DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

Final Report of Reference Committee B

Anna Brown, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 21 — Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care
2. Resolution 206 — Third-Party Litigation Funding in Medical Liability Claims
3. Resolution 211 — Fair and Clinically Appropriate EMTALA Investigations
4. Resolution 213 — Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings
5. Resolution 223 — Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine
6. Resolution 225 — Supporting a Common Legal Framework for Medical Capacity Holds
7. Resolution 231 — Medicare and Medicaid Payment Equity for Puerto Rico
8. Resolution 235 — Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions
9. *Resolution 236 — Standardization of Quality Performance Reporting in Value-Based Payment Arrangements
10. *Resolution 238 — Timely Processing of DACA Renewal Applications
11. *Resolution 239 — Protecting the Integrity of Public Participation in Federal Health Policymaking

RECOMMENDED FOR ADOPTION AS AMENDED

12. Board of Trustees Report 06 — Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care
13. *Board of Trustees Report 07 — Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
14. *Board of Trustees Report 08 — Access to, and Retention of, Electronic Medical Records
15. *Board of Trustees Report 09 — Medicare Should Not Unfairly Penalize Physicians
16. *Board of Trustees Report 16 — Ensuring Medical Liability Insurance Transparency and Continuity
17. *Board of Trustees Report 17 — Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform

18. Resolution 201 — Artificial Intelligence Having Prescriptive Authority
19. *Resolution 204 — Federal Framework for Social Media Access by Minors Under Age 16
20. Resolution 207 — Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety
21. *Resolution 208 — Facilitating Short-Term Supervised Clinical Training for International Physicians
22. Resolution 209 — Protecting GME Subject to Funding Uncertainty
23. Resolution 212 — Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract
24. Resolution 214 — Prohibiting Health Care Sale-Leaseback Transactions
25. *Resolution 215 — Establishing Product Liability for Clinical Augmented Intelligence Failures
26. Resolution 219 — Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material
27. Resolution 226 — Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review
28. *Resolution 227 — Increasing Access to Long-Acting Injectable Medications for SUD
29. *Resolution 228 — Hospital-Based Substance Use Disorder Care
30. Resolution 229 — Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation
31. *Resolution 232 — Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care
32. Resolution 234 — Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers
33. *Resolution 240 — Minimizing Patient Harm from Autonomous Artificial Intelligence

RECOMMENDED FOR ADOPTION IN LIEU OF

34. Resolution 220 — Advocating for the Older Americans Act and Community-Based Services for Older Adults
35. *Resolution 221 — Preserving Duration of Status for J-1 Physicians in Graduate Medical Education
36. *Resolution 237 — Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs

Resolution 241 — Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs

RECOMMENDED FOR REFERRAL

37. *Resolution 203 — Set-Aside Federal Funding for Tribal Health Programs
38. Resolution 205 — Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs
39. *Resolution 224 — Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

40. Resolution 202 — Rapid Response Framework for Unsupported Medical Claims by Public Officials
41. Resolution 210 — Requiring Physician Oversight for Artificial Intelligence Tools
42. Resolution 216 — Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process
43. Resolution 217 — Strengthening the Patients First Act and Medicare Physician Payment Reform
44. Resolution 218 — Firearm Manufacturer Accountability for the Cost of Gun Violence
45. Resolution 222 — Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)
46. Resolution 230 — Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities
47. Resolution 233 — Medicaid Protections & Continuous Coverage for Active Cancer Care
48. *Resolution 242 — Opposing Reimbursement Cuts to Modifier 25

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 21 — EXTENDING AND EXPANDING THE AMA TASK FORCE TO PRESERVE THE PATIENT PHYSICIAN RELATIONSHIP TO ENSURE ACCESS AND REGULATORY CLARITY IN GENDER AFFIRMING CARE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 21 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 21 is adopted, and the remainder of the Report be filed.

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)

Your Reference Committee heard strong support for adopting the recommendations made by Board of Trustees Report 21 regarding our AMA's continued efforts to assist physicians navigating the rapidly changing legal and regulatory landscape. Testimony reflected concern about increasing uncertainty for both physicians and patients, while emphasizing the importance of protecting the patient-physician relationship, preserving access to medically necessary care, and providing practical, accurate guidance. Therefore, your Reference Committee recommends that Board of Trustees Report 21 be adopted, and the remainder of the Report be filed.

(2) RESOLUTION 206 — THIRD-PARTY LITIGATION FUNDING IN MEDICAL LIABILITY CLAIMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 206 be adopted.

HOD ACTION: Resolution 206 is adopted.

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

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

RESOLVED, that our AMA develop and advocate for model state legislation consistent with these principles, including provisions prohibiting a litigation funder from controlling or influencing litigation strategy, expert selection, or settlement decisions and providing effective enforcement through voiding prohibited agreements and authorizing civil remedies or penalties, to promote a fair, transparent, and stable medical liability environment for patients and physicians. (Directive to Take Action)

Your Reference Committee heard strong support for the adoption of Resolution 206, with testimony expressing concern that outside financial interests may distort litigation, increase costs, and add to the stress physicians face when defending claims. Testimony broadly agreed that Resolution 206 addresses an important gap in existing policy. Although there were recommendations made for minor amendments, your Reference Committee primarily heard broad agreement that third-party litigation funding warrants closer scrutiny and stronger safeguards. Therefore, your Reference Committee recommends that Resolution 206 be adopted.

(3) RESOLUTION 211 — FAIR AND CLINICALLY APPROPRIATE EMTALA INVESTIGATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 211 be adopted.

HOD ACTION: Resolution 211 is adopted.

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

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

Your Reference Committee heard strong support for adoption of Resolution 211, with testimony emphasizing fairness, urgency, and the need to preserve Emergency Medical Treatment and Active Labor Act's (EMTALA) core purpose as a patient access statute rather than a substitute for malpractice review or retrospective quality of care adjudication. Testimony broadly supported the Resolution's effort to protect EMTALA's role in ensuring nondiscriminatory access to emergency screening, stabilizing treatment, and appropriate transfer. Your Reference Committee heard testimony which overall strongly favored adoption of the Resolution as written to reinforce patient protections while promoting accurate, fair, and clinically grounded EMTALA enforcement. Therefore, your Reference Committee recommends that Resolution 211 be adopted.

(4) RESOLUTION 213 — CLEAR IDENTIFICATION AND DIFFERENTIATION OF PHYSICIANS AND NONPHYSICIANS IN CLINICAL ROSTERS, SIGNAGE, AND LISTINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 213 be adopted.

HOD ACTION: Resolution 213 is adopted.

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

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

Your Reference Committee heard strong support for adoption of Resolution 213, with demonstrated concern about ongoing patient confusion, and a clear call for greater transparency in how clinicians are identified across patient-facing settings. Testimony broadly supported the Resolution's intent and emphasized that patients deserve to know who is providing their care. Testimony highlighted the importance of patients being able to distinguish clearly between physicians and nonphysician members of the care team in rosters, signage, directories, and online listings. While minor amendments were offered, your Reference Committee heard broad support for clear identification practices that will advance patient understanding. Therefore, your Reference Committee recommends that Resolution 213 be adopted.

(5) RESOLUTION 223 — ADVANCING PHYSICIAN PAYMENT AND MEDICARE AND MEDICAID ACCESS FOR STREET MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 223 be adopted.

HOD ACTION: Resolution 223 is adopted.

RESOLVED, that the following American Medical Association (AMA) 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":

1. 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.
2. 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."
3. 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.
4. 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.

Your Reference Committee heard strong support for the adoption of Resolution 223, and the efforts our AMA is making to advocate for the improvements of Medicaid enrollment, coverage continuity, and reimbursement for the growing practice of street medicine services provided to people experiencing homelessness. Your Reference Committee heard how current payment and coverage systems often do not match how or where care is actually delivered for this population, creating barriers to both access and the sustainability of physician-led street medicine programs. Therefore, your Reference Committee recommends that Resolution 223 be adopted.

(6) RESOLUTION 225 — SUPPORTING A COMMON LEGAL FRAMEWORK FOR MEDICAL CAPACITY HOLDS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 225 be adopted.

HOD ACTION: Resolution 225 is adopted.

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)

Your Reference Committee heard strong support for adoption Resolution 225, with testimony emphasizing that studying the legal, ethical, and institutional frameworks surrounding medical holds is a prudent and necessary step in an area where physicians often lack clear guidance. Testimony favored adoption of Resolution 225 noting that it is a measured approach to clarifying this difficult area of practice while protecting both patient's rights and physician decision-making. Therefore, your Reference Committee recommends that Resolution 225 be adopted.

(7) RESOLUTION 231 — MEDICARE AND MEDICAID PAYMENT EQUITY FOR PUERTO RICO

RECOMMENDATION:

Your Reference Committee recommends that Resolution 231 be adopted.

HOD ACTION: Resolution 231 is adopted.

RESOLVED, that our American Medical Association reaffirm Policy H-390.953, "Medicare Payments for Physicians' Services in Puerto Rico," supporting elimination of inequities in Medicare reimbursement for physicians' services in Puerto Rico (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA advocate before the United States Congress, the Centers for Medicare & Medicaid Services, and other pertinent federal agencies for long-term legislative and regulatory measures that provide equitable and sustainable Medicare Advantage and physician reimbursement policies for Puerto Rico (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for long-term, adequate, and sustainable federal financing for the Puerto Rico Medicaid program and oppose interruptions or reductions in federal support that would impair patient access to care or physician workforce stability (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Puerto Rico Medical Association and other relevant stakeholders to advance policies that strengthen Puerto Rico's health care infrastructure, physician recruitment and retention, and long-term health system sustainability. (Directive to Take Action)

Your Reference Committee heard primarily uniform support for adoption of Resolution 231, with testimony emphasizing that more equitable and sustainable Medicare and Medicaid financing is essential to the stability of Puerto Rico's health care system. Overall, testimony strongly favored adoption of the Resolution as an important step toward ensuring that geography does not determine whether physicians and patients receive fair support through federal health programs. Therefore, your Reference Committee recommends that Resolution 231 be adopted.

(8) RESOLUTION 235 — ASSISTING PHYSICIANS IN NAVIGATING CHANGES TO MEDICAID MEDICAL FRAILTY EXEMPTIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 is adopted.

RESOLVED, that our American Medical Association collaborate with state and specialty medical associations to develop and disseminate guidance, educational materials, and other resources to assist physicians and physician practices in navigating changes to Medicaid medical frailty exemptions resulting from Public Law 119-21 and its implementing regulations, including medical frailty determinations, documentation, verification, and related requirements. (Directive to Take Action)

Your Reference Committee heard uniformly supportive testimony in favor of adoption of Resolution 235, with testimony emphasizing the need for practical guidance and education to help physicians and practices navigate medical frailty exemptions to newly established Medicaid work requirements.

Testimony noted the significant work that our AMA has already undertaken in its work with state and specialty medical associations on medical frailty provisions since Public Law 119-21 was enacted. Testimony highlighted that our AMA has convened the Federation numerous times to collaborate and strategize on medical frailty exemptions, developed a patient guide and a roadmap addressing exemptions and hardship protections, submitted detailed comments on the Centers for Medicare and Medicaid Services' (CMS') interim final rule implementing the work requirements, provided education on CMS' medical frailty guidance, and created a repository of state-based assistance materials. Your Reference Committee also heard that our AMA has undertaken litigation work, including the amicus brief cited in the preamble to this Resolution. Testimony noted that, as part of this litigation work, our AMA's legal filings explain the risks of coverage loss and the burdens these rules could place on physicians and their patients. Your Reference Committee also heard that our AMA is continuing to work through the practical questions states and physicians face as implementation approaches. Your Reference Committee would like to highlight that these resources can be found on our AMA's website.

Overall, strong testimony indicated that adoption of Resolution 235 would reinforce and continue the ongoing efforts described above. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

(9) RESOLUTION 236 — STANDARDIZATION OF QUALITY PERFORMANCE REPORTING IN VALUE-BASED PAYMENT ARRANGEMENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 236 be adopted.

HOD ACTION: Resolution 236 is referred.

RESOLVED, that our American Medical Association advocate at the state and federal level for the development and adoption of a standardized quality performance reporting framework across all public and private payers that promotes consistent and actionable information and preserves flexibility for population-specific, program-specific differences when clinically or operationally warranted, while limiting duplicative reporting requirements and unnecessary administrative burdens (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that standardized quality performance reporting frameworks provide transparent, accessible, and accountable information regarding the measures and specifications used, including the applicable measure version and effective date, attribution and risk-adjustment methodologies, applicable benchmarks and comparison populations, underlying data sources, current and longitudinal performance, and methods for calculating composite scores or other performance measures and ensure quality performance information should be timely, accurate, clinically meaningful, and auditable, with transparent processes that allow physicians and physician organizations to review, validate, dispute, and seek correction of material errors (Directive to Take Action).

Your Reference Committee heard support for Resolution 236, with testimony noting that practices spend more than 15 hours per physician each week on quality reporting and that payers often define the same measures differently. Two amendments were offered: one clarifying that the framework applies to those who choose to participate in value-based arrangements, and one dividing the second Resolve for clarity. Some testimony supported referral, citing diversity of practice settings and the need for pediatric-specific measures; your Reference Committee notes that the first Resolve already preserves flexibility for population-specific differences.

