸ and

Whereas, at the time of the writing of this resolution, Illinois and New Jersey have under active consideration state legislation that would require firearm manufacturers to financially contribute to a state fund aimed at supporting victims of gun violence in an amount proportional to the public costs associated with injuries and deaths related to their company's firearms;^{19,20} and

Whereas, the Responsibility in Firearm Legislation (RIFL) Act proposed in Illinois has garnered widespread support, including from over 60 endorsing partner organizations representing both healthcare entities and victims of gun violence;²¹ and

Whereas, legislation that ties fees on firearm manufacturers to the damage caused by their weapons creates a financial incentive for manufacturers to invest in prevention of firearm-related violence and to make their weapons safer and less prone to theft, tampering, and outfitting for mass murder; and

Whereas, manufacturer-led investment in firearm-related violence prevention and safer firearms would be expected to not only save lives but also decrease healthcare costs currently absorbed by patients, taxpayers, and hospitals; and

Whereas, in AMA policy H-145.985, our AMA already supports surtaxes on firearm manufacturers to generate revenue for health and law enforcement activities related to the prevention and control of violence in U.S. society, but does not tie the size of these surtaxes to the damage caused by the manufacturer, and thereby provides no financial incentive for manufacturer-led investments in increased firearm safety and violence prevention; and

Whereas, our AMA has robust existing policy that describes the gun violence epidemic as a public health crisis and recognizes the duty of our AMA to fight for policies that might reduce firearm injuries; therefore be it

RESOLVED, that our American Medical Association supports legislative, regulatory, and national advocacy efforts to require firearm manufacturers to pay a proportion of the public costs associated with firearm injuries and deaths related to their products (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policies that would direct the revenue from firearm manufacturer harm-related payments towards evidence-based methods of firearm-related violence prevention and to support people and communities affected by firearm-related violence. (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/16/26

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Relevant AMA Policy

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992

1. Our American Medical Association will make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence.
2. Our AMA will establish a task force to focus on gun violence prevention including gun-involved suicide.
3. Our AMA will support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics.
4. Our AMA will collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety.
5. Our AMA will report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Firearms and High-Risk Individuals H-145.972

1. Our American Medical Association supports the establishment of laws allowing family members, intimate partners, household members, and state, federal, local, and tribal law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence.
2. Our AMA supports the establishment of laws and procedures through which physicians and other medical professionals can, in partnership with appropriate parties, contribute to the inception and development of such petitions.
3. Our AMA supports the prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms.
4. Our AMA supports the expanding domestic violence restraining orders to include dating partners.
5. Our AMA supports the requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons.
6. Our AMA supports the requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System.
7. Our AMA supports efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Prevention of Firearm Accidents in Children H-145.990

1. 1. Our American Medical Association supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to:
 - a. inquire as to the presence of household firearms as a part of childproofing the home;
 - b. educate patients to the dangers of firearms to children;
 - c. encourage patients to educate their children and neighbors as to the dangers of firearms; and
 - d. routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms.
2. Our AMA encourages state medical societies to work with other organizations to increase public education about firearm safety.
3. Our AMA encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.
4. Our AMA supports enactment of Child Access Prevention laws and other types of comprehensive safe storage laws that are consistent with AMA policy.
5. Our AMA and all interested medical societies will educate the public about:
 - a. best practices for firearm storage safety;
 - b. misconceptions families have regarding child response to encountering a firearm in the home; and
 - c. the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

Control of Non-Detectable Firearms H-145.994

1. Our American Medical Association supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms.
2. Our AMA supports a ban on the production and distribution of 3D firearm digital blueprints.

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our American Medical Association endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our American Medical Association supports:
 - a. federal and state research on firearm-related injuries and deaths;
 - b. increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
 - c. encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
 - d. the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
 - e. encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
 - f. encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and

- g. encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
- 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
- 3. Our AMA:
 - a. recognizes the role of firearms in suicides,
 - b. encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and
 - c. encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
- 4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
- 5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
- 6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
- 7. Our AMA and all interested medical societies will:
 - a. educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families;
 - b. educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of our American Medical Association to:

- 1. Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - a. Mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers.
 - b. Bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21.
 - c. Bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel).
 - d. The imposition of significant licensing fees for firearms dealers.
 - e. The imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society.
 - f. Mandatory destruction of any weapons obtained in local buy-back programs.
- 2. Support legislation outlawing the Black Talon and other similarly constructed bullets.

3. Our AMA support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
4. Our AMA opposes "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
5. Our AMA supports the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Gun Violence as a Public Health Crisis D-145.995

1. Our American Medical Association will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution.
2. Our AMA will actively lobby Congress to lift the gun violence research ban.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our American Medical Association recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore our AMA:
 - a. encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
 - b. urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
 - c. urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
 - d. urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
 - e. encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
 - f. urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
 - g. strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.
4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-26)

Introduced by: American Academy of Child and Adolescent Psychiatry, Medical Student
Section

Subject: Opposing the Use of Artificial Intelligence to Produce Child and Adolescent
Sexual Exploitative Material

Referred to: Reference Committee B

1 Whereas, artificial intelligence (AI) is rapidly growing with the ability to produce more realistic
2 media, including deepfakes or synthetic media where the human eye is unable to distinguish
3 between real and fake¹; and
4

5 Whereas, there are no federal guidelines regulating AI use at this time²; and
6

7 Whereas, AI may be employed to produce child sexual abuse material (CSAM) depicting minors
8 under the age of 18 participating in sexually explicit content or being exploited sexually^{3,4}; and
9

10 Whereas, across 11 countries, at least 1.2 million children have had their images manipulated
11 into sexually explicit deepfakes using AI³; and
12

13 Whereas, a study conducted among American adolescents found that 55.3% reported creating
14 and 54.4% reported receiving at least one AI-generated nude image⁵; and
15

16 Whereas, 36.3% of American adolescents experienced having a non-consensual AI-generated
17 image created and 33.2% experienced having at least one AI-generated image non-
18 consensually shared⁵; and
19

20 Whereas, in August 2026, *United States vs. Steven Anderegg* ruled that a person can privately
21 own AI-generated CSAM as protected by the First Amendment⁶; and
22

23 Whereas, several leaders in the field of AI agree that greater federal oversight, alongside
24 slowing the pace of development, is needed⁷; and
25

26 Whereas, there is a current “alignment problem” in AI, defined as the risk of AI becoming
27 discordant with human values (e.g., avoiding the creation of child exploitative material)⁸; and
28

29 Whereas, AI-generated deepfakes directly harm children and may severely impact their mental
30 health and jeopardize their safety if they are recognized by perpetrators^{9,10,11}; therefore, be it
31

32 RESOLVED, that our American Medical Association oppose the use of artificial intelligence to
33 produce any sexual and other exploitative material of minors (New HOD Policy); and be it
34 further
35

36 RESOLVED, that our AMA advocate for legislation that opposes the use of artificial intelligence
37 to produce sexual and other exploitative material of minors (Directive to Take Action); and be it
38 further

- 1 RESOLVED, that our AMA encourage State Delegations to adopt similar resolutions and
2 advocate at the state level. (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/16/26

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RELEVANT AMA POLICY

Child Pornography H-60.990

Our AMA: (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; (5) supports efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations; and (6) supports research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence.

[BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Appended: Res. 913, I-18; Appended: Res. 528, A-19]

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

1. Our American Medical Association recognizes the positive role of the Internet in providing health information to children and youth.
2. Our AMA recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
3. Our AMA supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.

4. Our AMA encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
5. Our AMA supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
6. Our AMA actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.

[BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Res. 926, I-22]

Identifying and Reporting Suspected Child Abuse H-515.960

1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.
2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.
6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

[CSAPH Rep. 2, I-09; Appended: Res. 411, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-26)

Introduced by: Senior Physicians Section

Subject: Advocating for the Older Americans Act and Community-Based Services for Older Adults

Referred to: Reference Committee B

1 Whereas, The Older Americans Act (OAA) is the primary federal statute supporting
2 comprehensive services that allow older adults to successfully “age in place”; and
3

4 Whereas, OAA programs, including home and congregate nutrition services, caregiver support,
5 and chronic disease self-management, all of which improve health outcomes and prevent
6 avoidable hospitalization and institutionalization with commensurate cost savings¹; and
7

8 Whereas, reauthorization for the OAA and adequate funding has been caught up in
9 congressional dysfunction leading to diminished services while the demand continues to be
10 driven by demographics; and
11

12 Whereas, both the One Big Beautiful Bill Act (OBBBA) and recent proposed rule changes to the
13 Affordable Care Act marketplace will indirectly increase demand further²; therefore be it
14

15 RESOLVED, that our American Medical Association advocate for the reauthorization and
16 adequate funding for the Older Americans Act (Directive to Take Action); and be it further
17

18 RESOLVED, that our AMA oppose federal or state policies that would reduce access, eligibility
19 or funding for the Older Americans Act (OAA) programs (New HOD Policy); and be it further
20

21 RESOLVED, that our AMA collaborate with appropriate organizations to educate legislators and
22 policymakers of the health benefits and fiscal effectiveness of the Older Americans Act (OAA).
23 (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

REFERENCES

1. Administration for Community Living. *Chronic Disease Self Management Education Programs*. Accessed August 24, 2026. (acl.gov)
2. Centers for Medicare & Medicaid Services. 2025 Marketplace Integrity and Affordability Proposed Rule. CMS. March 10, 2025. (ama-assn.org)

RELEVANT AMA POLICY

H-440.817 Protecting the Integrity of Public Health Data Collection

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

[Res. 002, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-26)

Introduced by: International Medical Graduates Section, Resident and Fellow Section

Subject: Preserving Duration of Status for J-1 Physicians in Graduate Medical Education

Referred to: Reference Committee B

1 Whereas, international medical graduates (IMGs) constitute approximately 25 percent of the
2 U.S. physician workforce, nearly 325,000 physicians⁶; and that J-1 exchange visitor physicians,
3 sponsored by Intealth, provide essential training and patient care in communities facing
4 physician shortages; and
5

6 Whereas, under the longstanding Duration of Status (D/S) framework, J-1 physicians remained
7 in lawful status for the full duration of their authorized training program, generally capped at
8 seven years², subject to Intealth's rigorous annual sponsorship review and SEVIS oversight³;
9 and
10

11 Whereas, the Department of Homeland Security has replaced D/S with a fixed four-year
12 admission period¹, requiring J-1 physicians in training programs exceeding four years, or
13 needing unanticipated extensions for illness, remediation, or board examinations, to separately
14 file for a USCIS extension of stay; creating administrative burdens, legal costs, and delays that
15 risk disrupting training and patient care; and
16