Given that the weight of testimony supported adoption of the Resolution as written and the offered amendments were relatively superficial, your Reference Committee believes the best course of action is to adopt. Therefore, your Reference Committee recommends that Resolution 236 be adopted.

(10) RESOLUTION 238 — TIMELY PROCESSING OF DACA RENEWAL APPLICATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 238 be adopted.

HOD ACTION: Resolution 238 is adopted.

RESOLVED, that our American Medical Association (AMA) will advocate for timely processing of Deferred Action for Childhood Arrivals (DACA) renewal requests and employment authorization applications, including sufficient federal administrative capacity and processes to minimize lapses in deferred action and work authorization caused by processing delays; and be it further

RESOLVED, that our AMA advocate for policies that protect DACA recipients from interruptions in employment, training, or clinical practice resulting from delays in the adjudication of timely filed DACA renewal requests.

Your Reference Committee heard unanimous support for Resolution 238. Testimony described Deferred Action for Childhood Arrivals (DACA) renewal backlogs that have caused recipients who applied on time to lose work authorization, driver's licenses, and training opportunities, disrupting care for patients and communities. Your Reference Committee agrees that no one should lose the ability to work, train, or care for patients because of administrative delays. Therefore, your Reference Committee recommends that Resolution 238 be adopted.

(11) RESOLUTION 239 — PROTECTING THE INTEGRITY OF PUBLIC PARTICIPATION IN FEDERAL HEALTH POLICYMAKING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 239 be adopted.

HOD ACTION: Resolution 239 be adopted.

RESOLVED, that our American Medical Association (AMA) support transparent, viewpoint-neutral standards for publication, redaction, withholding, and removal of public comments in federal health policymaking; and be it further

RESOLVED, that our AMA advocate that federal health agencies publicly document the basis for removing, withholding, or redacting public comments and preserve an auditable record of such actions, consistent with applicable privacy, safety, and legal protections.

Your Reference Committee heard unanimous support for Resolution 239. Testimony noted a recent incident in which posted public comments on a federal proposed rule were removed without explanation and emphasized that a transparent public comment process is essential to sound rulemaking and to our AMA's ability to inform federal health policy. Your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 239 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(12) BOARD OF TRUSTEES REPORT 06 — RESTORING BALANCE BILLING AND ALLOWING COPAY FORGIVENESS TO PRESERVE INDEPENDENT PRACTICE AND IMPROVE ACCESS TO CARE

RECOMMENDATION A:

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

That our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations ~~as currently required under state and federal law~~. (New HOD Policy)

RECOMMENDATION B:

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

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

ADOPTED LANGUAGE:

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

1. **That our American Medical Association reaffirm: Policy H-385.991, "Balance Billing;" Policy D-380.996, "Balance Billing for All Physicians;" Policy D-390.985, "Medicare Balance Billing;" Policy D-390.986, "Medicare Balance Billing;" Policy H-390.854, "Freedom of Choice;" and Policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement." (Reaffirm HOD Policy)**

2. **That our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations. (New HOD Policy)**

3. **That our AMA advocate at the federal level for clarification of standards governing physician waiver of patient cost-sharing obligations for patients experiencing documented financial hardship, including reduction of the administrative, documentation, and collection-effort burdens associated with existing hardship exceptions under federal fraud and abuse authorities; and that our AMA oppose payer contracting provisions that restrict physicians from exercising discretion permitted under those authorities. (New HOD Policy)**

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

1. That our American Medical Association reaffirm: Policy H-385.991, "Balance Billing;" Policy D-380.996, "Balance Billing for All Physicians;" Policy D-390.985, "Medicare Balance Billing;" Policy D-390.986, "Medicare Balance Billing;" Policy H-390.854, "Freedom of Choice;" and Policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement." (Reaffirm HOD Policy)

2. That our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently required under state and federal law. (New HOD Policy)

3. That our AMA advocate at the federal level for clarification of standards governing physician waiver of patient cost-sharing obligations for patients experiencing documented financial hardship, including reduction of the administrative, documentation, and collection-effort burdens associated with existing hardship exceptions under federal fraud and abuse authorities; and that our AMA oppose payer contracting provisions that restrict physicians from exercising discretion permitted under those authorities. (New HOD Policy)

Your Reference Committee heard supportive testimony that conveyed appreciation for Board of Trustees Report 06 and its thoughtful, practical approach to strengthening existing policy while addressing important remaining gaps. Testimony noted that the Report supported continued balance billing protections for emergency care, Medicaid beneficiaries, and other populations that cannot meaningfully choose their physician's network status, which was widely supported. Testimony also highlighted that the Report called for clearer federal standards and lower administrative burden for physicians who waive cost-sharing for patients in documented financial hardship and opposed payer contract terms that restrict discretion in this space. Testimony broadly agreed with reaffirming current policy on physician autonomy and fair reimbursement, while also supporting continued protections for patients who may not have meaningful choice over the network status of their physician. Testimony also noted that new AMA policy on restoring balance billing or prohibiting caps would duplicate positions our AMA already holds. Your Reference Committee received a minor amendment which would make the language more durable and less vulnerable to future changes in state or federal law by removing specific references to timebound federal and legal standards. Your Reference Committee agreed that this minor amendment was a positive addition to the Report. Therefore, your Reference Committee recommends that Board of Trustees Report 06 be adopted as amended and that the remainder of the report be filed.

(13) BOARD OF TRUSTEES REPORT 07 — SUPPORT FOR LEGISLATIVE CHANGES ALLOWING PARTIAL MEDICARE OPT-OUT FOR PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the second Recommendation of Board of Trustees Report 07 be amended by addition and deletion to read as follows:

That our American Medical Association explore options to allow physicians who practice through distinct ~~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)

RECOMMENDATION B:

Your Reference Committee recommends that the third Recommendation of Board of Trustees Report 07 be amended by addition to read as follows:

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, with appropriate safeguards to ensure advance informed consent, financial transparency, and protection of vulnerable beneficiaries, ensuring that Medicare patients can keep their benefits when they privately contract with any physician of their choice. (New HOD Policy)

RECOMMENDATION C:

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

HOD ACTION: Board of Trustees Report 07 is adopted as amended, and the remainder of the Report is filed.

ADOPTED LANGUAGE:

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 distinct practice entities 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, with appropriate safeguards to ensure advance informed consent, financial transparency, and protection of vulnerable beneficiaries, ensuring that Medicare patients can keep their benefits when they privately contract with any physician of their choice. (New HOD Policy)**

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)

Your Reference Committee heard supportive testimony for Board of Trustees Report 07, including from the sponsors of the underlying resolution. Testimony highlighted the importance of giving physicians greater flexibility to contract for care without having to opt out of Medicare entirely. An amendment was offered to ensure that any new contracting flexibility is paired with appropriate safeguards for beneficiaries, including advance informed consent, financial transparency, and protection of vulnerable beneficiaries. Testimony noted that Medicare patients differ widely in health literacy, financial resources, and bargaining power, and that patients should be protected against unexpected costs or uninformed financial decisions. The Board of Trustees supported the concept of this amendment. Your Reference Committee agrees that greater physician flexibility and strong patient protections are complementary goals and that the amendment strengthens

the Report. Therefore, your Reference Committee recommends that Board of Trustees Report 07 be adopted as amended, and the remainder of the Report be filed.

(14) BOARD OF TRUSTEES REPORT 08 — ACCESS TO, AND RETENTION OF, ELECTRONIC MEDICAL RECORDS

RECOMMENDATION A:

Your Reference Committee recommends that the second Recommendation of Board of Trustees Report 08 be amended by addition to read as follows:

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 with appropriate protections for patient privacy and adolescent confidentiality; (New HOD Policy) and

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 08 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 08 is adopted as amended and the remainder of the report is filed.

ADOPTED LANGUAGE:

The Board of Trustees recommends that the following be adopted in lieu of Resolution 211 I-25 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 with appropriate protections for patient privacy and adolescent confidentiality; (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)

The Board of Trustees recommends that the following be adopted in lieu of Resolution 211 I-25 and that the remainder of the report be filed.

4. 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

5. 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

6. 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)

Your Reference Committee heard supportive testimony expressing appreciation for Board of Trustees Report 08's practical and targeted approach to improving access to and retention of electronic medical records. Testimony reflected broad support for the recommendations within the Report, with some testimony recommending targeted amendments to strengthen enforceability and confidentiality protections. An amendment was offered to add language that accounts for patient privacy protections, explicitly including adolescent confidentiality. Your Reference Committee heard unanimous support for the amendment. Therefore, your Reference Committee recommends that Board of Trustees Report 08 be adopted as amended and the remainder of the report be filed.

(15) BOARD OF TRUSTEES REPORT 09 — MEDICARE SHOULD NOT UNFAIRLY PENALIZE PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation of Board of Trustees Report 09 be amended by addition to read as follows:

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. Such program would be required to test models recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that second Recommendation of Board of Trustees Report 09 be amended by addition and deletion to read as follows:

That our AMA support legislation to require that physician participation in new payment models tested by CMMI ~~to test all new payment models~~ be on a voluntary basis. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 09 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 09 is adopted as amended and the remainder of the Report is filed.

ADOPTED LANGUAGE:
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. Such program would be required to test models recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

That our AMA support legislation to require that physician participation in new payment models tested by CMMI be on a voluntary basis.

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)

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)

Your Reference Committee heard supportive testimony for Board of Trustees Report 09. Testimony noted appreciation for the Report's efforts to advance a more balanced and physician-centered approach to Medicare Alternative Payment Model reform. Testimony reflected broad agreement that physicians should not be compelled to participate in payment models that impose financial risk for costs and outcomes beyond their reasonable control, and that future models should be voluntary and better aligned with clinical realities.

An amendment was offered to require that the Center for Medicare and Medicaid Innovation (CMMI) test models recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). This amendment received support and your

Reference Committee believes it should be adopted. In addition, to better communicate the concept that physician participation in CMMI payment models should be on a voluntary basis, your Reference Committee recommends a friendly amendment to the second Recommendation of the Report.

Therefore, your Reference Committee recommends that Board of Trustees Report 09 be adopted as amended and that the remainder of the Report be filed.

(16) BOARD OF TRUSTEES REPORT 16 — ENSURING MEDICAL LIABILITY INSURANCE TRANSPARENCY AND CONTINUITY

RECOMMENDATION A:

Your Reference Committee recommends that the following Alternate Recommendations be adopted in lieu of the Recommendation of Board of Trustees Report 16:

1. Our AMA recognizes occurrence-based medical liability insurance or claims-made medical liability insurance with a pre-paid tail is strongly recommended for medical liability coverage, provided that such coverage is fully funded, and that any coverage issued through a captive, self-insurance trust or risk retention group maintains actuarially sound reserves segregated from and protected against the claims of the sponsoring entity's creditors, as certified annually by an independent actuary, and not subject to loans, dividends or other transfers back to the sponsoring entity. (New HOD Policy)

2. That our AMA advocate that hospitals, health systems and other entities that provide physician medical liability coverage disclose to physicians in writing whether that coverage is self-insured, the funding status of any captive, and how any tail obligation is funded. (Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Board of Trustees Report 16 is adopted as amended and the remainder of the Report is filed.

ADOPTED LANGUAGE:

1. Our AMA recognizes occurrence-based medical liability insurance or claims-made medical liability insurance with a pre-paid tail is strongly recommended for medical liability coverage, provided that such coverage is fully funded, and that any coverage issued through a captive, self-insurance trust or risk retention group maintains actuarially sound reserves segregated from and protected against the claims of the sponsoring entity's creditors, as certified annually by

an independent actuary, and not subject to loans, dividends or other transfers back to the sponsoring entity. (New HOD Policy)

2. **That our AMA advocate that hospitals, health systems and other entities that provide physician medical liability coverage disclose to physicians in writing whether that coverage is self-insured, the funding status of any captive, and how any tail obligation is funded. (Directive to Take Action)**

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

Your Reference Committee heard largely supportive testimony that reflected concern about gaps in medical liability coverage and appreciation for the Report's effort to promote greater transparency and continuity. Testimony supported the Report's comparison of occurrence-based coverage and claims-made coverage with a pre-paid tail against standard claims-based policies. Overall, testimony favored adoption of the Report, while also reflecting interest in clarifying how best practices can be recognized without creating unrealistic expectations across all practice settings. In alignment with this concern, your Reference Committee heard that amended language that removed the reference to a "gold standard," while still recognizing the benefits of a pre-paid tail, would be more flexible and allow for instances where other forms of coverage would be more beneficial for the physician and the patient. Therefore, your Reference Committee recommends that alternate recommendations within Board of Trustees Report 16 be adopted and that the remainder of the Report be filed.

(17) BOARD OF TRUSTEES REPORT 17 — ADDRESSING AND REDUCING PATIENTS BOARDING IN THE EMERGENCY/REDUCING EMERGENCY DEPARTMENT BOARDING THROUGH PAYMENT REFORM

RECOMMENDATION A:

Your Reference Committee recommends that the Second recommendation of Board of Trustees Report 17 be amended by addition to read as follows:

9. That our AMA study and report back regarding the financial and operational impacts that could be expected from linking hospital reimbursement incentives and penalties to ED boarding.

RECOMMENDATION B:

Your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 17 is adopted as amended, and the remainder of the Report is filed.

ADOPTED LANGUAGE:

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 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.**
4. **That our AMA continue our advocacy on the myriad, system-wide causes of ED boarding, including but not limited to misaligned financial incentives for hospitals, workforce constraints, prior authorization reform, and strengthening federal coverage for care and physician reimbursement.**
5. **That our AMA continue our advocacy to address the negative impacts of ED boarding on physicians, health systems, and patients.**
6. **That our AMA continue to support initiatives led by state and specialty medical associations to advance action on ED boarding at the federal and state levels as appropriate.**

7. **That our AMA communicate updates on the AMA's ED boarding advocacy efforts through organizational communications channels such as the weekly Advocacy Update. (Directive to Take Action)**
8. **That the sixth bullet of policy D-120.957 be rescinded as it has been accomplished by this report.**
9. **That our AMA study and report back regarding the financial and operational impacts that could be expected from linking hospital reimbursement incentives and penalties to ED boarding.**

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

Your Reference Committee heard strong support for Board of Trustees Report 17 and its focus on the root causes of emergency department (ED) boarding, including workforce constraints, prior authorization, inpatient capacity, and transfer barriers. Testimony emphasized that boarding is not solely an emergency medicine problem and supported broadening the Report's recommendations to all physicians who care for patients in emergency settings. Testimony agreed that directly tying hospital reimbursement to boarding performance presents significant legislative and regulatory complexities and that CMS quality measurement efforts, including the Emergency Care Access & Timeliness measure, remain the most promising federal vehicle to tie hospital reimbursement to ED boarding performance in the near term.

An amendment was offered directing our AMA to study how hospital reimbursement could be aligned with boarding performance without penalizing physicians for factors beyond their control, including the operational and financial consequences of potential solutions

such as surgical schedule smoothing and inpatient hallway boarding. Testimony noted that the consequences of tying reimbursement to boarding were the central question when the underlying resolution was referred, and that the Report did not fully address it. This amendment received broad support, including from the Board of Trustees. Your Reference Committee agrees that a focused study would build on the Report and strengthen future advocacy. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended, and the remainder of the Report be filed.

(18) RESOLUTION 201 — ARTIFICIAL INTELLIGENCE HAVING PRESCRIPTIVE AUTHORITY

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

RESOLVED, that our AMA develop~~s~~ model state legislation regulating AI prescriptive authority so that both new ~~and refill~~ prescriptions and refills are under the ~~direct~~ supervision ~~and control~~ of a physician-led team ~~or other licensed healthcare professional~~. (Directive to Take Action)

RECOMMENDATION C:

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

HOD ACTION: Resolution 201 is referred for decision as amended.

AMENDED LANGUAGE:

RESOLVED, that our American Medical Association oppose the use of Artificial Intelligence (AI) without supervision by a physician-led team to prescribe new prescriptions, refills, and renewals (New HOD Policy); and be it further

RESOLVED, that our AMA develop~~s~~ model state legislation regulating AI prescriptive authority so that both new prescriptions and refills are under the supervision of a physician-led team. (Directive to Take Action)

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

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

Your Reference Committee heard testimony in support of the spirit of Resolution 201. Your Reference Committee heard significant concern that artificial intelligence (AI) is already moving beyond a supportive role and into unsupervised prescribing activity without adequate safeguards. Testimony emphasized that prescribing and renewing medications are not merely administrative tasks, but core clinical decisions requiring medical judgment, accountability, and meaningful oversight by a physician. Your Reference Committee heard support for model state legislation to prevent autonomous AI from exercising prescriptive authority and to help states respond quickly as pilots in this space continue to emerge. Testimony also stressed the importance of preserving a physician-led framework, ensuring patient access to human review, maintaining clear documentation, and assigning responsibility when AI-generated recommendations are used in care. Your Reference Committee also received amendments for this Resolution. Testimony noted that "direct supervision" has a specific legal definition. Given this definition, and the shifting landscape, testimony noted that it may be beneficial to just have the Resolution reference "supervision" which is a much broader term. Testimony also noted that our AMA policy should always align with our need for physician-led teams, in accordance with our scope of practice work. Finally, a few grammatical amendments were offered. Therefore, your Reference Committee recommends that Resolution 201 be adopted as amended.

(19) RESOLUTION 204 — FEDERAL FRAMEWORK FOR SOCIAL MEDIA ACCESS BY MINORS UNDER AGE 16

RECOMMENDATION A:

Your Reference Committee recommends that the first and second Resolves of Resolution 204 be deleted.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 204 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 204 be changed to read as follows:

SOCIAL MEDIA ACCESS BY MINORS

HOD ACTION: Resolution 204 is adopted as amended with a change in title.

ADOPTED LANGUAGE:

SOCIAL MEDIA ACCESS BY MINORS

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)

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)

Your Reference Committee heard strong support for protecting children and adolescents from the harms of social media. However, significant testimony urged deletion of the first and second Resolves, which call for a minimum age for account creation, age assurance, and parental consent. Testimony noted that there is no evidence supporting a specific minimum age, that the harms to young people stem largely from engagement-driven platform design rather than age of access, and that age restrictions are easily circumvented and can shift blame to youth and parents rather than platforms. Testimony also noted that age verification and parental consent requirements raise significant privacy, surveillance, and First Amendment concerns, and could cut off LGBTQ and neurodivergent youth from important sources of support and community. Your Reference Committee also heard testimony supporting adoption as amended and testimony supporting referral. Your Reference Committee agrees that our AMA's advocacy is best focused on the platform design and accountability measures addressed in the remaining Resolves. Your Reference Committee also notes that, because the title of the Resolution references age 16, the title should also be changed. Therefore, your Reference Committee recommends that the first and second Resolves be deleted, that Resolution 204 be adopted as amended, and that the title be changed.

Therefore, your Reference Committee recommends that Resolution 204 be adopted as amended with a change in title.

(20) RESOLUTION 207 — PROTECTING PHYSICIAN-LED INTERVENTIONAL PAIN MEDICINE, ENDING UNSUPERVISED NONPHYSICIAN PRACTICE, AND ENSURING PATIENT TRANSPARENCY AND SAFETY

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association oppose the independent, unsupervised establishment and operation of pain clinics, pain institutes, or similar ~~practices~~ facilities by certified registered nurse anesthetists or other nonphysician clinicians, and oppose any expansion of scope of practice permitting the independent performance of complex interventional pain procedures ~~absent active, onsite physician supervision~~ consistent with AMA Policy; and be it further

RECOMMENDATION B:

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

RESOLVED, that our AMA call upon relevant state licensing and other state and federal regulatory bodies to investigate pain ~~practices~~ clinics reasonably suspected of allowing non-physicians to practice ~~operating~~ outside applicable ~~licensure~~ scope-of-practice laws, ~~or~~ including physician-oversight requirements, and to enforce, where applicable, ~~the~~ laws requiring physician ownership of pain clinics, ~~on-site physician~~; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 207 be amended by addition of a new Resolve to read as follows:

RESOLVED, that policies H-410.950, H-410.958 and 35-984 be reaffirmed.

RECOMMENDATION D:

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

HOD ACTION: Resolution 207 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association oppose the independent, unsupervised establishment and operation of pain clinics, pain institutes, or similar facilities by certified registered nurse anesthetists or other nonphysician clinicians, and oppose any expansion of scope of practice permitting the independent performance of complex interventional pain procedures consistent with AMA Policy; and be it further

RESOLVED, that our AMA call upon relevant state licensing and other state and federal regulatory bodies to investigate pain clinics reasonably suspected of allowing non-physicians to practice outside applicable scope-of-practice laws, including physician-oversight requirements, and to enforce, where applicable, laws requiring physician ownership of pain clinics; and be it further

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

RESOLVED, that policies H-410.950, H-410.958 and 35-984 be reaffirmed.

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

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

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

Your Reference Committee received testimony that supported the spirit of Resolution 207. Testimony noted overarching support for patient safety, physician-led care, and the need for clear oversight in complex pain management settings. Testimony highlighted that the intent of Resolution 207 was consistent with longstanding principles around appropriate

training, supervision, and transparency for patients. Testimony frequently underscored that complex interventional procedures should remain under physician direction and that regulatory bodies should investigate practices operating outside applicable licensure or oversight requirements. However, multiple amendments were offered for the Resolution. Your Reference Committee heard that the Resolution needed to be amended to avoid ambiguity, align with existing policy, and improve enforceability at the state and federal levels. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended.

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 diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

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

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and

immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

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

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.

(21) RESOLUTION 208 — FACILITATING SHORT-TERM SUPERVISED CLINICAL TRAINING FOR INTERNATIONAL PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 208 be amended by addition and deletion to read as follows:

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~~ efforts to expand existing visa categories or establish a new visa category to allow visiting international physicians to participate in short-term supervised clinical training that includes structured educational clinical experiences at U.S. teaching hospitals with ACGME accredited residency programs 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; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second and third Resolves of Resolution 208 be deleted.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 is adopted as amended.

ADOPTED LANGUAGE:

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

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.**

3. Our AMA supports efforts to expand existing visa categories or establish a new visa category to allow visiting international physicians to participate in short-term supervised clinical training that includes structured educational clinical experiences at U.S. teaching hospitals with ACGME accredited residency programs without enrollment in an ACGME-accredited residency or fellowship program or completion of USMLEs or COMPLEX, 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.**

RESOLVED, that our AMA study additional barriers to clinical training for international physicians including but not limited to: medical licensure, malpractice liability protections, institutional oversight, patient awareness and safety, and safeguards for participating international physicians.

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

3. <u>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</u>

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)

Your Reference Committee heard mixed testimony surrounding Resolution 208. Your Reference Committee heard that though there was support for the concept of supervised clinical training for international physicians, there was also significant concern about implementation. Testimony highlighted that the J-1 visa category is an extremely important mechanism that the United States utilizes to help ensure that more physicians are trained and can provide care in the country. However, testimony noted that if our AMA were to advocate to alter this category it could have detrimental effects on the program in its entirety since opening up the visa category in this manner could result in negative and restrictive changes, rather than an expansion, especially given the current political climate. Your Reference Committee also heard that the J-1 visa might not be the correct visa to utilize for this type of training. Additional concerns were raised centering around patient safety, liability insurance, adherence with ACGME standards, the burden on teaching physicians, and the impact on U.S. residents and their training. Your Reference Committee also heard that a B-1 observer program already exists which is a short-term program that allows medical professionals from other countries come to the United States

and observe medical practice. Testimony noted that although this program does not allow hands-on experience, it does provide a strong educational experience for individuals from other countries.

Your Reference Committee also received multiple proffered amendments for this Resolution that were offered with the intention of broadening the implementation. Your Reference Committee agrees that a broader stance on this issue would be more beneficial for our AMA's advocacy overall and would allow for our AMA to advocate on this topic in a nuanced manner that takes into account the political climate as well as the technicalities that exist behind this Resolution.

Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(22) RESOLUTION 209 — PROTECTING GME SUBJECT TO FUNDING UNCERTAINTY

RECOMMENDATION A:

Your Reference Committee recommends that the first and fourth Resolves of Resolution 209 be deleted.

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve of Resolution 209 be amended by deletion to read as follows:

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

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 209 be amended by addition of a new Resolve to read as follows:

RESOLVED, that policies D-305.967, H-310.916, H-305.929, and D-305.955 be reaffirmed.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 209 be adopted as amended.

HOD ACTION: Resolution 209 is adopted as amended.

ADOPTED LANGUAGE:

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

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

RESOLVED, that policies D-305.967, H-310.916, H-305.929, and D-305.955 be reaffirmed.

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

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

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

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

Your Reference Committee heard testimony in support of the spirit of Resolution 209. Testimony noted the need to protect graduate medical education (GME) funding from disruption and uncertainty. Your Reference Committee heard that instability in discretionary funding threatens training continuity, workforce development, financial planning for programs, and patient access to care, particularly during government shutdowns or delayed appropriations. However, your Reference Committee also heard that our AMA has extensive policy on the topic and has undertaken extensive advocacy related to GME funding, including for GME programs that are funded through discretionary funding including Department of Defense, Veterans Affairs, Indian Health Service, Centers for Disease Control and Prevention, and more. Testimony noted that AMA policy also explicitly supports residency funding for pediatrics (CHGME), preventive medicine, public health, and more, all of which operate under discretionary funding. Your Reference Committee heard that, in alignment with existing AMA policy, in the 119th Congress alone, our AMA has undertaken advocacy work that includes but is not limited to:

- In May 2026, our AMA signed onto a letter asking Congress for $1.02 billion in FY 2027 to fund CHGME with the same priority as other federal physician training programs.
- On April 15, 2026, our AMA signed onto a letter led by the AI/AN Health Partners coalition asking for additional funding for FY 2027 for the Indian Health Service through the appropriations process.
- Our AMA signed onto a letter and sent our own letter expressing strong support for the Rural Residency Planning and Development Act of 2025 (H.R. 6468) which would fund Rural Residency Planning and Development pilot programs.
- On March 6, 2026, our AMA submitted a Statement for the Record to the U.S. House of Representatives Ways and Means Health Subcommittee as part of the hearing entitled, “Advancing the Next Generation of America’s Health Care Workforce.” Our AMA urged Congress to consider sustained long-term

investments in our physician workforce to help mitigate current and impending physician shortages and preserve patient access to care.