17 Whereas, our AMA formally urged the Department of Homeland Security to exclude J-1
18 physicians and their J-2 dependents from the rule, noting that approximately 17,000 J-1
19 physicians train at more than 770 teaching hospitals nationwide and that USCIS extension-of-
20 stay processing times of six to nineteen months are incompatible with the annual residency and
21 fellowship contract cycle⁹; and
22

23 Whereas, Intealth, the designated J-1 physician sponsor, formally recommended that the
24 Department of Homeland Security preserve D/S or, alternatively, adopt a fixed admission period
25 equal to the full training program plus six months, expand VSRE/SEVIS integration, and confirm
26 that physicians may change training programs during a pending extension¹¹; that Intealth has
27 begun issuing multi-year Forms DS-20194 consistent with the U. S. Citizenship and Immigration
28 Service's (USCIS) existing deference policy¹⁰; and that HRSA projects a shortage of
29 approximately 187,000 physicians by 2037¹²; and
30

31 Whereas, maintaining the Duration of Status, or an equivalent physician-specific mechanism,
32 would allow J-1 physicians to complete their authorized medical training without unnecessary
33 immigration-related interruptions, while preserving existing federal oversight, Intealth
34 sponsorship requirements, and the established limits on J-1 physician training; therefore be it
35

36 RESOLVED, that our American Medical Association advocate that the Department of Homeland
37 Security maintain or restore the Duration of Status for J-1 physicians in graduate medical
38 education, or, if not restored, allow a fixed admission period equal to the full training program
39 plus six months (Directive to Take Action); and be it further

40 RESOLVED, that our AMA advocate that the U. S. Citizenship and Immigration Service provide
41 premium processing, deference to Intealth's multi-year DS-2019 sponsorship, automatic J-2
42 work-authorization extensions, and VSRE/SEVIS integration for J-1 extension-of-stay
43 applications (Directive to Take Action); and be it further
44

45 RESOLVED, that our AMA work with the Department of Homeland Security, the U. S.
46 Citizenship and Immigration Service, Intealth, and other stakeholders to confirm J-1 physicians
47 may change training programs or employers during a pending extension of stay, minimizing
48 administrative burdens on physician training and patient care. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

REFERENCES

1. AMA opposition to the 2020 proposal to eliminate J-1 Duration of Status - In 2020, our AMA joined the American Hospital Association, leading medical education organizations, and a bipartisan group of 36 members of Congress in formally opposing an earlier Department of Homeland Security proposal to eliminate Duration of Status for J-1 physicians, warning that the change would disrupt IMG training, threaten patient access to care, and sever the pipeline of physicians into the Conrad State 30 program.
2. U.S. Department of Homeland Security, "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media," Final Rule, 90 Fed. Reg. 44,976 (July 17, 2026) (DHS Docket No. ICEB-2025-0001), effective Sept. 15, 2026. <https://www.federalregister.gov/documents/2026/07/17/2026-14439/>
3. U.S. Citizenship and Immigration Services, USCIS Policy Manual, Vol. 2, Part D, Ch. 3, "Terms and Conditions of J Exchange Visitor Status" (describing duration of status and the general seven-year maximum program duration). <https://www.uscis.gov/policy-manual/volume-2-part-d-chapter-3>
4. U.S. Citizenship and Immigration Services, "Exchange Visitors." <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/exchange-visitors>
5. AMA Comment Letter to DHS on the Fixed Time Period of Admission Rule (Sept. 24, 2025)
6. Our AMA formally urged DHS to exclude J-1 physicians and their J-2 dependents from the proposed rule, stating that J-1 physicians are "already thoroughly vetted and carefully monitored, making additional guardrails redundant for this cohort," and that the proposed extension-of-stay process would be "duplicative, unnecessary, and wasteful" given existing Intealth and SEVIS oversight. The comment letter is a matter of public record filed with DHS under Docket No. ICEB-2025-0001
7. Intealth's Comment Letter to DHS: Summary of Policy Recommendations (Sept. 2025) - Intealth, the sole Department of State-designated sponsor of J-1 physicians, submitted formal comments to DHS recommending: (a) preservation of Duration of Status for J-1 physicians; (b) if D/S is not preserved, a fixed admission period equal to the full approved training program plus six months; (c) expansion of the Voluntary Self-Report Exit (VSRE) pilot program integrated with SEVIS; (d) express regulatory language confirming that J-1 physicians may change training programs or employers, with an appropriately endorsed Form DS-2019, during the pendency of an extension-of-stay application, and a corresponding update to Form M-274, Employer Handbook; (e) premium processing service for extension-of-stay applications; and (f) automatic extension of work authorization for J-2 Employment Authorization Document holders who timely file renewal applications. This resolution incorporates each of these recommendations.
8. Intealth (ECFMG), "Update on U.S. Department of Homeland Security Rule to End Duration of Status Framework for J, F, and I Visa Holders," ECFMG/Intealth News, July 16, 2026. <https://www.ecfm.org/news/2026/07/16/update-on-u-s-department-of-homeland-security-rule-to-end-duration-of-status-framework-for-j-f-and-i-visa-holders/>
9. Intealth's multi-year Form DS-2019 recommendation - Beginning fall 2026, Intealth plans to issue Forms DS-2019 reflecting a physician's full approved training program rather than annual increments, specifically to reduce administrative burden and align sponsorship documentation with the new fixed-period admission framework. Intealth has stated it will continue working with training programs, national GME organizations, and government stakeholders to identify further opportunities to mitigate the rule's impact. This resolution builds on that recommendation by asking USCIS to give appropriate evidentiary weight to Intealth's multi-year sponsorship determination when adjudicating extension-of-stay applications, consistent with USCIS's own existing deference policy.
10. American Medical Association, "Advocacy in action: Clearing IMGs' route to practice." <https://www.ama-assn.org/education/international-medical-education/advocacy-action-clearing-imgs-route-practice>

11. 7. American Medical Association, "Misguided J-1 visa proposal is a 'solution in search of a problem'," Nov. 23, 2020. <https://www.ama-assn.org/education/international-medical-education/misguided-j-1-visa-proposal-solution-search-problem>
12. American Medical Association, House of Delegates, International Medical Graduates Section, Resolution, "Ensuring Timely J-1 Visa Processing to Protect IMG Physicians" (Interim 2025). <https://www.ama-assn.org/system/files/i25-imgs-resolution-2.pdf>
13. American Medical Association (John Whyte, MD, MPH, EVP/CEO), Comment Letter to DHS Secretary Kristi Noem re: DHS Docket No. ICEB-2025-0001 / RIN 1653-AA95, "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure...", Sept. 24, 2025. https://downloads.regulations.gov/ICEB-2025-0001-21954/attachment_1.pdf
14. U.S. Citizenship and Immigration Services, USCIS Policy Manual, Vol. 2, Part A, Ch. 4, "Extension of Stay, Change of Status, and Extension of Petition Validity" (deference to prior determinations of eligibility absent material error, material change, or new material information). <https://www.uscis.gov/policy-manual/volume-2-part-a-chapter-4>
15. Intealth, Comment Letter to U.S. Department of Homeland Security, Re: DHS Docket No. ICEB-2025-0001, "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media" -- Summary of Policy Recommendations (Sept. 2025). On file with the AMA International Medical Graduates Section; a publicly posted copy was not independently located on regulations.gov at the time of drafting.
16. Health Resources and Services Administration, National Center for Health Workforce Analysis, "Physician Workforce: Projections, 2022-2037" (Nov. 2024) (projecting a shortage of approximately 187,130 full-time equivalent physicians by 2037). <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf>

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
 - a. completion of medical school and residency training outside the U.S.;
 - b. extensive U.S. medical practice; and
 - c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
 - a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
 - b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
 - c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
 - d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19 Modified: CME Rep. 2, A-21 Modified: CME Rep. 1, A-22 Modified: CCB/CLRPD Rep. 1, A-22 Reaffirmed: CME Rep. 03, A-23 Reaffirmed: Res. 312, A-25 Reaffirmed in lieu of the first resolve: Res. 234, A-25 Reaffirmed: Res. 241, A-25

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will 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.

Res. 216, I-25; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-26)

Introduced by: International Medical Graduates Section

Subject: Increasing Legislative Advocacy and Dedicated National Educational
Programming for International Medical Graduates (IMGs)

Referred to: Reference Committee B

1 Whereas, International Medical Graduates (IMGs) constitute approximately 25% of the active
2 physician workforce in the United States, providing critical medical care across primary care and
3 subspecialty fields; and
4

5 Whereas, IMGs disproportionately serve in federally designated Health Professional Shortage
6 Areas (HPSAs), Medically Underserved Areas (MUAs), and rural communities, providing care to
7 over 20 million Americans who reside in regions where foreign-trained physicians account for at
8 least half of the local physician pipeline; and
9

10 Whereas, the Association of American Medical Colleges (AAMC) projects a severe shortage of
11 up to 86,000 to 124,000 physicians, underscoring the indispensable necessity of recruiting,
12 retaining, and supporting IMG physicians to preserve healthcare access; and
13

14 Whereas, IMG physicians navigate complex regulatory, administrative, and immigration hurdles,
15 including visa processing delays, Conrad 30 waiver caps, and green card backlogs which
16 frequently disrupt clinical training, delay entry into practice, and jeopardize continuity of patient
17 care; and
18

19 Whereas, federal and state legislators, policymakers, and health system leaders often lack
20 comprehensive education regarding the structural barriers IMGs face and the vital role they play
21 in sustaining the U.S. healthcare safety net; and
22

23 Whereas, creating dedicated, recurring advocacy tracks, legislative education forums, and
24 unique programming focused on IMGs at national venues (such as the AMA National Advocacy
25 Conference and House of Delegates meetings) would elevate the IMG voice, build legislative
26 allies, and foster proactive policy solutions; therefore be it
27

28 RESOLVED, that our American Medical Association expand its federal and state advocacy
29 efforts to actively educate legislators, administrative agencies, and health system policymakers
30 on the critical role International Medical Graduates (IMGs) play in addressing national physician
31 workforce shortages and improving healthcare access in underserved populations (Directive to
32 Take Action); and be it further
33