- Our AMA signed onto a letter and sent our own support letters for H.R. 4731 and S.2439, the Resident Physician Shortage Reduction Act of 2025, which would add 2,000 Medicare-supported GME slots annually over seven years, for a total of 14,000 new positions.
- On August 26, 2025, our AMA sent a letter supporting H.R. 3885, the Community Training, Education, and Access for Medical Students (Community TEAMS) Act, which would provide grants for training opportunities for medical students in rural health clinics, federally qualified health centers, and healthcare facilities located in medically underserved communities.
- On August 18, 2025, our AMA sent a letter in strong support of the House Energy and Commerce Committee's efforts to advance legislation that would reauthorize the Health Resources and Services Administration Title VII health professions workforce development programs.
- On May 28, our AMA signed onto a letter asking Congress for $778 million in FY 2026 funding for the CHGME program.
- On April 29, our AMA signed onto letters to the House and Senate in support of additional funding in FY 2026 for the Indian Health Service, including increased loan repayment and scholarships, more staff quarters, and additional medical and diagnostic equipment for the IHS.

Given the strong ongoing advocacy in this space, testimony noted that existing AMA policy should be reaffirmed. Additionally, your Reference Committee heard that the third resolve needs to be amended for accuracy because the GME Compendium is updated every other year, not every year. Additionally, testimony noted that the fourth resolve should be struck since the requested information will be added into the GME Compendium and the requested information would likely be duplicative of what is added to the Compendium. Moreover, by adding this information into the GME Compendium the information will be updated every other year and will remain evergreen. Therefore, your Reference Committee recommends that Resolution 209 be adopted as amended and that existing AMA Policies D-305.967, H-310.916, H-305.929, and D-305.955 be reaffirmed.

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

1. 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).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. 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).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. 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.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. 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.
9. 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.
10. 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.
11. Our AMA:
    a. 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.
    b. 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.
    c. 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.
12. 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.
13. 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.
14. 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.

15. 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.
16. 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.
17. 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.
18. 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.
19. 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.
20. 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.
21. 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.
22. 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.
23. 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.
24. 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.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. 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.
27. 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.
28. 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.
29. 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.
30. 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.
31. 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.
32. Our AMA will:
    a. 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.
    b. 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.
    c. 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.
33. 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.

34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. 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.

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

1. 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.
2. Our AMA strongly advocates that:
    a. 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.
    b. 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.
3. 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.

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

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

b. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
c. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
d. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
e. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
f. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
g. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
h. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
i. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary

reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

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

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.

(23) RESOLUTION 212 — MEDICAL STAFF APPROVAL OF QUALITY-OF-CARE ISSUES PRIOR TO EXCLUSIVE CONTRACT

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend Policy H-225.985 by addition and deletion to read:

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

(a) ~~1.the~~ ~~any~~decision to execute an exclusive contract in a previously open department or service;
(b) the decision to execute an exclusive contract that replaces an existing contracted physician group in a particular department or service;
(c) ~~2. the any~~ decision to renew or otherwise materially modify an exclusive contract in a particular department or service; or
(d) ~~3. the any~~ decision to terminate an exclusive contract in a particular department or service~~; and~~.
~~prior to termination of the contract~~

2. Prior to any such action, the medical staff should receive reasonable advance notice and the information needed to assess the effect of the proposed action on quality of care, continuity of care, and medical staff privileges, and ~~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.~~

3. Where the governing body acts contrary to the medical staff's recommendation, it should provide the medical staff with a written explanation of its reasons, and the matter should be eligible for a dispute-resolution process, agreed upon by the medical staff and governing body, in which both are equally represented.

4. Our AMA encourages organized medical staffs to establish in their bylaws the scope of medical staff authority over exclusive contracting decisions. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and hospital accrediting organizations to require ~~the above recommendations~~ hospitals to provide the organized medical staff with reasonable advance notice, an opportunity to review and make recommendations, and a hearing before executing, replacing, renewing, materially modifying, or terminating an exclusive physician services contract (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~seek federal legislation requiring organized medical staff approval in the above listed situations, and~~ develop model state legislation ~~incorporating the same protections~~ providing organized medical staffs with reasonable advance notice, an opportunity to review and make recommendations, and a hearing before a hospital executes, replaces, renews, materially modifies, or terminates an exclusive physician services contract. (Directive to Take Action)

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 212 be adopted as amended.

HOD ACTION: Resolution 212 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association amend Policy H-225.985 by addition and deletion to read:

1. 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:

- **a. the decision to execute an exclusive contract in a previously open department or service;**
- **b. the decision to execute an exclusive contract that replaces an existing contracted physician group in a particular department or service;**
- **c. the decision to renew or otherwise materially modify an exclusive contract in a particular department or service; or**
- **d. the decision to terminate an exclusive contract in a particular department or service.**

2. Prior to any such action, the medical staff should receive reasonable advance notice and the information needed to assess the effect of the proposed action on quality of care, continuity of care, and medical staff privileges, and 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.

3. Where the governing body acts contrary to the medical staff's recommendation, it should provide the medical staff with a written explanation of its reasons, and the matter should be eligible for a dispute-resolution process, agreed upon by the medical staff and governing body, in which both are equally represented.

4. Our AMA encourages organized medical staffs to establish in their bylaws the scope of medical staff authority over exclusive contracting decisions. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and hospital accrediting organizations to require hospitals to provide the organized medical staff with reasonable advance notice, an opportunity to review and make recommendations, and a hearing before executing, replacing, renewing, materially modifying, or terminating an exclusive physician services contract (Directive to Take Action); and be it further

RESOLVED, that our AMA develop model state legislation providing organized medical staffs with reasonable advance notice, an opportunity to review and make recommendations, and a hearing before a hospital executes, replaces, renews, materially modifies, or terminates an exclusive physician services contract. (Directive to Take Action)

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

Our American Medical Association believes that the medical staff should review, ~~and~~ make recommendations to the governing body, and ultimately approve arrangements related to

exclusive contract ~~arrangements~~, prior to any decision being made, in the following situations:

1. ~~the~~ any decision to execute an exclusive contract in a previously open department or service;
2. ~~the~~ any decision to renew or otherwise modify an exclusive contract in a particular department or service;
3. ~~the~~ any decision to terminate an exclusive contract in a particular department or service; and
4. ~~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.~~ (Modify Current HOD Policy); and be it further

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

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

Your Reference Committee heard support for the spirit of Resolution 212, however significant testimony noted the need for amendments to the Resolution. Your Reference Committee heard that the Medicare Conditions of Participation recognize that the organized medical staff is responsible for the quality of medical care, but also make clear that the medical staff operates within a structure in which the governing body holds final authority:

- The hospital must have a governing body that is legally responsible for the conduct of the hospital (42 CFR 482.12).
- That governing body is responsible for all services furnished under contract and must ensure they are provided safely and effectively (42 CFR 482.12(e)).
- The medical staff must be accountable to the governing body for the quality of care (42 CFR 482.12(a)(5); 482.22(b)).
- The medical staff operates under bylaws approved by the governing body (42 CFR 482.22; 482.22(c)(1)).
- On appointments, the medical staff makes recommendations and the governing body acts (42 CFR 482.12(a)(2); 482.22(a)(2)).

Your Reference Committee heard that accreditation standards and state law follow the same structure. Testimony noted that asking the Centers for Medicare and Medicaid Services (CMS), accreditors, and Congress to require medical staff approval of exclusive contracts would ask them to restructure this framework, an objective with no realistic path that would draw strong opposition. Testimony highlighted that a medical staff veto over which group receives a contract would also raise antitrust and conflict-of-interest concerns, since medical staff members may compete with, or belong to, the groups involved.

Your Reference Committee heard that the Conditions of Participation already require the governing body to consult directly with medical staff leadership on the quality of care (42

CFR 482.12(a)(10)). Requiring notice, review, and a hearing before exclusive contracting decisions builds on that existing obligation and is an achievable advocacy goal. Accordingly, your Reference Committee heard that amendments were needed to strengthen the Resolution and to bring it into alignment with regulations and the law. Testimony strongly favored these amendments and noted that the proffered amendments gave medical staff a meaningful voice in decisions that affect the quality of care, in a form our AMA can achieve.

Your Reference Committee heard testimony in support of an amendment that was endorsed by multiple delegations. However, the amendment was not provided in writing to the Committee and therefore the Committee was unable to completely consider the content of the proposed amendment.

Therefore, your Reference Committee recommends that Resolution 212 be adopted as amended.

(24) RESOLUTION 214 — PROHIBITING HEALTH CARE SALE-LEASEBACK TRANSACTIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 214 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 214 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA develop~~s~~ a model state legislative template to assist state medical associations and specialty societies in opposing the ~~model federal and state legislation prohibiting the~~ imposition of sale-leaseback provisions on the state and federal levels related to the purchase of health care entities ~~as above~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 214 be adopted as amended.

HOD ACTION: Resolution 214 is adopted as amended.

ADOPTED LANGUAGE:

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

RESOLVED, that our AMA develops a model state legislative template to assist state medical associations and specialty societies in opposing the imposition of sale-

leaseback provisions on the state and federal levels related to the purchase of health care entities.

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

RESOLVED, that our AMA develops model federal and state legislation prohibiting the imposition of sale-leaseback provisions related to the purchase of health care entities as above.

Your Reference Committee heard mixed testimony for Resolution 214. Your Reference Committee heard support for addressing sale-leaseback arrangements associated with health care acquisitions, particularly where such transactions may extract value from clinical entities and threaten long-term stability. Testimony highlighted examples of situations where leaseback agreements had negatively impacted hospitals and ultimately harmed access to care. However, additional testimony noted that sometimes leaseback provisions are used for legitimate reasons, such as for retirement planning for physicians who own their practice and their offices. Accordingly, your Reference Committee heard that Resolution 214 should be refined to ensure the policy targets coercive or abusive arrangements without unintentionally restricting legitimate, voluntary, arm's-length real estate transactions that may serve appropriate financing, retirement, or succession-planning purposes for physicians and practices.

Your Reference Committee heard that it would be a more effective strategy to develop a state model template to help the Federation oppose sale-leaseback provisions. Testimony noted that states are just now grappling with how best to address leasebacks and some state medical associations have expressed the need to have flexibility when it comes to leaseback provisions for fear of foreclosing some transactions and lease arrangements that might benefit physicians. Thus, your Reference Committee heard that it is premature to codify a single approach in a model bill. However, testimony noted that our AMA has already developed a 137-page state legislative template entitled "Legislative Approaches to Curb Corporate Influence in Health Care" that is available on our AMA website and contains different approaches states are considering related to corporate influence. Your Reference Committee heard that this template could be revised to include options to address leasebacks and be continually updated to assist the federation on state and federal advocacy concerning lease-back arrangements by providing a multiplicity of options. Therefore, your Reference Committee recommends that Resolution 214 be adopted as amended.

(25) RESOLUTION 215 — ESTABLISHING PRODUCT LIABILITY FOR CLINICAL AUGMENTED INTELLIGENCE FAILURES

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association advocate for federal and state legislation establishing that when a clinical AI product produces an erroneous output and a physician has used the product as intended while exercising appropriate clinical judgment, the liability for resulting patient harm ~~constitutes a product liability claim against~~ should rest with the AI vendor, manufacturer, or distributor, not a medical malpractice claim against the physician; and be it further

RECOMMENDATION B:

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

RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same product liability standards as manufacturers of other medical devices ~~under the Restatement (Third) of Torts: Products Liability~~, including, but not limited to, strict liability for manufacturing defects, and liability for design defects and failure to provide adequate instructions or warnings; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve of Resolution 215 be amended by addition to read as follows:

RESOLVED, that our AMA advocate for legislation requiring that AI vendors and manufacturers maintain product liability insurance adequate to cover claims arising from AI product failures in clinical settings, and that such insurance obligations be a condition of FDA marketing authorization required by law as a condition of deployment; and be it further

RECOMMENDATION D:

Your Reference Committee recommends that the fourth Resolve of Resolution 215 be amended by deletion to read as follows:

RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions, including end-user license agreements and vendor contracts, that attempt to shift ~~product~~ liability for AI tool failures from the manufacturer to the physician or health system end user; and be it further

RECOMMENDATION E:

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

RECOMMENDATION F:

Your Reference Committee recommends that the title of Resolution 215 be changed to read as follows:

ESTABLISHING LIABILITY FOR CLINICAL AUGMENTED INTELLIGENCE FAILURES

HOD ACTION: Resolution 215 is adopted as amended with a change in title.