34 RESOLVED, that our AMA collaborate with the AMA International Medical Graduates Section
35 (AMA-IMGs), state medical societies, and relevant specialty organizations to establish unique,
36 dedicated events and educational programming, including legislative briefings, advocacy
37 workshops, and policy panels focused on IMG workforce integration at national meetings such
38 as the AMA National Advocacy Conference (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA develop educational materials and policy toolkits highlighting key
- 2 IMG workforce issues (such as visa reauthorization, green card backlog relief, and licensing
- 3 equity) for distribution to federal and state lawmakers to support targeted healthcare workforce
- 4 legislation. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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1. American Medical Association. (2024). IMGs overcome barriers to offer critically needed care. AMA Education & Advocacy. <https://www.ama-assn.org/education/international-medical-education/imgs-overcome-barriers-offer-critically-needed-care>
2. Association of American Medical Colleges. (2024). The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. AAMC. <https://www.aamc.org/data-reports/workforce/data-open-data/physician-supply-and-demand-projections>
3. American Medical Association. (2026). National Advocacy Update: Clearing IMGs' Route to Practice. AMA Advocacy in Action. <https://www.ama-assn.org/health-care-advocacy/advocacy-update>
4. Health Resources and Services Administration. (2023). Designated Health Professional Shortage Areas Statistics. U.S. Department of Health and Human Services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy
Section

Subject: Advancing Physician Payment and Medicare and Medicaid Access for Street
Medicine

Referred to: Reference Committee B

1 Whereas, a systematic scoping review of 79 studies found that people experiencing
2 homelessness face profound structural barriers to health care, including transportation-related
3 costs, lack of documentation, administrative barriers, and poor continuity and integration of
4 service, which contribute to unmet health needs and delayed, fragmented care¹; and
5

6 Whereas, a review of 42 studies found that people experiencing unsheltered homelessness
7 often lack health insurance and use health care less despite disproportionately high rates of
8 chronic illness, serious mental illness, substance use, and premature mortality²; and

9 Whereas, street medicine brings health and social services directly to people experiencing
10 unsheltered homelessness in their own environments, and has emerged as a patient-centered
11 model that improves engagement, insurance enrollment, housing linkage, and some health
12 outcomes for people experiencing homelessness, with more than 150 programs operating
13 across the United States³⁻⁵; and
14

15 Whereas, street medicine programs have demonstrated the potential to reduce health care
16 utilization and costs, including reductions in hospital admissions and length of stay among
17 individuals experiencing homelessness^{3,5,6}; and
18

19 Whereas, federal and state policy landscapes are rapidly evolving to recognize and reimburse
20 care delivered outside traditional clinical settings, including federal designation of “outreach site/
21 street” as reimbursable sites for Medicare and Medicaid services and state Medicaid
22 innovations such as California’s AB 543 (2025), creating new opportunities while introducing
23 variability in implementation^{4,7,8}; and
24

25 Whereas, significant barriers to access persist for patients experiencing homelessness,
26 including low Medicaid reimbursement rates and administrative reimbursement challenges
27 disincentivizing providers, administrative churn due to frequent eligibility redeterminations,
28 delays in enrollment, and work/reporting requirements that disproportionately disrupt coverage
29 for individuals experiencing homelessness, contributing to delayed clinical presentation,
30 increased reliance on emergency departments, and higher rates of hospitalization⁹⁻¹¹; and
31

32 Whereas, emerging federal policies, including Medicaid work requirements enacted under H.R.1
33 (2025), risk further exacerbating coverage instability among the high-risk population of patients
34 experiencing homelessness¹²; and
35

36 Whereas, strategies including presumptive eligibility to facilitate point-of-care enrollment and
37 flexible network access have been shown to improve coverage continuity and access to care for

marginalized populations but remain inconsistently implemented and insufficiently aligned with street medicine delivery models¹³⁻¹⁵; and

Whereas, existing AMA policy supports innovative care delivery models, such as street medicine, but does not fully address the evolving reimbursement framework, administrative barriers to Medicaid access, or the need for standardized policies supporting physicians practicing in nontraditional care environments; therefore be it

RESOLVED, that the following American Medical Association policy, "Payment for Physicians who Practice Street Medicine H-160.886," be amended by addition to read as follows, and that the title be revised to "Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine":

- a. Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long-term costs.
- b. Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets."
- c. Our AMA supports presumptive eligibility and point-of-care Medicaid enrollment for individuals experiencing homelessness, reduced eligibility redeterminations to promote continuous coverage, and access to street medicine services regardless of network assignment.
- d. Our AMA supports exemptions or alternative pathways for individuals experiencing homelessness from Medicaid work and reporting requirements, including automatic or data-driven exemptions based on clinical and socioeconomic risk factors.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

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1. Gorski D, Alves da Costa F, Fuertes R, Gama-Marques J, Tavooschi L, Tonin FS. Barriers to and facilitators of healthcare access among people experiencing homelessness: a systematic scoping review. *Int J Equity Health*. 2026;25(1):99. Published 2026 Apr 3. doi:10.1186/s12939-026-02840-z
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12. National Health Care for the Homeless Council. Letter to state Medicaid directors and state legislative leaders: Medicaid eligibility changes under H.R. 1 and people experiencing homelessness. December 18, 2025. <https://nhchc.org/wp-content/uploads/2025/12/HR-1-homelessness-Letter-to-states.pdf>. Accessed September 16, 2026.
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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients.
10. Our AMA:
 - a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
 - b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
 - a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties;

- b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and
 - c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
- 13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

Payment for Physicians who Practice Street Medicine H-160.886

- a. Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long- term costs.
- b. Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with “street medicine” defined, in keeping with the Street Medicine Institute, as “the provision of health care directly to people where they are living and sleeping on the streets.”

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-26)

Introduced by: Resident and Fellow Section

Subject: Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents

Referred to: Reference Committee B

1 Whereas, resident clinics serve disproportionately vulnerable patient populations characterized
2 by higher psychosocial complexity, lower socioeconomic status, and greater barriers to care
3 compared to faculty and attending physician patient panels^{1,2}; and
4

5 Whereas, resident clinics generally experience financial difficulty that can be attributed, in part,
6 due to suboptimal coding and billing practices. with outpatient clinics considered to be a net
7 negative cost to health systems^{3,4}; and
8

9 Whereas, the Medicare Primary Care Exception (PCE) permits teaching physicians to bill for
10 evaluation and management services when residents performed low- and middle- complexity
11 visits in primary care settings without the teaching physician being physically present during the
12 key portion of the service, promoting graduated autonomy in a training context^{5,6,7}; and
13

14 Whereas, the PCE has implications on billing practices and may contribute to billing for lower
15 complexity visits that would otherwise qualify for higher complexity coding in part, due to in-
16 person supervision requirements, with estimated financial losses of \$2,558 per resident and
17 \$57,569 per year for an average residency, and up to 72.1% of visits billed at lower complexity
18 that could have been billed at higher complexity^{8,9,10}; and
19

20 Whereas, temporarily from March 31, 2020, to January 1, 2022 during the COVID-19 Public
21 Health Emergency, Medicare expanded the PCE to cover all patient visits regardless of
22 complexity level, allowing teaching physicians to bill for higher complexity visits under indirect
23 supervision without an in-person assessment required¹¹; and
24

25 Whereas, studies examining coding and billing patterns during and after the COVID-19 Public
26 Health Emergency noted a significant increase in higher complexity billing code utilization during
27 the expansion period and then a notable decrease in higher complexity billing code utilization
28 after its expiration^{12,13}; and
29

30 Whereas, the persistent inappropriate use of lower complexity billing codes may result in
31 significant revenue losses in outpatient practices of numerous fields in which the Medicare PCE
32 applies, including family medicine, outpatient internal medicine, geriatric medicine, pediatrics,
33 and obstetrics & gynecology⁷; and
34

35 Whereas, limited single-institution data suggests that trainees further along in their training (Post
36 Graduate Year 3) may utilize higher complexity billing codes less frequently than their more
37 junior peers, with potential revenue implications estimated to be greater than \$300,000 per fiscal
38 year¹³; and

Whereas, the current regulatory requirement for teaching physicians to be directly present in-person for moderate- or high- complexity visits may therefore influence senior trainees to underutilize higher complexity codes despite delivering higher complexity level of care to avoid supervision requirements^{9,11,13}; and

Whereas, underutilization of higher complexity codes may negatively impact clinic sustainability, staffing, productivity metrics (including Relative Value Units), case mix index, audit burden, and resource allocation; and

Whereas, analyses of the PCE by a working group from the Society of General Internal Medicine and by a group of academic teaching physicians offers recommendations for reform, including allowing moderate complexity visits to be eligible for the Primary Care Exception^{14,15}; and

Whereas, our American Medical Association is currently actively advocating to the Centers for Medicare & Medicaid Services on modernizing standards for appropriate supervision of residents, including recent changes to the Medicare Physician Fee Schedule permanently allowing virtual supervision of residents providing telehealth services in all training settings, a regulation that was temporarily allowed via the CMS Interim Final Rule issued during the COVID-19 Public Health Emergency^{16,17}; therefore be it

RESOLVED, that our American Medical Association study the Medicare Primary Care Exception and develop specific, evidence-based advocacy recommendations to CMS for modernizing teaching-physician regulations governing reimbursement in resident continuity clinics while maintaining appropriate supervision and patient safety safeguards. (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/16/26

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RELEVANT AMA POLICY

H-385.952: Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed. [Reaffirmed: CMS Rep. 01, A-19]

H-385.942: CMS Use of Regulatory Authority to Implement Reimbursement Policy

The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies. [Reaffirmed: Res. 105, A-18]

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

...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. [Reaffirmed: Res. 237, I-25]

H-330.939: Reimbursement by Medicare for Psychotherapy Provided by Residents

Our AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy. [Reaffirmed: BOT Rep. 09, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy
Section

Subject: Supporting a Common Legal Framework for Medical Capacity Holds

Referred to: Reference Committee B

1 Whereas, patients often lack decision-making capacity regarding the need to stay in the hospital
2 for treatment¹⁻⁴; and
3

4 Whereas, loss of decision-making capacity can occur due to both general medical conditions or
5 primary psychiatric disorders^{1-3,5}; and
6

7 Whereas, surrogate decision-making policies, guardianship laws, and practices are complex
8 and vary dramatically across states, courts, and institutions⁶⁻⁸; and
9

10 Whereas, physicians, facilities, and other healthcare providers may face legal liability for
11 permitting a patient who lacks decision-making capacity to leave the healthcare setting and
12 subsequently suffer harm^{2,9,10}; and
13

14 Whereas, physicians, facilities, and other healthcare practitioners can be held liable for unlawful
15 detention of a patient except in situations explicitly authorized by law^{1,2,11}; and
16

17 Whereas, there is currently no comprehensive federal statutory framework that specifically
18 permits physicians or facilities to detain an adult patient who lacks decision-making capacity due
19 to medical causes such as delirium, acute brain injury, dementia, or severe metabolic
20 derangement^{1,2,9}; and
21

22 Whereas, five states (Arkansas, Hawaii, Illinois, Maryland, and New York) enable the
23 involuntary detainment of patients without requiring that patients be diagnosed with a mental
24 illness, and Virginia allows physicians to petition the court to issue a temporary detention order
25 for a patient in a medical facility who is incapable of informed decision-making “due to a mental
26 or physical condition”¹; and
27

28 Whereas, states across the country have adopted psychiatric holds that provide clear standards
29 for who qualifies, protections of patient’s rights with due process, and appropriate protections for
30 healthcare workers and healthcare systems to use them^{1,2,12}; and
31

32 Whereas, psychiatric holds are commonly misused for patients lacking decision-making
33 capacity due to a condition other than a primary psychiatric condition or related substance use
34 disorder, with one large academic medical center finding 17.6% of involuntary psychiatric holds
35 were placed on patients who did not qualify for them, initiated for medical conditions rather than
36 psychiatric ones^{1,2,9}; and
37

38 Whereas, in the absence of statutory authority, healthcare systems have come to rely on ad hoc
39 institutional policies to detain medically incapacitated patients, policies that operate without any

explicit legal framework, standardized due-process protections, or liability protection for those involved^{1,2,9}; and

Whereas, the lack of standardized legal frameworks for medical capacity holds may result in inconsistent protections of patient rights, with the potential to exacerbate health inequities given that this population includes older adults, patients with cognitive impairment, and those with limited social support^{1,6,8,9,13}; and

Whereas this issue affects all inpatient hospital settings and medical specialties, and appropriate solutions may reduce the inappropriate use of involuntary psychiatric holds^{1,2,9}; therefore be it

RESOLVED, that the American Medical Association study existing laws, institutional practices, and ethical frameworks related to the use of medical holds for patients who lack medical decision-making capacity, with the goal of identifying best practices and informing potential model legislation. (Directive to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 09/16/2026

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RELEVANT AMA POLICY

E-2.1.2 Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is

impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
 - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
 - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.
- (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
 - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
 - (ii) the patient's views about life and how it should be lived;
 - (iii) how the patient constructed his or her life story; and
 - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
 - (i) the pain and suffering associated with the intervention;
 - (ii) the degree of and potential for benefit;
 - (iii) impairments that may result from the intervention;
 - (iv) quality of life as experienced by the patient.
- (f) Consult an ethics committee or other institutional resource when:
 - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
 - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
 - (iii) the physician judges that the surrogate's decision:
 - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
 - b. could not reasonably be judged to be in the patient's best interest; or
 - c. primarily serves the interests of the surrogate or other third party rather than the patient.

E-1.2.7 Use of Restraints

All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.

Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.

Physicians who order chemical or physical restraints should:

- (a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.
- (b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate:
 - (i) why restraint is recommended;
 - (ii) what type of restraint will be used;
 - (iii) length of time for which restraint is intended to be used.
- (c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed.

Involuntary Civic Commitment for Substance Use Disorder H-95.912

Our American Medical Association opposes civil commitment proceedings for patients with a substance use disorder unless:

A physician or mental health professional determines that civil commitment is in the patient's best interest consistent with our AMA Code of Medical Ethics.

Judicial oversight is present to ensure that the patient can exercise their right to oppose the civil commitment.

The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by their physician.

The facility is separate and distinct from a correctional facility.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review

Referred to: Reference Committee B

1 Whereas, state medical boards are increasingly regulating the clinical use of augmented
2 intelligence by physicians through professional standards and oversight of physician practice,
3 including guidance issues by the Federation for State Medical Boards, and credentialing bodies
4 are left to translate that into hospital privileges and competency requirements¹; and
5

6 Whereas, hospitals and health systems are increasingly incorporating augmented intelligence
7 into administrative and clinical governance workflows, with emerging applications supporting
8 credentialing, privileging, peer review, quality review, and other professional practice evaluation
9 processes²; and
10

11 Whereas, organized medical staff has overall responsibility for the quality of professional
12 services provided by physicians and other practitioners who hold privileges, including oversight
13 through credentialing, privileging, peer review, and ongoing professional practice evaluation³;
14 and
15

16 Whereas, physicians must have the ability to access, understand, and, when appropriate,
17 challenge the data, methodology, and rationale underlying the use of augmented intelligence
18 within administrative governance workflows, particularly when such information informs
19 credentialing, privileging, peer review, quality review, or any adverse medical staff action; and
20

21 Whereas, as per AMA policy H-225.942, physicians who report patient safety concerns must be
22 protected from retaliation; therefore be it
23

24 RESOLVED, that our American Medical Association advocate that any use of augmented
25 intelligence in credentialing, privileging, peer review, quality review, or corrective action requires
26 physician-led oversight and this be codified in medical staff bylaws (Directive to Take Action);
27 and be it further
28

29 RESOLVED, that our AMA encourage the requirement of hospital and health systems to fully
30 disclose the data sources, validation, limitations, governance, and intended use of any
31 augmented intelligence tool used in medical staff processes (New HOD Policy); and be it further
32

33 RESOLVED, that our AMA will communicate its policy on requiring physician-led oversight of
34 augmented intelligence when used in credentialing, privileging, peer review and quality review
35 on a continuing basis to the American Hospital Association, Federation of American Health
36 System, and other appropriate organizations (Directive to Take Action); and be it further
37

38 RESOLVED, that our AMA reaffirm policy H-225.942, Physician and Medical Staff Member Bill
39 of Rights, that opposes any retaliatory peer review privileging action, corrective action, or

- 1 employment action taken against a physician for good-faith safety reporting advocacy, or
- 2 participation in organized medical staff governance. (Reaffirmed HOD Policy)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/16/26

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RELEVANT AMA POLICY

Physician and Medical Staff Member Bill of Rights H-225.942

Our American Medical Association adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

- I. **Our AMA recognizes the following fundamental responsibilities of the medical staff:**
 - a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
 - b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
 - c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to
 - i. initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations,
 - ii. selecting and removing medical staff leaders,
 - iii. controlling the use of medical staff funds,
 - iv. being advised by independent legal counsel, and
 - v. establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
- g. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

- IV. **Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to their patients, the medical staff, and the health care organization:**
- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
 - b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
 - c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
 - d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
 - e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
 - f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
 - g. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

Economic Credentialing H-230.975

The AMA (1) adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges;

(2) strongly opposes the practice of economic credentialing;

(3) believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected;

(4) believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments;

(5) will communicate its policy and concerns on economic credentialing on a continuing basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations;

(6) encourages state medical societies to review their respective state statutes with regard to economic credentialing and, as appropriate, to seek modifications therein;

(7) will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and

(8) will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems.

Citation: CMS Rep. B, I-91; Reaffirmed: BOT Rep. 14, A-98; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: CMS Rep. 4, I-20

Hospital Medical Staff Self-Governance H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.

2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.

3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:

- (a) Application, reapplication, credentialing and privileging standards;
- (b) Fair hearing and appeal process;
- (c) Selection, election and removal of medical staff officers;
- (d) Clinical criteria and standards which manage quality assurance, utilization review;
- (e) Structure of the medical staff organization;
- (f) Rules and regulations that affect the entire medical staff.

4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

Citation: Sub Res. 201, A-89; Reaffirmed: Sub Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25

Credentialing and the Quality-of-Care H-225.971

1. It is the policy of our American Medical Association that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care.
2. It is the policy of the AMA that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges.
3. It is the policy of the AMA that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care.
4. It is the policy of the AMA that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals.
5. It is the policy of the AMA that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities.
6. It is the policy of the AMA that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws.
7. It is the policy of the AMA that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff.
8. It is the policy of the AMA that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.

Citation: BOT Rep. T, I-92; Reaffirmed: Rep. 10, A-03; Modified: CMS Rep. 4, A-13; Reaffirmed; CMS Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-26)

Introduced by: American Society of Addiction Medicine

Subject: Increasing Access to Long-Acting Injectable Medications for SUD

Referred to: Reference Committee B

1 Whereas, long-acting injectable (LAI) medications, also commonly described as extended-release
2 injectable medications, have been approved by the Food and Drug Administration (FDA) to treat
3 opioid use disorder (OUD) and alcohol use disorder (AUD); and ^{1,2}
4

5 Whereas, LAIs expand treatment options for patients with OUD or AUD by reducing the need for
6 daily medication administration and may support treatment continuity while reducing risks
7 associated with lost, stolen, or diverted medication; and ³
8

9 Whereas, medication acquisition and billing requirements, mandatory specialty-pharmacy
10 distribution, and utilization-management protocols such as prior authorization, step therapy, and
11 fail-first policies can delay or impede access to LAI medications; and ^{4,5}
12

13 Whereas, patient cost-sharing requirements, including deductibles, copayments, and coinsurance,
14 may reduce adherence to and retention in medication treatment for OUD; and ⁶
15

16 Whereas, permitting appropriately trained pharmacists to administer lawfully prescribed long-acting
17 injectable medications for substance use disorders in pharmacy settings, after the initial dose and
18 with appropriate patient-safety safeguards and communication with the prescribing clinician, could
19 expand access to treatment; and ⁷
20

21 Whereas, federal controlled-substance registration requirements generally require a separate
22 registration for each principal place of professional practice where controlled substances are
23 dispensed, creating administrative and financial barriers when practitioners furnish controlled-
24 substance LAIs at multiple practice locations; and ⁸
25

26 Whereas, FDA-approved prescribing information for extended-release buprenorphine permits a
27 second injection as early as one week after the initial injection based on patient need; and ⁹

28 Whereas, Medicare OTP coding and payment distinguish between weekly and monthly injectable
29 buprenorphine bundles, and payment policies should clearly account for every medically necessary
30 dose permitted under FDA-approved initiation and dosing protocols, including a second injection
31 administered as early as one week after the first; therefore be it ¹⁰
32

33 RESOLVED, that our American Medical Association reaffirm its support for coverage of all FDA-
34 approved medications for SUDs without prior authorization, step therapy, fail-first requirements, or
35 other non-evidence-based utilization-management restrictions (New HOD Policy); and be it further
36

37 RESOLVED, that our AMA support the elimination of patient cost-sharing for FDA-approved
38 medications used to treat SUDs and their administration (New HOD Policy); and be it further
39

40 RESOLVED, that our AMA advocate for payer payment policies for LAIs that appropriately account
41 for each medically necessary dose and its preparation and administration (Directive to Take
42 Action); and be it further

RESOLVED, that our AMA support federal and state rules and regulations permitting appropriately trained pharmacists to administer lawfully prescribed LAI medications for substance use disorders, after the initial dose, pursuant to a physician's prescription and with appropriate communication with the prescribing physician, in pharmacy settings that satisfy applicable federal and state registration, certification, medication-security, and patient-safety requirements (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Drug Enforcement Administration (DEA), FDA, and other relevant federal agencies to study and support opportunities to reduce unnecessary and duplicative administrative and financial barriers to furnishing LAIs for SUDs across multiple sites of care, including by developing pathways that allow qualified practitioners to administer such medications at multiple appropriately licensed or certified locations without duplicative registrations, fees, or site-enrollment requirements, while preserving appropriate medication-security and patient-safety safeguards. (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

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RELEVANT AMA POLICY

D-95.948 Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder

Our AMA advocates 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. [Res. 221, I-25]

D-95.968 Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders

Our American Medical Association will:

- a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and

b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder and other evidence-based options are first-line treatments for this chronic medical disease.