ADOPTED LANGUAGE:

ESTABLISHING LIABILITY FOR CLINICAL AUGMENTED INTELLIGENCE FAILURES

RESOLVED, that our American Medical Association advocate for federal and state legislation establishing that when a clinical AI product produces an erroneous output and a physician has used the product as intended while exercising appropriate clinical judgment, the liability for resulting patient harm should rest with the AI vendor, manufacturer, or distributor, not a medical malpractice claim against the physician; and be it further

RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same product liability standards as manufacturers of other medical devices, including, but not limited to, strict liability for manufacturing defects, and liability for design defects and failure to provide adequate instructions or warnings; and be it further

RESOLVED, that our AMA advocate for legislation requiring that AI vendors and manufacturers maintain product liability insurance adequate to cover claims arising from AI product failures in clinical settings, and that such insurance obligations be a condition of FDA marketing authorization required by law as a condition of deployment; and be it further

RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions, including end-user license agreements and vendor contracts, that attempt to shift liability for AI tool failures from the manufacturer to the physician or health system end user (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation requiring AI vendors and manufacturers to disclose known failure rates, limitations, and performance data for their clinical AI products, including performance across different patient populations, so that physicians can make informed decisions about the clinical appropriateness of AI tool outputs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that when a health system, hospital, payer, or other entity mandates the use of a specific AI tool and that tool produces an error resulting in patient harm, the mandating entity and the AI vendor bear the liability, and the physician who was required to use the tool and exercised appropriate clinical judgment is not liable for errors originating in the mandated product. (Directive to Take Action)

RESOLVED, that our American Medical Association advocate for federal and state legislation establishing that when a clinical AI product produces an erroneous output and a physician has used the product as intended while exercising appropriate clinical judgment, the liability for resulting patient harm constitutes a product liability claim against the AI vendor, manufacturer, or distributor, not a medical malpractice claim against the physician (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same product liability standards as manufacturers of other medical devices under the Restatement (Third) of Torts: Products Liability, including strict liability for manufacturing defects, and liability for design defects and failure to provide adequate instructions or warnings (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation requiring that AI vendors and manufacturers maintain product liability insurance adequate to cover claims arising from AI product failures in clinical settings, and that such insurance obligations be a condition of FDA marketing authorization (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions, including end-user license agreements and vendor contracts, that attempt to shift product liability for AI tool failures from the manufacturer to the physician or health system end user (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation requiring AI vendors and manufacturers to disclose known failure rates, limitations, and performance data for their clinical AI products, including performance across different patient populations, so that physicians can make informed decisions about the clinical appropriateness of AI tool outputs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that when a health system, hospital, payer, or other entity mandates the use of a specific AI tool and that tool produces an error resulting in patient harm, the mandating entity and the AI vendor bear the liability, and the physician who was required to use the tool and exercised appropriate clinical judgment is not liable for errors originating in the mandated product. (Directive to Take Action)

Your Reference Committee heard significant testimony opposing the preliminary report's recommendation to refer Resolution 215. The majority of testimony supported adopting amended language rather than referral. Testimony broadly agreed that physicians who appropriately use AI tools and exercise sound clinical judgment should not be held responsible for product defects, unsafe deployment, or failures beyond their reasonable ability to detect, control, or correct. Testimony highlighted the importance of ensuring that our AMA policy assigns accountability to the parties best positioned to understand, prevent, and mitigate AI-related risks, including developers, manufacturers, vendors, and, in some circumstances, institutions that mandate use of a particular tool. Significant testimony noted the need to better distinguish erroneous outputs from true product defects, address overlapping legal theories, and ensure that our AMA policy remains accurate as this rapidly evolving area develops. Therefore, your Reference Committee recommends that Resolution 215 be adopted as amended.

(26) RESOLUTION 219 — OPPOSING THE USE OF ARTIFICIAL INTELLIGENCE TO PRODUCE CHILD AND ADOLESCENT SEXUAL EXPLOITATIVE MATERIAL

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 219 be amended by addition to read as follows:

RESOLVED, that our American Medical Association opposes the use of artificial intelligence to produce any sexual and other exploitative material of minors and will advocate for legislation to prohibit the use of artificial intelligence for such purposes; (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 219 be deleted.

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve of Resolution 219 be amended by addition to read as follows:

RESOLVED, that our AMA encourages State Delegations to adopt similar resolutions opposing the use of artificial intelligence to produce any sexual and other exploitative material of minors and advocate on this topic at the state level. (New HOD Policy)

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association opposes the use of artificial intelligence to produce any sexual and other exploitative material of minors and will advocate for legislation to prohibit the use of artificial intelligence for such purposes; (New HOD Policy); and be it further

RESOLVED, that our AMA encourages State Delegations to adopt similar resolutions opposing the use of artificial intelligence to produce any sexual and other exploitative material of minors and advocate on this topic at the state level. (New HOD Policy)

RESOLVED, that our American Medical Association oppose the use of artificial intelligence to produce any sexual and other exploitative material of minors (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation that opposes the use of artificial intelligence to produce sexual and other exploitative material of minors (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage State Delegations to adopt similar resolutions and advocate at the state level. (New HOD Policy)

Your Reference Committee heard wildly supportive testimony for the spirit of Resolution 219. Testimony noted that our AMA does not have policy specifically opposing the use of artificial intelligence (AI) to produce child sexual abuse material (CSAM). Your Reference Committee also heard that Resolution 219 would establish our AMA's opposition to this practice, call on our AMA to advocate for legislation against AI-produced CSAM, and encourage State Delegations to adopt similar resolutions and advocate against AI-produced CSAM at the state level. An amendment was offered, which was widely supported, that would clarify the language in the Resolution without changing the impact. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(27) RESOLUTION 226 — PHYSICIAN-LED GOVERNANCE OF THE USE OF AUGMENTED INTELLIGENCE IN HOSPITAL CREDENTIALING, PRIVILEGING, AND PEER REVIEW

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 226 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate that any use of augmented intelligence in credentialing, privileging, peer review, quality review, or corrective action requires physician-led oversight and ~~this be codified in medical staff bylaws~~ transparency regarding its use, function, and role in decision-making (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve of Resolution 226 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~will~~ encourage appropriate organizations to require ~~communicate its policy on requiring~~ physician-led oversight of augmented intelligence when used in credentialing, privileging, peer review and quality review ~~on a continuing basis to the American Hospital Association, Federation of American Health System, and other appropriate organizations~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the fourth Resolve of Resolution 226 be deleted.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 226 be amended by addition of a new Resolve to read as follows:

RESOLVED, that policies H-375.973 and H-225.942 be reaffirmed.

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 226 be adopted as amended.

HOD ACTION: Resolution 226 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate that any use of augmented intelligence in credentialing, privileging, peer review, quality review, or corrective action requires physician-led oversight and transparency regarding its use, function, and role in decision-making (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the requirement of hospital and health systems to fully disclose the data sources, validation, limitations, governance, and intended use of any augmented intelligence tool used in medical staff processes (New HOD Policy); and be it further

RESOLVED, that our AMA encourage appropriate organizations to require physician-led oversight of augmented intelligence when used in credentialing, privileging, peer review and quality review (Directive to Take Action); and be it further

RESOLVED, that policies H-375.973 and H-225.942 be reaffirmed.

RESOLVED, that our American Medical Association advocate that any use of augmented intelligence in credentialing, privileging, peer review, quality review, or corrective action requires physician-led oversight and this be codified in medical staff bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the requirement of hospital and health systems to fully disclose the data sources, validation, limitations, governance, and intended use of any augmented intelligence tool used in medical staff processes (New HOD Policy); and be it further

RESOLVED, that our AMA will communicate its policy on requiring physician-led oversight of augmented intelligence when used in credentialing, privileging, peer review and quality review on a continuing basis to the American Hospital Association, Federation of American Health System, and other appropriate organizations (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm policy H-225.942, Physician and Medical Staff Member Bill of Rights, that opposes any retaliatory peer review privileging action, corrective action, or employment action taken against a physician for good-faith safety

reporting advocacy, or participation in organized medical staff governance (Reaffirmed HOD Policy)

Your Reference Committee received testimony that supported the spirit of Resolution 226. Your Reference Committee heard that the use of augmented intelligence (AI) in credentialing, privileging, peer review, quality review, and corrective action must remain under physician-led oversight and not replace physician judgment. However, testimony noted that existing policy on protecting physicians in the peer review process captures the spirit of the Resolution by requiring guaranteed due process and civil rights safeguards for physicians in peer review and credentialing. Your Reference Committee also heard that amendments to this Resolution would be beneficial for clarity and to allow for more flexibility and additional options when working to accomplish the goals highlighted in Resolution 226. Furthermore, it was noted that amendments were needed because the Federation of American Health Systems no longer exists, accordingly it is important to tie our AMA policy to concepts rather than named entities, when possible, to ensure accuracy and longevity. Therefore, your Reference Committee recommends that Resolution 226 be adopted as amended and that existing AMA policies H-375.973 and H-225.942 be reaffirmed.

Protecting Physicians at the Peer Review Process in the Current Managed Care Environment H-375.973

1. Our AMA will work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider.
2. Our AMA espouses as policy the guarantee of due process and civil rights safeguards to physicians in peer review and in credentialing.

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.

(28) RESOLUTION 227 — INCREASING ACCESS TO LONG-ACTING INJECTABLE MEDICATIONS FOR SUD

RECOMMENDATION A:

Your Reference Committee recommends that the fourth Resolve of Resolution 227 be deleted.

RECOMMENDATION B:

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

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, including Alcohol Use Disorder, 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 scope of practice restrictions, medication-security, patient privacy, and patient-safety safeguards. (New HOD Policy)

RECOMMENDATION C:

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

RECOMMENDATION D:

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

INCREASING ACCESS TO LONG-ACTING INJECTABLE (LAI) MEDICATIONS FOR SUBSTANCE USE DISORDER (SUD)

HOD ACTION: Resolution 227 is <u>adopted as amended</u> with a <u>change in title</u>.

ADOPTED LANGUAGE:

INCREASING ACCESS TO LONG-ACTING INJECTABLE (LAI) MEDICATIONS FOR SUBSTANCE USE DISORDER (SUD)

RESOLVED, that our American Medical Association reaffirm its support for coverage of all FDA-approved medications for SUDs without prior authorization, step therapy, fail-first requirements, or other non-evidence-based utilization-management restrictions (New HOD Policy); and be it further

RESOLVED, that our AMA support the elimination of patient cost-sharing for FDA-approved medications used to treat SUDs and their administration (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for payer payment policies for LAIs that appropriately account for each medically necessary dose and its preparation and administration (Directive to Take Action); 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, including Alcohol Use Disorder, 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 scope of practice restrictions, medication-security, patient privacy, and patient-safety safeguards. (New HOD Policy)

RESOLVED, that our American Medical Association reaffirm its support for coverage of all FDA-approved medications for SUDs without prior authorization, step therapy, fail-first requirements, or other non-evidence-based utilization-management restrictions (New HOD Policy); and be it further

RESOLVED, that our AMA support the elimination of patient cost-sharing for FDA-approved medications used to treat SUDs and their administration (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for payer payment policies for LAIs that appropriately account for each medically necessary dose and its preparation and administration (Directive to Take 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)

Your Reference Committee heard strong support for expanding access to long-acting injectable (LAI) medications for substance use disorders. Testimony agreed that these medications can improve treatment continuity, reduce the burden of frequent dosing, and help overcome barriers that limit effective care. However, some testifiers offered amendments or supported amendments offered by others.

While there was strong consensus that LAI medications should be treated like other evidence-based therapies for chronic conditions and not be subject to additional obstacles driven by stigma or non-evidence-based utilization management, significant testimony raised concerns with the provision related to pharmacist administration. This testimony stressed the importance of physician-led care and offered or supported amendments to ensure that the Resolution promotes physician oversight of LAI medications. An amendment was offered that requested the Resolution be expanded to include LAI medications for Alcohol Use Disorder.

Your Reference Committee agrees that LAI medications are an important tool in the treatment of substance use disorders and shares the concerns of those who testified to the importance of preserving physician-led care and ensuring that scope of practice restrictions are followed and patient privacy is protected. The Committee also appreciates the expansion of this policy to include LAI medications for Alcohol Use Disorder. Also, your Reference Committee noted that the acronyms needed to be defined and as such the title was updated. Therefore, your Reference Committee recommends that Resolution 227 be adopted as amended with a change in title.

(29) RESOLUTION 228 — HOSPITAL-BASED SUBSTANCE USE DISORDER CARE

RECOMMENDATION A:

Your Reference Committee recommends that the second Resolve of Resolution 228 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for increased availability of and access to hospital-based Substance Use Disorder, including Alcohol Use Disorder, ~~addiction~~ treatment services~~,~~ including a multidisciplinary consult service, as appropriate to hospital size, patient volume, and community need (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the first and third Resolves of Resolution 228 be deleted.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 228 be amended by addition of a new Resolve to read as follows:

RESOLVED, that policies H-95.922 and D-95.967 be reaffirmed.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 228 be adopted as amended.

HOD ACTION: Resolution 228 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our AMA advocate for increased availability of and access to hospital-based Substance Use Disorder, including Alcohol Use Disorder, treatment services, including a multidisciplinary consult service, as appropriate to hospital size, patient volume, and community need (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)

RESOLVED, that policies H-95.922 and D-95.967 be reaffirmed.

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)

Your Reference Committee heard testimony that was generally supportive of improving hospital-based care for substance use disorders, with broad agreement that hospitals and emergency departments are important settings for identifying substance use disorders, initiating evidence-based treatment, managing overdose and withdrawal, and linking patients to ongoing care after discharge.

Your Reference Committee heard testimony that emphasized the need to expand hospital-based addiction services, improve continuity of care, and ensure adequate reimbursement for the clinical teams, consult services, care coordination, and support systems required to deliver this care effectively.

At the same time, significant testimony raised concerns that new competencies or quality-measure requirements could become unfunded mandates or add burdens to already strained settings. An amendment to strike the first and third resolved clauses was offered to address these concerns. Additionally, an amendment to the second resolved clause was offered to encourage the development of hospital-based addiction service infrastructure. A further amendment was offered that requested the Resolution be expanded to include Alcohol Use Disorder.

Your Reference Committee agrees with the consensus reflected in the testimony that access to evidence-based substance use disorder and alcohol use disorder care in hospital settings should be increased but is also appreciative of the concerns highlighted by the testimony that focused on the potential impact of the Resolution on emergency department and hospital operations. Your Reference Committee also found that existing AMA policies provide strong support for access to substance use disorder treatments, including in hospitals. For these reasons, your Reference Committee recommends that Resolution 228 be adopted as amended, and that existing AMA Policies H-95.922 and D-95.967 be reaffirmed in lieu of the first resolved clause.

Substance Use and Substance Use Disorders H-95.922

1. Our American Medical Association will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders.
2. Our AMA will renew efforts to:
    a. have substance use disorders addressed across the continuum of medical education.
    b. provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment.
    c. develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults.
    d. assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease.
3. Our AMA will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Treating Opioid Use Disorder in Hospitals D-95.967

1. 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.

2. 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.

3. 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.

(30) RESOLUTION 229 — PROTECTING INDIVIDUAL RIGHTS IN THE ERA OF DEVELOPING NEUROTECHNOLOGIES, INCLUDING FOR MENTAL AUGMENTATION

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 229 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association strongly supports ~~a hybrid approach to~~ improving state consumer data privacy laws that ~~both (1)~~ defines neural data consistent with existing AMA policy ~~and protects neural data as sensitive data; and (2) provides heightened protections based on use for data inferred from nonneural information gathered by biosensors, including biometric devices, when such data is used to infer sensitive information about an individual's mental or cognitive states. Any such use-based category should be precisely defined to distinguish mental or cognitive inferences warranting heightened protection because their sensitivity approaches that of neural data from other inferences derived from nonneural information that do not warrant such protection~~ (New HOD Policy); and be it further

RECOMMENDATION B:

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

HOD ACTION: Resolution 229 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association strongly supports improving state consumer data privacy laws that defines neural data consistent with existing AMA policy (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes the right of individuals to make voluntary and informed decisions whether to use mental augmentation neurotechnologies, consistent with applicable standards governing safety, efficacy, and informed consent, and supports protections against coercion, undue pressure, or unjust discrimination based on an individual's decision to use or decline such technologies, except where otherwise ethically and legally justified under narrowly defined circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA support policies promoting equitable access to safe and effective mental augmentation neurotechnologies when lack of access would create or substantially exacerbate disparities in health, education, employment, or participation in society (New HOD Policy); and be it further

RESOLVED, that our AMA support appropriate protections for the mental privacy, neural data, identity, and agency of individuals using mental augmentation neurotechnologies, including meaningful control over the collection, use, disclosure, and commercialization of neural data generated through such technologies (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physicians, neuroscientists, patients, ethicists, disability advocates, and other relevant stakeholders to participate in developing evidence-based standards and ethical frameworks governing the safety, efficacy, voluntary use, and equitable availability of mental augmentation neurotechnologies. (New HOD Policy)

RESOLVED, that our American Medical Association strongly supports a hybrid approach to improving state consumer data privacy laws that both (1) defines neural data consistent with existing AMA policy and protects neural data as sensitive data; and (2) provides heightened protections based on use for data inferred from nonneural information gathered by biosensors, including biometric devices, when such data is used to infer sensitive information about an individual's mental or cognitive states. Any such use-based category should be precisely defined to distinguish mental or cognitive inferences warranting heightened protection because their sensitivity approaches that of neural data from other inferences derived from nonneural information that do not warrant such protection (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes the right of individuals to make voluntary and informed decisions whether to use mental augmentation neurotechnologies, consistent with applicable standards governing safety, efficacy, and informed consent, and supports protections against coercion, undue pressure, or unjust discrimination based on an individual's decision to use or decline such technologies, except where otherwise ethically and legally justified under narrowly defined circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA support policies promoting equitable access to safe and effective mental augmentation neurotechnologies when lack of access would create or substantially exacerbate disparities in health, education, employment, or participation in society (New HOD Policy); and be it further

RESOLVED, that our AMA support appropriate protections for the mental privacy, neural data, identity, and agency of individuals using mental augmentation neurotechnologies, including meaningful control over the collection, use, disclosure, and commercialization of neural data generated through such technologies (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physicians, neuroscientists, patients, ethicists, disability advocates, and other relevant stakeholders to participate in developing

evidence-based standards and ethical frameworks governing the safety, efficacy, voluntary use, and equitable availability of mental augmentation neurotechnologies. (New HOD Policy)

Your Reference Committee heard mixed testimony for Resolution 229. Your Reference Committee heard support for the concepts of protecting mental privacy, autonomy, informed consent, and freedom from coercion as neurotechnology develops. Testimony highlighted that technologies capable of recording, interpreting, or influencing neural activity raise important ethical and policy questions, especially as they expand beyond traditional clinical settings and increasingly intersect with artificial intelligence (AI) and consumer products. However, your Reference Committee heard that the Resolution would likely impose a substantial compliance burden on physicians and create a tiered privacy framework for health information. Testimony highlighted that the Resolution conflicts with our AMA's longstanding approach to individual privacy, which advocates in favor of protecting the privacy of an individual's data, regardless of whether that data collection occurs in a clinical setting, during an individual's daily activities, or online. Testimony noted that our AMA has consistently advocated in favor of protecting the privacy and security of all such data, as it can readily be combined with other data elements to identify an individual. Your Reference Committee also heard concerns that this Resolution could be viewed as tantamount to standing up a separate regulatory regime to apply heightened protections to neural data, while failing to address the protection of a myriad of other individual data collected in other contexts. Testimony noted that AMA has consistently advocacy to protect individually identifiable information regardless of the context in which it was collected, especially in our current era of AI deployment and technology development, allowing near-instantaneous combination of data points to identify the target individual. Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

(31) RESOLUTION 232 — TIMELY PROCESSING OF DEA PRACTITIONER REGISTRATIONS TO PROTECT PATIENT ACCESS TO CARE

RECOMMENDATION A:

Your Reference Committee recommends that the fifth Resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA urge the Drug Enforcement Administration (DEA) ~~Congress and the Department of Justice~~ to fill vacant ~~Drug Enforcement Administration~~ Registration Program Specialist positions~~, exempt fee-funded registration positions from federal hiring freezes, and ensure that practitioner registration fees are used to maintain timely registration services~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the sixth Resolve of Resolution 232 be amended by addition to read as follows:

RESOLVED, that our AMA advocates that any new quality assurance or review procedures the Drug Enforcement Administration adopts for practitioner registration applications be developed with opportunities for public comment, including input from organized medicine before being finalized, be adequately staffed, and be implemented without lengthening registration processing times (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the seventh Resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested parties ~~survey its membership, in collaboration with interested state and specialty medical societies,~~ to assess the extent of Drug Enforcement Administration registration processing delays and their effects on physician practice, credentialing, employment, and patient access to care, and communicate those findings to the DEA ~~report findings to the House of Delegates~~ (Directive to Take Action); and be it further

RECOMMENDATION D:

Your Reference Committee recommends that the eighth Resolve of Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA request an update from the ~~work with Congress, the Department of Justice Office of the Inspector General, and the Government Accountability Office to monitor~~ Drug Enforcement Administration on practitioner registration processing times and staffing and their effect on patient access to care (Directive to Take Action); and be it further

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 232 be amended by addition of a new tenth Resolve that reads as follows:

RESOLVED, that our AMA will assess the extent of registration delays within the Drug Enforcement Administration by collaborating with relevant specialty societies, surveying AMA membership, collaborating with the Advocacy Resource Center as well as relevant, existing AMA Task Forces. Assessment should include but not be limited to evaluating clinical and administrative impact on physician practice, credentialing, employment and patient access to care with communication of findings to the DEA. (Directive to Take Action).

RECOMMENDATION F:

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

HOD ACTION: Resolution 232 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate that the Drug Enforcement Administration restore timely processing of complete practitioner registration applications, including initial, renewal, and modification applications, consistent with its historical processing times (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Drug Enforcement Administration provide each practitioner registration applicant with an estimated date of issuance and timely status updates, and publicly report average practitioner registration processing times by field division (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Drug Enforcement Administration establish a transparent expedited review process for practitioner registration applications when a processing delay would interrupt patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that no physician who has submitted a complete and timely Drug Enforcement Administration registration application experience a lapse in controlled substance prescribing authority due to agency processing delays, including through continuation of an existing registration or issuance of a provisional registration while the application is pending (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Drug Enforcement Administration (DEA) to fill vacant Registration Program Specialist positions (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that any new quality assurance or review procedures the Drug Enforcement Administration adopts for practitioner registration applications be developed with opportunities for public comment, including input from organized medicine before being finalized, be adequately staffed, and be implemented without lengthening registration processing times (Directive to Take Action); and be it further

RESOLVED, that our AMA work with interested parties to assess the extent of Drug Enforcement Administration registration processing delays and their effects on physician practice, credentialing, employment, and patient access to care, and communicate those findings to the DEA (Directive to Take Action); and be it further

RESOLVED, that our AMA request an update from the Drug Enforcement Administration on practitioner registration processing times and staffing and their effect on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy D-100.970, "Drug Enforcement Administration Licensure Fees," and Policy D-100.975, "One Fee One Number," in its entirety, which directs our AMA to work with the Drug Enforcement Administration and Congress toward a registration system in which a single DEA registration number can be used by physicians who prescribe, dispense, or administer controlled substances in multiple states, and in which the full DEA registration fee is paid only once, at initial registration, with only a small re-registration fee every three years thereafter. (Reaffirm HOD Policy)

RESOLVED, that our AMA will assess the extent of registration delays within the Drug Enforcement Administration by collaborating with relevant specialty societies, surveying AMA membership, collaborating with the Advocacy Resource Center as well as relevant, existing AMA Task Forces. Assessment should include

but not be limited to evaluating clinical and administrative impact on physician practice, credentialing, employment and patient access to care with communication of findings to the DEA. (Directive to Take Action).

RESOLVED, that our American Medical Association advocate that the Drug Enforcement Administration restore timely processing of complete practitioner registration applications, including initial, renewal, and modification applications, consistent with its historical processing times (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Drug Enforcement Administration provide each practitioner registration applicant with an estimated date of issuance and timely status updates, and publicly report average practitioner registration processing times by field division (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Drug Enforcement Administration establish a transparent expedited review process for practitioner registration applications when a processing delay would interrupt patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that no physician who has submitted a complete and timely Drug Enforcement Administration registration application experience a lapse in controlled substance prescribing authority due to agency processing delays, including through continuation of an existing registration or issuance of a provisional registration while the application is pending (New HOD Policy); and be it further

RESOLVED, that our AMA urge Congress and the Department of Justice to fill vacant Drug Enforcement Administration Registration Program Specialist positions, exempt fee-funded registration positions from federal hiring freezes, and ensure that practitioner registration fees are used to maintain timely registration services (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that any new quality assurance or review procedures the Drug Enforcement Administration adopts for practitioner registration applications be developed with input from organized medicine, be adequately staffed, and be implemented without lengthening registration processing times (Directive to Take Action); and be it further

RESOLVED, that our AMA survey its membership, in collaboration with interested state and specialty medical societies, to assess the extent of Drug Enforcement Administration registration processing delays and their effects on physician practice, credentialing, employment, and patient access to care, and report findings to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA work with Congress, the Department of Justice Office of the Inspector General, and the Government Accountability Office to monitor Drug Enforcement Administration practitioner registration processing times and staffing and their effect on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy D-100.970, “Drug Enforcement Administration Licensure Fees,” and Policy D-100.975, “One Fee One Number,” in its entirety, which directs our AMA to work with the Drug Enforcement Administration and Congress toward a registration system in which a single DEA registration number can be used by physicians who prescribe, dispense, or administer controlled substances in multiple states, and in which the full DEA registration fee is paid only once, at initial registration, with only a small re-registration fee every three years thereafter. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 232. Most testimony supported adoption, but some testifiers offered amendments and others supported reaffirmation in lieu of adoption. Overall, the testimony was largely supportive of the Resolution’s goal of reducing delays in Drug Enforcement Administration (DEA) practitioner registrations, which can reduce patient access to care and increase administrative burdens on physicians.

Your Reference Committee heard testimony that agreed that DEA processing delays targeted by the Resolution are a real problem, but some raised concerns about implementation challenges and the potential for unintended consequences (such as increased licensing fees) associated with the policies sought by the Resolution. Some testifiers offered friendly amendments to mitigate these concerns. Additional amendments were offered that highlighted the importance of our AMA collaborating with specialty societies to assess registration delays.

Your Reference Committee agrees that the DEA’s practitioner registration process should be improved and further agrees that some of the targeted amendments offered clarify how the Resolution should be implemented. Therefore, your Reference Committee recommends that Resolution 232 be adopted as amended.