Our AMA will support further research into how primary care practices can implement medications for opioid use disorder into their practices and disseminate such research in coordination with primary care specialties.

Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy and publicize those resources to the Federation.

Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders. [Res. 222, A-18; Appended: BOT Rep. 02, I-19; Modified: Res. 228, A-23]

D-100.975 One Fee One Number

Our American Medical Association will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, providers should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single-state requirements.

Our AMA continues to monitor implementation of the National Provider Identifier system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database. [Reaffirmed: Res. 302, A-26]

D-100.980 One Fee, One Number

Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific. [Reaffirmed: Res. 302, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-26)

Introduced by: American Society of Addiction Medicine

Subject: Hospital-Based Substance Use Disorder Care

Referred to: Reference Committee B

1 Whereas, almost 12 percent of inpatient hospitalizations and approximately 9 percent of
2 emergency departments (ED) visits were for patients with substance use disorder (SUD)
3 between 2014 and 2018;¹ and
4

5 Whereas, the Substance Abuse and Mental Health Services Administration (SAMHSA)
6 estimated 8.4 million drug-related visits (including visits involving alcohol) to hospital EDs in
7 2024, up more than 10 percent from the year prior;² and
8

9 Whereas, in 2017 alone, the medical costs associated with SUD care in US hospitals and EDs
10 exceeded \$13 billion;³ and
11

12 Whereas, some studies show a 12-month mortality rate of 8 percent for patients hospitalized
13 with opioid use disorder (OUD) after discharge ⁴ and 6 percent for patients with fentanyl use
14 after an ED visit⁵; and
15

16 Whereas, SUD often is unaddressed in hospital settings despite existence of effective
17 treatments; and
18

19 Whereas, substantial gaps remain in the availability of hospital-based addiction services,
20 particularly in rural and underserved communities; and
21

22 Whereas, the lack of treatment is associated with increased rates of premature hospital
23 discharge;⁶ and
24

25 Whereas, the lack of training, education, and guidance on how to manage SUD and the limited
26 integration of SUD treatment into hospitals and EDs may also contribute to stigma among
27 clinicians;^{7, 8} and
28

29 Whereas, evidence exists that initiating SUD treatment in hospital settings can improve clinical
30 outcomes,⁹ reduce subsequent acute care utilization,¹⁰ overdose risk¹¹ and post-discharge
31 mortality;¹² and
32

33 Whereas, there are consensus standards and implementation guidance¹³ identifying core
34 competencies for hospital-based SUD care; and
35

36 Whereas, this guidance identifies prominent models of care, such as addiction consultation
37 services (ACS), practice-based models, and bridge clinics that have demonstrated effectiveness
38 in increasing medication initiation and linkage to ongoing care; and
39

40 Whereas, the Medicare Hospital Outpatient Quality Reporting Program does not currently

include quality measures that assess hospital performance in delivering evidence-based outpatient addiction treatment;^{14, 15} and

Whereas, existing private and public payment systems inadequately recognize the resources and staffing, including multidisciplinary clinical expertise, care navigation, peer support, and community-based services necessary to deliver comprehensive hospital-based addiction treatment as described in these models;^{16, 17} therefore be it

RESOLVED, that our American Medical Association support the development, implementation, and dissemination of evidence-based competencies for SUD care in hospitals and emergency departments, including screening, assessment, withdrawal management, overdose care, initiation and continuation of FDA-approved addiction medications, risk-reduction services, and linkage to ongoing treatment (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for increased availability of and access to hospital-based addiction treatment services, as appropriate to hospital size, patient volume, and community need (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the development, testing, adoption, and public reporting of hospital quality measures related to SUD treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and other payers for evaluation and modernization of hospital payment systems to ensure adequate recognition and reimbursement of resources required to deliver evidence-based hospital-based SUD care. (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

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RELEVANT AMA POLICY

D-95.967 Treating Opioid Use Disorder in Hospitals

Our AMA's Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.

Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.

Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations. [Res. 223, A-18]

D-95.968 Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders

Our American Medical Association will:

- a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and
- b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder and other evidence-based options are first-line treatments for this chronic medical disease.

Our AMA will support further research into how primary care practices can implement medications for opioid use disorder into their practices and disseminate such research in coordination with primary care specialties.

Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy and publicize those resources to the Federation.

Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders. [Res. 222, A-18; Appended: BOT Rep. 02, I-19; Modified: Res. 228, A-23]

H-450.966 Quality Management

Our AMA continues to advocate for quality management provisions that are consistent with AMA policy.

Our AMA seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures.

Our AMA continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures.

Our AMA emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts.

Our AMA urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures.

Our AMA advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:

- a. Standards and measures shall have demonstrated validity and reliability.
- b. Standards and measures shall reflect current professional knowledge and available medical technologies.
- c. Standards and measures shall be linked to health outcomes and/or access to care.
- d. Standards and measures shall be representative of the range of health care services commonly provided by those being measured.
- e. Standards and measures shall be representative of episodes of care, as well as team-based care.
- f. Standards and measures shall account for the range of settings and practitioners involved in health care delivery.
- g. Standards and measures shall recognize the informational needs of patients and physicians.
- h. Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.
- i. Standards and measures shall recognize the importance and implications of patient choice and preference.
- j. Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.
- k. Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. [BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed: CMS Rep. 7, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-26)

Introduced by: Colorado

Subject: Protecting Individual Rights in the Era of Developing Neurotechnologies,
Including for Mental Augmentation

Referred to: Reference Committee B

1 Whereas, neurotechnologies are devices capable of recording, interpreting, or altering the
2 response of an individual's central or peripheral nervous system to its internal or external
3 environment; and¹
4

5 Whereas, the AMA House of Delegates adopted Resolution 503 of June 11, 2025, creating a
6 new policy stating: "RESOLVED, that our AMA recognizes that neural data is information
7 obtained by measuring the activity of a person's central or peripheral nervous system through
8 the use of neurotechnologies, but neural data does not include data inferred from nonneural
9 information"; and¹
10

11 Whereas, in Resolution 503, the House of Delegates also created a new policy stating:
12 "RESOLVED, that our AMA oppose any efforts to broaden the consensus medical definition of
13 neural data to include data inferred from nonneural information gathered by biosensors
14 (including biometric devices), as this is a distinct category of data with its own independent
15 qualities and regulatory needs"; and¹
16

17 Whereas, advances in neurotechnology increasingly permit modulation of neural functions
18 associated with memory, attention, perception, communication, mood, learning, and other
19 cognitive capacities, creating opportunities both to treat neurological and psychiatric disease
20 and to augment human capabilities, although the distinction between therapy and augmentation
21 may not always be scientifically or clinically discrete; and²⁻⁵
22

23 Whereas, mental augmentation may provide substantial benefits to individuals and society,
24 including improvements in cognition, communication, independence, education, occupational
25 performance, and human flourishing; and²⁻⁵
26

27 Whereas, the increasing availability of mental augmentation neurotechnologies may expose
28 individuals to coercion or undue pressure from employers, educational institutions,
29 governments, health insurers, military organizations, or other entities, implicating individual
30 autonomy and the freedom both to use and to decline such technologies; and⁴⁻⁶
31

32 Whereas, unequal access to effective mental augmentation neurotechnologies could create or
33 exacerbate disparities in health, education, employment, economic opportunity, and
34 participation in society; and⁴⁻⁷
35

36 Whereas, neurotechnologies capable of augmenting mental function may generate sensitive
37 neural data and alter cognition, behavior, perception, emotion, or decision-making, raising
38 distinct concerns regarding mental privacy, identity, agency, and continuity of the self; and^{1,4,5,8}

1 Whereas, physicians and medical specialty societies possess important expertise regarding the
2 safety, efficacy, appropriate use, and consequences of technologies that alter neurological and
3 cognitive function, while their broader social use also implicates ethical, legal, and human-rights
4 considerations; therefore be it^{4,5,9}

5
6 RESOLVED, that our American Medical Association strongly supports a hybrid approach to
7 improving state consumer data privacy laws that both (1) defines neural data consistent with
8 existing AMA policy and protects neural data as sensitive data; and (2) provides heightened
9 protections based on use for data inferred from nonneural information gathered by biosensors,
10 including biometric devices, when such data is used to infer sensitive information about an
11 individual's mental or cognitive states. Any such use-based category should be precisely
12 defined to distinguish mental or cognitive inferences warranting heightened protection because
13 their sensitivity approaches that of neural data from other inferences derived from nonneural
14 information that do not warrant such protection (New HOD Policy); and be it further

15
16 RESOLVED, that our AMA recognizes the right of individuals to make voluntary and informed
17 decisions whether to use mental augmentation neurotechnologies, consistent with applicable
18 standards governing safety, efficacy, and informed consent, and supports protections against
19 coercion, undue pressure, or unjust discrimination based on an individual's decision to use or
20 decline such technologies, except where otherwise ethically and legally justified under narrowly
21 defined circumstances (New HOD Policy); and be it further

22
23 RESOLVED, that our AMA support policies promoting equitable access to safe and effective
24 mental augmentation neurotechnologies when lack of access would create or substantially
25 exacerbate disparities in health, education, employment, or participation in society (New HOD
26 Policy); and be it further

27
28 RESOLVED, that our AMA support appropriate protections for the mental privacy, neural data,
29 identity, and agency of individuals using mental augmentation neurotechnologies, including
30 meaningful control over the collection, use, disclosure, and commercialization of neural data
31 generated through such technologies (New HOD Policy); and be it further

32
33 RESOLVED, that our AMA encourage physicians, neuroscientists, patients, ethicists, disability
34 advocates, and other relevant stakeholders to participate in developing evidence-based
35 standards and ethical frameworks governing the safety, efficacy, voluntary use, and equitable
36 availability of mental augmentation neurotechnologies. (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/18/26

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2. Grover S, Wen W, Viswanathan V, Gill CT, Reinhart RMG. Long-lasting, dissociable improvements in working memory and long-term memory in older adults with repetitive neuromodulation. *Nat Neurosci*. 2022;25:1237-1246. doi:10.1038/s41593-022-01132-3.
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8. Organisation for Economic Co-operation and Development. Recommendation of the Council on Responsible Innovation in Neurotechnology. OECD/LEGAL/0457. Adopted December 11, 2019.
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RELEVANT AMA POLICY

H-315.957 Safeguarding Neural Data Collected by Neurotechnologies

1. Our AMA supports legislative and regulatory efforts to protect the privacy and security of individuals' neurological data as well as protection from discrimination and inequality that may be caused by the use of neurotechnologies.
2. Our AMA recognizes that neural data is information obtained by measuring the activity of a person's central or peripheral nervous system through the use of neurotechnologies, but neural data does not include data inferred from nonneural information.
3. Our AMA opposes any efforts to broaden the consensus medical definition of neural data to include data inferred from nonneural information gathered by biosensors (including biometric devices), as this is a distinct category of data with its own independent qualities and regulatory needs.