(32) RESOLUTION 234 — RESEARCH INFRASTRUCTURE & OVERCOMING NON-MEDICAL CLINICAL TRIAL BARRIERS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 234 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for federal legislation and Anti-Kickback Statute safe harbors allowing clinical trial sponsors to cover patient non-medical trial costs (travel, lodging, childcare) without tax penalties or safety-net benefit disqualification (Directive to Take Action); and be it further

RESOLVED, that our AMA support modernizing clinical trial access by advocating for telehealth payment parity, cross-state licensure flexibilities, and local lab/imaging use (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to ensure clinical trial participation counts toward Medicaid community engagement or confers a reporting hardship exemption/n (Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Resolution 234 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for federal legislation and Anti-Kickback Statute safe harbors allowing clinical trial sponsors to cover patient non-medical trial costs (travel, lodging, childcare) without tax penalties or safety-net benefit disqualification (Directive to Take Action); and be it further

RESOLVED, that our AMA support modernizing clinical trial access by advocating for telehealth payment parity, cross-state licensure flexibilities, and local lab/imaging use (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to ensure clinical trial participation counts toward Medicaid community engagement or confers a reporting hardship exemption/n (Directive to Take Action)

RESOLVED, that our American Medical Association advocate for federal legislation and Anti-Kickback Statute safe harbors allowing trial sponsors to cover patient non-medical trial costs (travel, lodging, childcare) without tax penalties or safety-net benefit disqualification (Directive to Take Action); and be it further

RESOLVED, that our AMA support modernizing trial access by advocating for telehealth payment parity, cross-state licensure flexibilities, and local lab/imaging use (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to ensure trial participation counts toward Medicaid community engagement or confers a reporting hardship exemption/n (Directive to Take Action)

Your Reference Committee heard testimony that was mostly supportive of Resolution 234 including the goals of reducing non-medical barriers to clinical trial participation and improving equitable access to research. Testimony highlighted that costs such as travel, lodging, childcare, caregiving, missed work, and other out-of-pocket burdens can keep patients from enrolling in trials, particularly patients from rural, low-income, medically underserved, or historically underrepresented populations. Additional testimony supported efforts to modernize trial participation through telehealth, local laboratory and imaging options, and interstate practice flexibility, with the aim of reducing geographic and logistical barriers. Though some testimony noted concerns surrounding reimbursement related to trial participation unintentionally triggering tax consequences or loss of means-tested public benefits, the majority of the testimony still supported adoption. Your Reference Committee also heard testimony noting concern around cross-state licensure flexibilities. Your Reference Committee would like to note that existing AMA policy The Promotion of Quality Telemedicine H-480.969 specifically addresses licensure issues for clinical trials noting:

f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that:
    i. The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy;
    ii. The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and
    iii. Physicians planning to use telehealth identify a physician licensed in the patient's state to address in-person care needs that may arise from the clinical trial.

Accordingly, to align with existing AMA policy, and to ensure that there is a cross reference internally to address any questions surrounding licensure flexibilities, your Reference Committee made an amendment to add in the mention of "clinical" to Resolution 234. Therefore, your Reference Committee recommends that Resolution 234 be adopted as amended.

(33) RESOLUTION 240 — MINIMIZING PATIENT HARM FROM AUTONOMOUS ARTIFICIAL INTELLIGENCE

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 240 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association vocally oppose granting (or equating) artificial intelligence systems or other non-human entities with physician licensure, professional titles, or certification to practice medicine; and amend existing policy H-480.931, "Assessing the Intersection Between AI and Health Care" by addition:

i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

j. Artificial intelligence systems or other non-human entities should not be ~~equated with~~ granted physician licensure, professional titles, or certification to practice medicine; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that second Resolve of Resolution 240 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 240 be adopted as amended.

HOD ACTION: The second Resolve of Resolution 240 is referred and the remainder of Resolution is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association vocally oppose granting (or equating) artificial intelligence systems or other non-human entities with physician licensure, professional titles, or certification to practice medicine; and amend

existing policy H-480.931, "Assessing the Intersection Between AI and Health Care" by addition:

1. General Governance

- **a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.**
- **b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.**
- **c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.**
- **d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.**
- **e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]**
- **f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.**
- **g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.**
- **h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.**
- **i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]**

j. Artificial intelligence systems or other non-human entities should not be granted physician licensure, professional titles, or certification to practice medicine; and be it further

RESOLVED, that our AMA amend current policy D-480.947, "Prohibiting the Independent Practice of Medicine by Artificial Intelligence" by addition:

1. **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**
2. **Our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, their potential impact on the profession and the physician-patient relationship, and the changing implications of autonomous artificial intelligence in clinical care, including proposals to license or certify non-human entities to assume roles of healthcare professionals.**

RESOLVED, that our American Medical Association vocally oppose granting (or equating) artificial intelligence systems or other non-human entities with physician licensure, professional titles, or certification to practice medicine; and amend existing policy H-480.931, "Assessing the Intersection Between AI and Health Care" by addition:

i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

j. Artificial intelligence systems or other non-human entities should not be equated with physician licensure, professional titles, or certification to practice medicine; and be it further

RESOLVED, that our AMA create and disseminate model legislation that, at a minimum:

- Prohibits misrepresentation of non-human entities with titles reserved for physicians,
- Defines distinctions between authorization of medical technology and professional licensure,

- Prohibits non-human entities from performing clinical tasks traditionally associated with the practice of medicine without real-world evidence of superior safety and efficacy and board eligible/certified physician oversight,
- Prohibits artificial intelligence (AI) developers from prospectively collecting clinical patient data for proprietary or research purposes without explicit authorization by the patient,
- Creates a liability framework protecting physicians' independent decision-making from liability arising from non-use of AI recommendations or non-use of AI tools in general,
- Creates a robust supervision framework for physician oversight of AI clinical decision-making with adequate physician reimbursement for such supervision, (Directive to Take Action); and be it further

RESOLVED, that our AMA amend current policy D-480.947, "Prohibiting the Independent Practice of Medicine by Artificial Intelligence" by addition:

1. 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

2. Our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, their potential impact on the profession and the physician-patient relationship<u>, and the changing implications of autonomous artificial intelligence in clinical care, including proposals to license or certify non-human entities to assume roles of healthcare professionals;</u> and be if further

Your Reference Committee heard strong support for the intent of Resolution 240, with testimony noting that AI systems are already being permitted to renew prescriptions with limited physician review. Testimony broadly supported the first Resolve with an amendment to provide that AI systems should not be "granted" physician licensure or titles. Substantial testimony also supported adoption of the third Resolve. However, testimony noted that the second Resolve would create broad new policy, including limits on de-identified research data, and should be considered alongside our AMA's forthcoming report on AI. Your Reference Committee agrees. Therefore, your Reference Committee recommends that the first Resolve be adopted as amended, the third Resolve be adopted, and the second Resolve be referred.

RECOMMENDED FOR ADOPTION IN LIEU OF

(34) RESOLUTION 220 — ADVOCATING FOR THE OLDER AMERICANS ACT AND COMMUNITY-BASED SERVICES FOR OLDER ADULTS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 220 be adopted in lieu of Resolution 220 to read as follows:

ADVOCATING FOR COMMUNITY-BASED SERVICES FOR OLDER ADULTS

RESOLVED, that our American Medical Association support policies and programs that provide home- and community-based services to facilitate aging-in-place for older Americans, and will, to the extent it is otherwise consistent with AMA policy:

1. Advocate for the reauthorization and adequate funding for the Older Americans Act;
2. Support federal or state policies that would increase access, eligibility or funding for the Older Americans Act (OAA) programs; and
3. Collaborate with appropriate organizations to educate legislators and policymakers of the health benefits and fiscal effectiveness of the Older Americans Act (OAA). (Directive to Take Action)

HOD ACTION: Alternate Resolution 220 is adopted in lieu of Resolution 220.

ADOPTED LANGUAGE:

ADVOCATING FOR COMMUNITY-BASED SERVICES FOR OLDER ADULTS

RESOLVED, that our American Medical Association support policies and programs that provide home- and community-based services to facilitate aging-in-place for older Americans, and will, to the extent it is otherwise consistent with AMA policy:

1. **Advocate for the reauthorization and adequate funding for the Older Americans Act;**
2. **Support federal or state policies that would increase access, eligibility or funding for the Older Americans Act (OAA) programs; and**

3. Collaborate with appropriate organizations to educate legislators and policymakers of the health benefits and fiscal effectiveness of the Older Americans Act (OAA). (Directive to Take Action)

RESOLVED, that our American Medical Association advocate for the reauthorization and adequate funding for the Older Americans Act (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose federal or state policies that would reduce access, eligibility or funding for the Older Americans Act (OAA) programs (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with appropriate organizations to educate legislators and policymakers of the health benefits and fiscal effectiveness of the Older Americans Act (OAA). (Directive to Take Action)

Your Reference Committee heard strong support for Resolution 220. Speakers broadly emphasized that community-based services supported through this policy help older adults maintain health, dignity, independence, and connection to their communities while also supporting family caregivers. Testimony noted that these services can improve care coordination, reduce preventable hospitalization and institutionalization, ease discharge challenges, and lessen strain on post-acute and long-term care systems. Some testimony described the Resolution as both patient-centered and fiscally prudent, highlighting the value of nutrition, transportation, respite, and other supportive services in allowing older adults to remain safely at home.

Your Reference Committee agrees. Programs traditionally funded through the Older Americans Act (OAA), such as Meals on Wheels and other programs offering home and community-based services to seniors, are crucial to supporting aging-in-place and long-term health for seniors. Your Reference Committee is concerned, however, that the approach taken by Resolution 220 would tie our AMA's policy to a specific piece of legislation, which could be subject to changes outside of our AMA's control, rather than broader concepts that our AMA supports. While the OAA has been law for over 60 years, it has been amended multiple times and there is no guarantee that Congress will not amend the OAA in a manner that is inconsistent with our AMA's policies.

To address this concern, your Reference Committee is offering alternate language for Resolution 220 that would preserve the substance of the original language, including its call to reauthorize the OAA, while ensuring that our AMA's policies are paramount. The Alternate Resolution 220 offered by your Reference Committee takes a concepts-based approach (supporting policies and programs that provide home and community-based services that support aging in place) but incorporates the original language explicitly supporting the OAA, provided that the OAA remains consistent with AMA policy.

Therefore, your Reference Committee recommends that Alternate Resolution 220 be adopted in lieu of Resolution 220.

(35) RESOLUTION 221 — PRESERVING DURATION OF STATUS FOR J-1 PHYSICIANS IN GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 221 be adopted in lieu of Resolution 221 to read as follows:

PRESERVING VISA STATUS FOR J-1 PHYSICIANS IN GRADUATE MEDICAL EDUCATION

RESOLVED, that our American Medical Association support the maintenance of continuous J-1 visa status for physicians for the entirety of their graduate medical education plus additional time to gain licensure in the U.S. including the provision of premium processing, support for necessary changes in employment, and appropriate support for extension-of-stay applications.

RESOLVED, that existing AMA policies D-255.966, D-275.995, D-255.991, and D-275.989 be reaffirmed.

HOD ACTION: Alternate Resolution 221 is adopted in lieu of Resolution 221.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association support the maintenance of continuous J-1 visa status for physicians for the entirety of their graduate medical education plus additional time to gain licensure in the U.S. including the provision of premium processing, support for necessary changes in employment, and appropriate support for extension-of-stay applications.

RESOLVED, that existing AMA policies D-255.966, D-275.995, D-255.991, and D-275.989 be reaffirmed.

RESOLVED, that our American Medical Association advocate that the Department of Homeland Security maintain or restore the Duration of Status for J-1 physicians in graduate medical education, or, if not restored, allow a fixed admission period equal to the full training program plus six months (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the U. S. Citizenship and Immigration Service provide premium processing, deference to Intealth's multi-year DS-2019 sponsorship, automatic J-2 work-authorization extensions, and VSRE/SEVIS integration for J-1 extension-of-stay applications (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Department of Homeland Security, the U. S. Citizenship and Immigration Service, Intealth, and other stakeholders to confirm J-1 physicians may change training programs or employers during a pending extension of stay, minimizing administrative burdens on physician training and patient care. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 221. Your Reference Committee heard unanimous support for our international medical graduate (IMG) colleagues and testimony noted that IMGs are an essential part of the physician workforce, especially in residency and fellowship programs. Your Reference Committee also heard that our AMA undertook extensive work concerning the preservation and maintenance of the Duration of Status for J-1 physicians when the proposed rules were up for review under the first and second Trump Administration. Testimony noted that our AMA has written comment letters, joined multiple sign-on letters (one and two), participated in coalition work, educated and advocated on this topic on the Hill, and had meetings with the Department of State. However, testimony also highlighted that with the recent issuance of new regulations in this space, our AMA will need flexibility in how advocacy is undertaken on this topic to try and help increase potential success in this space since it is likely that this policy will not operate in the same manner, or under the same name, as it currently does given that it has been sunset, pending current litigation. Accordingly, your Reference Committee heard that tying AMA policy to a program that no longer exists reduces our accuracy and longevity.

Additionally, testimony noted that our AMA already has existing policy that addresses the second resolve. Your Reference Committee heard that AMA policy supports ECFMG/Intealth verification credentials, which includes the DS-2019, and additional AMA policy supports expedited processing for J-1 visas. Given existing AMA policy, testimony noted that additional AMA policy on this topic would be duplicative, as well as potentially more restrictive. Your Reference Committee heard that our AMA policy should remain expansive because, for example, with changes in Duration of Status, the Form I-94 will now become more important in the processing and extension of the fixed admission period. Testimony noted that since existing AMA policy is tied to the activities of ECFMG, rather than a specific form, our AMA can continue to advocate on important and shifting immigration issues for J-1 physicians without being waylaid by out-of-date policy. Furthermore, your Reference Committee heard that there is no indication that the DS-2019, or any other form, from ECFMG/Intealth will not be accepted by the Department of Homeland Security or the Department of State.