Policy Timeline: Res. 503, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-26)

Introduced by: Private Practice Physicians Section

Subject: Due Process, Transparency, and Accountability for Delegated Third-Party
Prior Authorization and Utilization Management Entities

Referred to: Reference Committee B

1 Whereas, health insurers increasingly delegate prior authorization (PA) and utilization
2 management (UM) determinations to third-party vendors such as EviCore (now part of
3 Evernorth, a Cigna subsidiary), which issues coverage recommendations for advanced imaging,
4 oncology, cardiology, pain management, and other services on behalf of more than 100 insurers
5 whose plans cover approximately 100 million Americans; and

6
7 Whereas, these delegated UM entities are retained and compensated by health plans — not by
8 patients, plan enrollees, or treating physicians — and therefore owe no contractual duty,
9 fiduciary obligation, or professional accountability to the patient whose care they adjudicate or to
10 the physician who ordered it; and

11
12 Whereas, investigative reporting has documented that such entities market their services to
13 insurers on the promise of a return on investment as high as 3-to-1 — three dollars in reduced
14 medical spending for every dollar of vendor fees — creating a direct financial incentive to deny
15 rather than approve medically necessary care; and

16
17 Whereas, that same reporting describes proprietary algorithmic controls, referred to internally as
18 “the dial,” which can be adjusted to raise or lower the proportion of requests routed for manual
19 clinical review, permitting effective denial rates to be calibrated to financial targets rather than to
20 clinical evidence or patient need; and

21
22 Whereas, peer-reviewed appraisal of one such entity’s advanced diagnostic imaging guidelines
23 for the spine found material departures from national medical specialty society
24 recommendations and the published evidence base, and the HHS Office of Inspector General
25 has repeatedly found that Medicare Advantage organizations deny prior authorization requests
26 that meet Medicare coverage rules, with denials overturned on appeal at very high rates; and

27
28 Whereas, AMA Policy H-480.940 calls for insurer use of augmented intelligence in claims and
29 prior authorization review to include review by physicians “with no incentive to deny care,” and
30 AMA Policy H-320.939 calls for adverse determinations to be reviewed directly by a physician of
31 the same medical specialty or subspecialty as the ordering physician, yet no federal
32 requirement operationalizes either standard when review has been delegated to a financially
33 interested third-party entity; and

34
35 Whereas, AMA Policy H-285.939 establishes that utilization review decisions to deny payment
36 for medically necessary care constitute the practice of medicine and that medical directors of
37 insurance entities must be held accountable and liable for those decisions, but delegation to a
38 third-party entity allows a health plan to place its own medical director beyond the reach of the
39 treating physician while retaining the coverage decision; and

Whereas, existing federal frameworks — the ERISA claims procedure regulation at 29 CFR 2560.503-1, the Affordable Care Act internal appeals and external review requirements, the Medicare Advantage utilization management rules at 42 CFR Part 422 Subpart M as strengthened by CMS-4201-F, and the Interoperability and Prior Authorization Final Rule (CMS-0057-F) — govern the plan's obligations but do not require a plan to make its own medical director available for peer-to-peer review following a delegated adverse determination, do not require disclosure of the financial terms of delegated UM contracts, and do not prohibit compensation contingent on denial or savings targets; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation and/or regulation requiring that, whenever a delegated third-party utilization management entity issues an adverse determination denying, reducing, or terminating requested care, the health plan make its own medical director — licensed in the state in which the patient is receiving care and of the same specialty or subspecialty as the ordering physician — directly available to the treating physician for peer-to-peer review, and that the health plan's medical director, rather than the delegated entity's reviewer, bear final accountability for the coverage determination (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate for federal legislation and/or regulation when appropriate, irrespective of contract type, requiring health plans and their delegated utilization management entities to publicly disclose the material financial terms of their utilization management contracts, in particular whether any portion of compensation is contingent upon or proportional to denial rates, cost-savings targets, or return-on-investment guarantees (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation and/or regulation establishing that delegated third-party utilization management entities and their clinical reviewers are subject to the same accountability standards applicable to health plan medical directors under AMA Policy H-285.939, and that the contracting health plan remain jointly accountable for adverse determinations issued on its behalf. (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/18/26

References:

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8. U.S. Department of Labor. ERISA Claims Procedure Regulation, 29 CFR 2560.503-1. <https://www.ecfr.gov/current/title-29/section-2560.503-1>

RELEVANT AMA POLICY

Managed Care Medical Director Liability H-285.939

AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

Citation: Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07; Reaffirmed in lieu of Res. 235, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmed: CMS Rep. 4, A-21.

Prior Authorization and Utilization Management Reform H-320.939

Our AMA will continue its widespread prior authorization advocacy and outreach; will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician; supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access and clinical outcomes, including the extent to which these processes contribute to patient harm; and will advocate for health plans to minimize burden when updates must be made to previously approved and/or pending prior authorization requests.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22.

Medical Necessity and Utilization Review H-320.942

Our AMA supports efforts to ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care.

Citation: Res. 810, I-16; Reaffirmation: A-18; Reaffirmation: A-22.

Utilization Review, Medical Necessity Determination, Prior Authorization Decisions D-320.977

Our AMA will advocate for implementation of a federal version of a prior authorization "gold card" law, and that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization.

Citation: Res. 727, A-22; CEJA Rep. 01, A-23.

Augmented Intelligence in Health Care H-480.940

Our AMA will advocate for greater regulatory oversight of insurers' use of augmented intelligence for review of patient claims and prior authorization requests, including that the process be based on accurate and up-to-date clinical criteria, include review by physicians and other health care professionals with expertise for the service under review and no incentive to deny care, and require human examination of patient records prior to a care denial.

Citation: BOT Rep. 41, A-18; Appended: A-23; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-26)

Introduced by: Puerto Rico

Subject: Medicare and Medicaid Payment Equity for Puerto Rico

Referred to: Reference Committee B

1 Whereas, existing American Medical Association policy supports eliminating inequities in
2 Medicare reimbursement for physicians' services in Puerto Rico so that payment is determined
3 under the Medicare rules applicable in the continental United States; and
4

5 Whereas, adequate and sustainable Medicare and Medicaid payment is essential to physician
6 participation and meaningful patient access to care; and
7

8 Whereas, Puerto Rico continues to face physician workforce shortages, accelerated population
9 aging, a substantial burden of chronic disease, and economic pressures that threaten the
10 stability of its health care delivery system; and
11

12 Whereas, low Medicaid payment and unstable financing can limit physician participation and
13 create barriers to timely care for patients with low incomes; and
14

15 Whereas, temporary federal funding measures have helped preserve coverage and continuity of
16 services in Puerto Rico, but the scheduled expiration of enhanced support in September 2027
17 could create a severe financing shortfall for the Puerto Rico Medicaid program; and
18

19 Whereas, this resolution concerns federal advocacy and seeks action before the next Annual
20 Meeting, consistent with the criteria for business at the 2026 Interim Meeting; therefore be it
21

22 RESOLVED, that our American Medical Association reaffirm Policy H-390.953, "Medicare
23 Payments for Physicians' Services in Puerto Rico," supporting elimination of inequities in
24 Medicare reimbursement for physicians' services in Puerto Rico (Reaffirm HOD Policy); and be
25 it further
26

27 RESOLVED, that our AMA advocate before the United States Congress, the Centers for
28 Medicare & Medicaid Services, and other pertinent federal agencies for long-term legislative
29 and regulatory measures that provide equitable and sustainable Medicare Advantage and
30 physician reimbursement policies for Puerto Rico (Directive to Take Action); and be it further
31

32 RESOLVED, that our AMA advocate for long-term, adequate, and sustainable federal financing
33 for the Puerto Rico Medicaid program and oppose interruptions or reductions in federal support
34 that would impair patient access to care or physician workforce stability (Directive to Take
35 Action); and be it further
36

37 RESOLVED, that our AMA work with the Puerto Rico Medical Association and other relevant
38 stakeholders to advance policies that strengthen Puerto Rico's health care infrastructure,
39 physician recruitment and retention, and long-term health system sustainability. (Directive to
40 Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/21/26

REFERENCES

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2. American Medical Association. Medicare Reform & Medicaid Payment. Updated June 2, 2026.
3. American Medical Association. 2026 Interim Meeting of the HOD: Sept. 2 Speakers' Update. September 2, 2026

RELEVANT AMA POLICY

H-390.953 Medicare Payments for Physicians' Services in Puerto Rico

Our AMA supports the elimination of inequities in Medicare reimbursement so that physicians' fees for Medicare patients in Puerto Rico are adjusted according to the Medicare regulations applicable in the continental United States.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-26)

Introduced by: American Society of Interventional Pain Physicians, American Academy of Pain Medicine, American Academy of Hospice and Palliative Medicine, American Society of Regional Anesthesia and Pain Medicine

Subject: Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care

Referred to: Reference Committee B

1 Whereas, Federal law requires health professionals licensed to prescribe, administer, or
2 dispense controlled substances to register with the Drug Enforcement Administration (DEA),
3 subject to limited exceptions; and
4

5 Whereas, DEA's Diversion Control Division is responsible for more than 1.9 million medical
6 practitioners; and
7

8 Whereas, Physicians in most specialties and practice settings depend on timely DEA
9 registration to begin practice, change practice locations, practice in additional states, and
10 maintain uninterrupted care for their patients; and
11

12 Whereas, DEA's published Customer Service Plan for Registrants does not include a
13 processing-time standard for practitioner registrations; and
14

15 Whereas, recently published guidance has advised physicians to expect roughly four to eight
16 weeks for a new application; and
17

18 Whereas, as recently as 2024, new DEA applicant registrations were approved in 24-48 hours
19 and renewals were processed automatically; and
20

21 Whereas, approximately 1.5 million renewal applications were approved automatically by DEA's
22 registration system in fiscal years 2022 through 2024; and
23

24 Whereas, DEA's published policy allows a registrant who submits a timely renewal application
25 to continue operating beyond the expiration date until final action is taken, but that published
26 policy addresses only renewal applications; and
27

28 Whereas, In September 2026, DEA's national Registration Service Center advised physician
29 applicants that registration processing queues exceeded one month, and registration staff
30 stated in writing that pending applications are processed in the order received, depending on
31 the workload of the assigned Registration Specialist, and that no timeframe can be given; and
32

33 Whereas, Hospitals, health systems, and payers commonly require a current DEA registration to
34 complete physician credentialing and privileging, so registration delays can leave credentialing
35 files incomplete, postpone start dates, threaten lapses in prescribing authority, worsen
36 workforce shortages, and delay patient care, including for our nation's veterans; and

1 Whereas, a July 2026 audit by the U.S. Department of Justice Office of the Inspector General
2 (OIG Report 26-069) found that, as of July 2025, DEA had 81 Registration Program Specialists
3 located across its 23 field divisions, that Specialist staffing had declined by six positions from
4 July 2024 to July 2025, and that this decline together with an extended 2025 hiring freeze
5 produced a 19 percent vacancy rate against a ceiling of 100 positions; and
6

7 Whereas, DEA informed the OIG that Diversion Investigators were assisting Registration
8 Program Specialists as a temporary solution that cannot be sustained long-term, and DEA
9 stated in its response to the OIG that it remains under a federal hiring freeze and will close its
10 Specialist staffing gap once the freeze is lifted; and
11

12 Whereas, the OIG reported that the DEA registrant population is growing an estimated 3
13 percent annually, about 66,000 new registrants per year; and
14

15 Whereas, the OIG reported that DEA's Diversion Control Program is fully funded by registrant
16 fees, collecting over \$1.8 billion between January 2022 and December 2024, and received over
17 94 percent of those fees from practitioners, whose registration fee is \$888 for a three-year
18 registration period; and
19

20 Whereas, the OIG also recommended, and DEA concurred, that DEA implement standardized
21 quality assurance measures for registration applications and include medical practitioners in its
22 scheduled investigation workplan, and the OIG noted the potential need to incorporate new
23 quality assurance measures alongside Specialists' existing duties; and
24

25 Whereas, Federal law and DEA regulations require a separate DEA registration in each state in
26 which a practitioner prescribes or dispenses controlled substances, so physicians who practice
27 in multiple states, relocate, provide locum tenens coverage, or deliver care by telehealth must
28 obtain, pay for, and renew multiple registrations, and each new registration exposes physicians
29 and their patients to the risk of processing delays; and
30

31 Whereas, a single DEA registration number usable in every state in which a physician is
32 authorized to practice, as envisioned by Policy D-100.975, would reduce the number of
33 applications physicians must file and DEA must process, and with it the opportunities for such
34 delays; and
35

36 Whereas, a review of AMA PolicyFinder identified policy supporting timely and expedited
37 processing of physician visas (D-255.980, D-255.966, H-255.961) and state medical licensure
38 (D-275.994), and policy on DEA registration fees and structure (D-100.970, D-100.975, D-
39 100.980), but identified no policy specifically addressing the timeliness of DEA registration
40 processing; and
41

42 Whereas, no publicly available comprehensive data was identified on the extent of DEA
43 registration processing delays or their effect on physicians and patients; therefore be it
44

45 RESOLVED, that our American Medical Association advocate that the Drug Enforcement
46 Administration restore timely processing of complete practitioner registration applications,
47 including initial, renewal, and modification applications, consistent with its historical processing
48 times (Directive to Take Action); and be it further

1 RESOLVED, that our AMA advocate that the Drug Enforcement Administration provide each
2 practitioner registration applicant with an estimated date of issuance and timely status updates,
3 and publicly report average practitioner registration processing times by field division (Directive
4 to Take Action); and be it further

5
6 RESOLVED, that our AMA advocate that the Drug Enforcement Administration establish a
7 transparent expedited review process for practitioner registration applications when a
8 processing delay would interrupt patient care (Directive to Take Action); and be it further

9
10 RESOLVED, that our AMA advocate that no physician who has submitted a complete and
11 timely Drug Enforcement Administration registration application experience a lapse in controlled
12 substance prescribing authority due to agency processing delays, including through continuation
13 of an existing registration or issuance of a provisional registration while the application is
14 pending (New HOD Policy); and be it further

15
16 RESOLVED, that our AMA urge Congress and the Department of Justice to fill vacant Drug
17 Enforcement Administration Registration Program Specialist positions, exempt fee-funded
18 registration positions from federal hiring freezes, and ensure that practitioner registration fees
19 are used to maintain timely registration services (Directive to Take Action); and be it further

20
21 RESOLVED, that our AMA advocates that any new quality assurance or review procedures the
22 Drug Enforcement Administration adopts for practitioner registration applications be developed
23 with input from organized medicine, be adequately staffed, and be implemented without
24 lengthening registration processing times (Directive to Take Action); and be it further

25
26 RESOLVED, that our AMA survey its membership, in collaboration with interested state and
27 specialty medical societies, to assess the extent of Drug Enforcement Administration
28 registration processing delays and their effects on physician practice, credentialing,
29 employment, and patient access to care, and report findings to the House of Delegates
30 (Directive to Take Action); and be it further

31
32 RESOLVED, that our AMA work with Congress, the Department of Justice Office of the
33 Inspector General, and the Government Accountability Office to monitor Drug Enforcement
34 Administration practitioner registration processing times and staffing and their effect on patient
35 access to care (Directive to Take Action); and be it further

36
37 RESOLVED, that our AMA reaffirm Policy D-100.970, "Drug Enforcement Administration
38 Licensure Fees," and Policy D-100.975, "One Fee One Number," in its entirety, which directs
39 our AMA to work with the Drug Enforcement Administration and Congress toward a registration
40 system in which a single DEA registration number can be used by physicians who prescribe,
41 dispense, or administer controlled substances in multiple states, and in which the full DEA
42 registration fee is paid only once, at initial registration, with only a small re-registration fee every
43 three years thereafter. (Reaffirm HOD Policy)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/22/26

References:

1. U.S. Department of Justice, Office of the Inspector General. *Audit of the Drug Enforcement Administration's Registration Process for Medical Practitioners*. Audit Division Report 26-069. July 2026.
<https://www.oversight.gov/sites/default/files/documents/reports/2026-07/26-069.pdf>
2. U.S. Drug Enforcement Administration, Diversion Control Division. Registration and Customer Service Plan for Registrants.
<https://www.deadiversion.usdoj.gov/drugreg/registration.html>; https://www.deadiversion.usdoj.gov/pubs/docs/cs_plan.html. Accessed September 18, 2026.
3. South Dakota Department of Health. Controlled Substance Registration (stating that new practitioners applying for both a South Dakota controlled substance registration and a new DEA registration can expect the process to take a minimum of six weeks, according to DEA). <https://doh.sd.gov/healthcare-professionals/health-facility-licensure/controlled-substance-registration/>. Accessed September 18, 2026.
4. CompHealth. How to Obtain a DEA License: Application, Fees, and Renewal Guide (stating first-time applicants should expect four to six weeks). <https://comphealth.com/resources/how-to-obtain-a-dea-license>. Accessed September 18, 2026.
6. U.S. Drug Enforcement Administration, Miami Field Division, Diversion Registration. Written correspondence to applicant, September 2026. [Author to retain copy.]
7. 21 U.S.C. § 822(e)(1); 21 C.F.R. § 1301.12(a); U.S. Drug Enforcement Administration, Diversion Control Division. Registration Q&A (stating that DEA requires a practitioner to obtain a separate DEA registration in each state).
<https://www.deadiversion.usdoj.gov/faq/registration-faq.html>. Accessed September 18, 2026.
8. U.S. Drug Enforcement Administration, Registration Service Center (1-800-882-9539). Communication to applicant, September 2026.

RELEVANT AMA POLICY**Drug Enforcement Administration Licensure Fees D-100.970**

Our American Medical Association will work through appropriate channels to freeze Drug Enforcement Administration (DEA) licensure fees for physicians.

[Res. 219, I-13; Reaffirmed: BOT Rep. 09, A-23]

One Fee One Number D-100.975

1. Our American Medical Association will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

2. Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements.

3. Our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database.

[BOT Rep. 5, I-08; I-18; Reaffirmed: Res. 302, A-26]

One Fee, One Number D-100.980

Our American Medical Association will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.

[Res. 701, I-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmed: Res. 302, A-26]

Evidence-Based Standard Requirement for Governmental Regulation H-270.956

Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ

evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded.

[BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes D-120.916

Our American Medical Association will advocate to the U.S. Department of Justice to rely on state medical board definitions of “the practice of medicine” to guide investigations into whether a practitioner has acted without a legitimate medical purpose.

Our AMA will advocate to the U.S. Department of Justice to work more closely with the AMA and its interested medical association partners to more clearly identify the factors it uses during an investigation to minimize disruptions to patient care.

Our AMA supports the U.S. Centers for Disease Control and Prevention Opioid Rapid Response Program and similar state-based efforts that seek to ensure continuity of care when patients lose access to care due to a law enforcement or other action that results in the closure of a physician’s practice.

[BOT Rep. 13, A-26]

Protecting the Prescriptive Authority of Plenary Licensed Physicians D-120.920

Our American Medical Association will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.

Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.

Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.

Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care.

[Res. 204, A-25; Modified: BOT Rep. 15, A-26]

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

Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

[Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will 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.

[Res. 216, I-25; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

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

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

[Res. 222, A-25; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

Facilitating Credentialing for State Licensure D-275.994

Our American Medical Association encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible.

Our AMA will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions.

Our AMA encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license.

Our AMA supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

[Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14; Reaffirmed: Res. 215, A-22]

Access to Health Care for Veterans H-510.985

Our American Medical Association will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system.

Our AMA will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system.

Our AMA will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans.

Our AMA will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician.

Our AMA will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans.

Our AMA will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

[Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17; Reaffirmation: A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(I-26)

Introduced by: Association for Clinical Oncology, American Society of Hematology,
American Academy of Hospice and Palliative Medicine, American Society for
Radiation Oncology

Subject: Medicaid Protections & Continuous Coverage for Active Cancer Care

Referred to: Reference Committee B

1 Whereas, oncology treatment regimens require sustained, uninterrupted adherence across
2 multi-month or multi-year cycles, and disruptions in coverage or treatment delivery have been
3 shown to directly increase cancer morbidity and mortality; and
4

5 Whereas, new Medicaid community engagement and work requirements enacted under federal
6 statute risk disenrollment of vulnerable individuals with severe health conditions unless they are
7 explicitly classified as medically frail; and
8

9 Whereas, recent federal regulations have narrowed medical frailty definitions by imposing
10 burdensome functional impairment standards, requiring extensive documentation and
11 retrospective encounter claims that penalize cancer patients whose treatment side effects vary
12 between chemotherapy or immunotherapy cycles; and
13

14 Whereas, lack of federal standardization creates a patchwork of state attestation procedures,
15 forcing physicians and clinical staff to absorb significant uncompensated administrative burden
16 to complete complex state recertification forms to keep patients covered; and
17

18 Whereas, existing AMA policy opposes work requirements as a condition of Medicaid eligibility
19 (H-290.961) and urges clinically grounded exemptions, yet lacks explicit directives addressing
20 continuous coverage across full therapeutic courses and dedicated physician compensation for
21 complex administrative eligibility attestations; therefore be it
22

23 RESOLVED, that our American Medical Association advocate for federal and state policies that
24 require Medicaid medical frailty exemptions for individuals under active treatment for cancer or
25 other medically complex chronic conditions and their caregivers remain in continuous effect
26 throughout treatment and survivorship follow-up and prohibit mid-treatment disenrollment or
27 procedural terminations. (Directive to Take Action).

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/22/26

REFERENCES

1. American Medical Association. AMA Adopts Policy Calling for Exemptions for Medicaid Work Requirements. Press Release, June 2026.
2. American Cancer Society Cancer Action Network (ACS CAN). The Impact of New Medicaid Work Requirements on People with Cancer. ACS CAN Policy Report, August 2026.
3. Centers for Medicare & Medicaid Services (CMS). Guidance on Medical Frailty Exclusions and Work Requirements Implementation. September 2026.
4. Association for Clinical Oncology (ASCO). ASCO Advocacy Priorities: Administrative Burden Reduction and Medicaid Access. 2026.

RELEVANT AMA POLICY

H-290.961 Opposition to Medicaid Work Requirements: Our AMA opposes work requirements as a criterion for Medicaid eligibility. [CMS Rep. 1, A-18; Reaffirmed: A-26]

AMA Policy on Medical Frailty Exemptions (Adopted A-26): The AMA urges states and the federal government to define “medical frailty” and “complex medical conditions” to include life-threatening or complex chronic medical conditions, ensuring automatic exemptions from community engagement and work requirements for patients and primary caregivers to avoid administrative burden and improper disenrollment.

H-385.913 Overcoming Administrative and Paperwork Burdens on Physicians: Our AMA supports initiatives that identify and reduce administrative burdens that detract from patient care, advocating for the elimination of redundant paperwork and promoting compensation models that recognize time spent on regulatory and administrative compliance.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(I-26)

Introduced by: Association for Clinical Oncology, American College of Rheumatology,
American Society of Hematology, American Society for Radiation Oncology

Subject: Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers

Referred to: Reference Committee B

1 Whereas, participation in clinical trials offers access to life-saving, cutting-edge therapies; and

2
3 Whereas, socioeconomically disadvantaged populations remain underrepresented in clinical
4 trials due to indirect non-medical expenses including transportation, long-distance lodging,
5 childcare, and lost wages; and

6
7 Whereas, clinical trial sponsors, non-profit institutions, and patient advocacy foundations are
8 often discouraged from reimbursing participants for travel and ancillary expenses due to legal
9 concerns surrounding the federal Anti-Kickback Statute (AKS) and Beneficiary Inducements
10 Civil Monetary Penalty (CMP); and

11
12 Whereas, financial stipends or direct expense reimbursements provided to low-income
13 participants can be classified as taxable income, inadvertently triggering disqualification from
14 essential public assistance programs such as Medicaid, the Supplemental Nutrition Assistance
15 Program (SNAP), and Supplemental Security Income (SSI); and

16
17 Whereas, distance hinders trial participation when patients must travel long distances for routine
18 laboratory testing or routine follow-up that could be delivered safely via local facilities,
19 decentralized clinical trial models, and telehealth; and

20
21 Whereas, financial burdens associated with trial participation act as a critical social determinant
22 of health (SDOH) that disproportionately excludes lower-income patients, thereby restricting
23 study cohorts to higher socioeconomic classes and compromising the generalizability of trial
24 results; and

25
26 Whereas, current AMA policy supports third-party coverage for clinical trials and AKS safe
27 harbors for cost-sharing (H-460.965), but does not fully address tax penalties, safety-net
28 eligibility preservation, or explicit coordination between clinical trial protocols and Medicaid
29 community engagement requirements; therefore be it

30
31 RESOLVED, that our American Medical Association advocate for federal legislation and Anti-
32 Kickback Statute safe harbors allowing trial sponsors to cover patient non-medical trial costs
33 (travel, lodging, childcare) without tax penalties or safety-net benefit disqualification (Directive to
34 Take Action); and be it further

35
36 RESOLVED, that our AMA support modernizing trial access by advocating for telehealth
37 payment parity, cross-state licensure flexibilities, and local lab/imaging use (New HOD Policy);
38 and be it further

- 1 RESOLVED, that our AMA advocate to ensure trial participation counts toward Medicaid
- 2 community engagement or confers a reporting hardship exemption. (Directive to Take Action)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/22/26

REFERENCES

1. U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). Request for Information Regarding the Federal Anti-Kickback Statute and Beneficiary Inducements CMP on Clinical Trial Remuneration. 89 FR, June 2026.
2. Association for Clinical Oncology (ASCO). Addressing Financial Barriers in Clinical Trials: Policy Statement Update. October 2026.
3. Food and Drug Administration (FDA) & HHS. Operation TrialBlazer: Expanding Clinical Trial Access and Modernization. 2026.
4. American Society of Clinical Oncology. ASCO Policy Statement: Telemedicine in Oncology. JCO Oncol Pract, 2021.

RELEVANT AMA POLICY

H-460.965 Viability of Clinical Research Coverages and Reimbursement: Our AMA believes that legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/deductibles, otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials. [Modified: A-22]

D-480.969 Decoupling Licensure from Telemedicine Delivery: Our AMA supports legislative and regulatory reforms to streamline interstate medical practice, supporting interstate compacts and cross-state licensure flexibilities that facilitate remote care while protecting physician autonomy and patient safety.

H-480.946 Coverage of and Payment for Telemedicine: Our AMA advocates for payment parity for telehealth services comparable to in-person services when clinically appropriate.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(I-26)

Introduced by: American Thoracic Society

Subject: Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions

Referred to: Reference Committee B

1 Whereas, Public Law 119-21 established Medicaid community engagement requirements for
2 certain adults as a condition of Medicaid eligibility and provides an exemption for individuals
3 who are medically frail; and
4

5 Whereas, the Centers for Medicare & Medicaid Services subsequently issued an interim final
6 rule implementing Medicaid community engagement requirements and establishing
7 requirements related to medical frailty exemptions; and
8

9 Whereas, the interim final rule requires certain individuals seeking a medical frailty exemption to
10 demonstrate that their medical condition significantly impairs their ability to comply with
11 Medicaid community engagement requirements and limits states' use of self-attestation to verify
12 medical frailty; and
13

14 Whereas, implementation of these requirements may require physicians and physician practices
15 to assist patients in navigating medical frailty determinations, documentation, verification, and
16 related processes; and
17

18 Whereas, our AMA, together with the Massachusetts Medical Society and other medical
19 associations, has prepared an amicus curiae brief in Massachusetts v. Oz emphasizing that the
20 interim final rule's medical frailty requirements may cause eligible patients to lose Medicaid
21 coverage, impose unnecessary administrative burdens on patients and physicians, and require
22 physicians to make individualized assessments of patients' ability to satisfy Medicaid community
23 engagement requirements without validated criteria or clear standards; and
24

25 Whereas, physicians will need clear and practical information regarding federal and state
26 implementation of medical frailty exemptions as states implement Medicaid community
27 engagement requirements; therefore be it
28

29 RESOLVED, that our American Medical Association collaborate with state and specialty medical
30 associations to develop and disseminate guidance, educational materials, and other resources
31 to assist physicians and physician practices in navigating changes to Medicaid medical frailty
32 exemptions resulting from Public Law 119-21 and its implementing regulations, including
33 medical frailty determinations, documentation, verification, and related requirements. (Directive
34 to Take Action)

Fiscal Note: Moderate – between \$10,000 - \$50,000

Received: 9/22/26

REFERENCES

1. One Big Beautiful Bill Act, Pub. L. No. 119-21, § 71119, 139 Stat. 72 (2025).
2. Centers for Medicare & Medicaid Services. Medicaid Program; Community Engagement Requirement for Certain Individuals. 91 Fed. Reg. 33348 (June 3, 2026).
3. American Medical Association. "AMA adopts policy calling for exemptions for Medicaid work requirements." June 9, 2026.
4. American Medical Association. Comments regarding the Centers for Medicare & Medicaid Services interim final rule implementing Medicaid community engagement requirements, 2026.
5. Brief of Amici Curiae American Medical Association, Massachusetts Medical Society, and Other Medical Associations in Support of Plaintiffs' Motion for Summary Judgment, Commonwealth of Massachusetts, et al. v. Mehmet Oz, M.D., et al., No. 1:26-cv-12962-RGS (D. Mass. 2026).

RELEVANT AMA POLICY

Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions D-290.969

Our AMA supports collaboration with CMS, state Medicaid agencies, and state and specialty medical associations to establish clinically grounded standards for medical frailty and complex medical conditions in connection with Medicaid community engagement requirements. AMA policy also supports automatic exemptions for patients and primary caregivers of patients with complex medical conditions and streamlined verification processes that minimize administrative burdens for patients and physicians.

[Res. 243, A-26]