Your Reference Committee also heard that the asks contained in the third resolve clause are already allowed within current immigration law. Testimony noted that the ability to change employers during a pending extension of stay is something that is already possible under existing regulations. The extension of stay for J-1 physicians is tied to ECFMG/Intealth and currently J-1 physicians can change specialty, move to a fellowship, participate in supplemental clinical activities, obtain a waiver, and more.

However, your Reference Committee understands the importance of the maintenance of visa status for our J-1 IMGs and strongly noted the testimony that highlighted that our AMA policy should be based on concepts that can have longevity and that can support our AMA advocacy in this space over time. In alignment with this, your Reference Committee has put forward alternative language which it believes fulfills the mandates that

were noted in the testimony it received, balancing the accuracy of our AMA policy given current legal changes while putting forward lasting principles.

Therefore, your Reference Committee recommends that Alternate Resolution 221 be adopted in lieu of Resolution 221.

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.

Primary Source Verification of Credentials D-275.995

1. Our American Medical Association supports recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions.
2. Our AMA encourages recognition of the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.

Visa Complications for IMGs in GME D-255.991

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

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Credentialing Issues D-275.989

Our American Medical Association encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept certification by the Educational Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source verification of an IMG's international medical education credentials.

(36) RESOLUTION 237 — ACTION REGARDING CMS AUTHORITY TO EXCLUDE ENTITIES FROM MEDICARE, MEDICAID, AND FEDERAL HEALTH CARE PROGRAMS

RESOLUTION 241 — ACTION REGARDING CMS AUTHORITY TO EXCLUDE ENTITIES FROM MEDICARE, MEDICAID, AND FEDERAL HEALTH CARE PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 237 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association oppose any ~~unilateral authority granted by the Department of Health and Human Services (HHS) to the Centers for Medicare & Medicaid Services (CMS) to exclude~~ exclusion of physicians or entities from federal healthcare programs without full administrative due process and rights to appeal (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 237 be amended by deletion to read as follows:

RESOLVED, that our AMA oppose the use of federal healthcare program exclusion authority targeting physicians or entities for providing ~~lawful,~~ evidence-based care~~ including reproductive and transgender healthcare~~ or for ~~non-clinical,~~ political~~,~~ or ideological reasons (New HOD Policy); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve of Resolution 237 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~investigate and pursue appropriate legislative or legal actions~~ advocate to safeguard physician due process following the October 2026 delegation of exclusion authority to CMS (Directive to Take Action).~~; and be it further~~

RECOMMENDATION D:

Your Reference Committee recommends that the fourth Resolve of Resolution 237 be deleted.

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 237 be adopted as amended in lieu of Resolution 241.

HOD ACTION: Resolution 237 is adopted as amended in lieu of Resolution 241.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association oppose any exclusion of physicians or entities from federal healthcare programs without full administrative due process and rights to appeal (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of federal healthcare program exclusion authority targeting physicians or entities for providing evidence-based care or for political or ideological reasons (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to safeguard physician due process following the October 2026 delegation of exclusion authority to CMS (Directive to Take Action).

RESOLUTION 237

RESOVED, that our American Medical Association oppose any unilateral authority granted by the Department of Health and Human Services (HHS) to the Centers for Medicare & Medicaid Services (CMS) to exclude physicians or entities from federal healthcare programs without full administrative due process and rights to appeal (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of federal healthcare program exclusion authority targeting physicians or entities for providing lawful, evidence-based care—including reproductive and transgender healthcare—or for non-clinical, political, or ideological reasons (New HOD Policy); and be it further

RESOLVED, that our AMA investigate and pursue appropriate legislative or legal actions to safeguard physician due process following the October 2026 delegation of exclusion authority to CMS (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the House of Delegates on the October 2026 delegation of exclusion authority to CMS at the 2027 Annual Meeting. (Directive to Take Action)

RESOLUTION 241

RESOLVED, that our American Medical Association oppose any unilateral authority granted by the Department of Health and Human Services (HHS) to the Centers for Medicare & Medicaid Services (CMS) to exclude physicians or entities from federal healthcare programs without full administrative due process and rights to appeal (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of federal healthcare program exclusion authority targeting physicians or entities for providing lawful, evidence-based care—including reproductive and transgender healthcare—or for non-clinical, political, or ideological reasons (New HOD Policy); and be it further

RESOLVED, that our AMA investigate and pursue appropriate legislative or legal actions to safeguard physician due process following the October 2026 delegation of exclusion authority to CMS (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the House of Delegates on the October 2026 delegation of exclusion authority to CMS at the 2027 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard strong support for Resolution 237, which responds to the October 2026 delegation of permissive exclusion authority to the Centers for Medicare & Medicaid Services. Testimony emphasized that exclusion from federal health care programs can effectively end a physician's ability to practice, and expressed concern that, without appropriate safeguards, this authority could be used to target physicians who provide evidence-based care and could worsen access in rural and underserved communities.

Your Reference Committee received an amendment that would broaden the first Resolve to oppose any exclusion without full administrative due process and the right to appeal; revise the second Resolve to protect physicians providing any evidence-based care and remove the reference to "non-clinical" reasons, which could be read to suggest opposition to excluding providers who commit fraud; focus the third Resolve on advocacy. Testimony noted that the last resolve should be deleted since the implications are not yet known. This amendment received support from multiple other speakers. Amendments were also offered to strike "lawful" and to use the evidence-based term "gender-affirming care" in place of "transgender healthcare." Your Reference Committee agrees with these proposed amendments, although the reference to "transgender healthcare" was struck by one of the amendments, making the wording change unnecessary.

Resolution 241 is identical to Resolution 237 and was considered together with Resolution 237.

For the above reasons, your Reference Committee recommends that Resolution 237 be adopted as amended in lieu of Resolution 241.

RECOMMENDED FOR REFERRAL

(37) RESOLUTION 203 — SET-ASIDE FEDERAL FUNDING FOR TRIBAL HEALTH PROGRAMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 203 be referred.

HOD ACTION: Resolution 203 is referred.

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

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

Your Reference Committee heard strong support for the goals of Resolution 203, including honoring federal trust and treaty obligations and preserving Tribal self-determination. However, nearly all testimony, including from the sponsors and Tribal health stakeholders, urged referral. Testimony noted that American Indian and Alaska Native Tribal nations and Native Hawaiian communities have distinct legal statuses, federal relationships, and funding mechanisms, and expressed concern that the amended language did not adequately account for these distinctions or fully reflect Tribal sovereignty. Testimony also noted that alternative language developed collaboratively by the sponsors and Tribal health stakeholders warranted further consideration. Your Reference Committee agrees that these complex issues require careful drafting with input from affected communities and subject matter experts. Therefore, your Reference Committee recommends that Resolution 203 be referred.

(38) RESOLUTION 205 — ENSURING ACCURACY AND PHYSICIAN PROTECTIONS FOR PATIENT ATTRIBUTION IN HEALTH PLAN QUALITY MEASUREMENT AND VALUE-BASED PROGRAMS

RECOMMENDATION:

Your Reference Committee recommends that the second, third, and fourth Resolves of Resolution 205 be referred and the remainder of the Resolution be adopted.

HOD ACTION: The second, third, and fourth Resolves of Resolution 205 are referred and the remainder of the Resolution is adopted.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for federal and state legislation and regulation that ensures accurate patient attribution and prevents physicians from being evaluated on patients with whom they have no established care relationship, including enforcement mechanisms for payers who fail to maintain accurate attribution lists (Directive to Take Action).

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

RESOLVED, that our AMA develop model state legislation and regulatory policy addressing accurate patient attribution in health plan quality measurement and value-based payment programs, based on the Universal Standards for Patient Attribution, with modular components adaptable to varying state legislative and regulatory environments (Directive to Take Action); and be it further

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

1. Clinical Relationship: Attribution must be based on a documented clinical relationship, defined by recent clinical encounter(s) within an appropriate timeframe or a verified patient designation of the physician as their primary care provider (PCP);
2. Prospective Notification: Payers must provide physicians with an option for retrospective or prospective attribution methodology and, if opting for prospective attribution, they should provide physicians with a list of attributed patients at least 30 days before the start of a measurement period;
3. Transparency: Payers must disclose the attribution algorithms, claims thresholds, and patient designation processes used to assign patients to physicians;

4. Mandatory Exclusion: Patients subject to an active attribution dispute must be excluded from all quality scoring and financial performance calculations until the dispute is resolved;
5. Dispute Resolution: Payers must provide a standardized, timely mechanism for physicians to correct or suppress inaccurate attributions, with a determination required within 30 days of submission;(New HOD Policy); and be it further

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

As an editorial matter, your Reference Committee would like to note the original amendments recommended in the Preliminary Report were purely technical in nature and do not need to be shown. The only remaining recommendations relate to referral. Therefore Resolution 205 was moved to Recommended for Referral in the Final Report.
Your Reference Committee heard mixed testimony for Resolution 205. Your Reference Committee heard support for the underlying goal of the Resolution concerning improving transparency, accountability, and physician protections, including clearer attribution standards, access to patient lists, and meaningful opportunities to dispute errors. However, your Reference Committee also heard testimony that urged caution about adopting highly prescriptive universal standards without further study, noting the complexity of specialist care, team-based models, episode-based payment arrangements, and the operational realities of payer and practice workflows. Testimony highlighted that our AMA has longstanding policy on this issue and noted that the Council on Medical Service authored a report, CMS Report 2-A-22, which emphasized that current retrospective attribution methods often fail to assign physicians the patients they actually treat, and that adjudicating inaccurate attribution lists is especially time-consuming for smaller practices.

Given the complexity of this Resolution, your Reference Committee heard that the second, third, and fourth resolve clauses should be referred. Testimony noted that the proposed Universal Standards for Patient Attribution in the third resolve would convert existing AMA principles into prescriptive mandates that warrant further study before they are adopted. Your Reference Committee heard that the proposed standards raise several questions that need further study including:

- that the clinical relationship standard is built around primary care and does not clearly address how patients should be attributed to specialists or for episodes of care;
- requiring that disputed patients be excluded from all quality and financial calculations would be a significant new position that current AMA policy does not support; and
- the 30-day notification and dispute-resolution deadlines should be checked against how payers and practices actually operate before our AMA commits to specific timeframes.

Testimony noted that since the second resolve clause directs our AMA to develop model state legislation based on these standards, it should also be referred. Additional testimony noted that the fourth resolve could also be addressed in the referral process. Therefore,

your Reference Committee recommends that Resolution 205 be adopted as amended and that the second, third, and fourth resolve clauses of Resolution 205 be referred.

(39) RESOLUTION 224 — MODERNIZE THE MEDICARE PRIMARY CARE EXCEPTION TO ENSURE APPROPRIATE REIMBURSEMENT FOR SERVICES PROVIDED BY RESIDENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 224 be referred.

HOD ACTION: Resolution 224 is referred.

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)

Your Reference Committee heard support for the goals of Resolution 224, with testimony emphasizing that resident continuity clinics care for some of the most medically and socially complex patients and that their financial sustainability is important to both resident training and patient access. However, testimony raised concerns that, as written, the Resolution presumes the outcome of its requested study by pointing toward making moderate-complexity visits eligible under the Primary Care Exception. Testimony noted that changing supervision requirements for more complex care raises patient safety and educational questions, including how resident competence should determine eligibility and what safeguards are needed so that residents are not used as substitutes for appropriately supervised attending care. Testimony also noted that any additional payment through the physician fee schedule would be subject to budget neutrality, reducing payment for all physicians, and that new funding through legislation may be the better path. Your Reference Committee agrees that these questions warrant careful examination before our AMA commits to a specific approach. Therefore, your Reference Committee recommends that Resolution 224 be referred.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(40) RESOLUTION 202 — RAPID RESPONSE FRAMEWORK FOR UNSUPPORTED MEDICAL CLAIMS BY PUBLIC OFFICIALS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-440.905 and D-440.922 be reaffirmed in lieu of Resolution 202.

HOD ACTION: Existing AMA policies D-440.905 and D-440.922 are reaffirmed in lieu of Resolution 202.

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)

Your Reference Committee heard mixed testimony for Resolution 202, though testimony universally expressed concern regarding the harms of inaccurate medical and public health claims by public officials.

Supporters of adopting the Resolution pointed to the strong influence that statements by public officials can have on public behavior and expressed concern that unchecked statements by public officials undermine public trust in medicine, create confusion, and jeopardize patient safety. This testimony highlighted that a transparent rapid response framework would allow our AMA to respond to these types of claims in a more timely and effective manner. An amendment was offered that, among other changes, would call for our AMA to study the development of a rapid response framework instead of studying and developing such a framework.

Other testimony urged reaffirmation in lieu of adoption, noting that our AMA maintains policies committing our AMA to evidence-based medicine and a strong public health system that protects science, clinical integrity, and the patient-physician relationship. Testimony noted a concern that the Resolution could intrude on the executive functions of the Board of Trustees, lead our AMA to take actions that would harm other advocacy efforts, or limit our AMA's flexibility to respond appropriately under different circumstances.

Your Reference Committee also heard testimony that much of the work described in the Resolution will be undertaken by the Task Force to Preserve the Patient-Physician Relationship and embedded into the ongoing operations of our AMA.

Your Reference Committee appreciates the range of perspectives provided in the testimony and shares the concern that unsupported medical claims by public officials pose a threat to public health. However, your Reference Committee also acknowledges that the request made by Resolution 202 is not without its own risks. As some testimony noted, it is crucial that the Board of Trustees and our AMA's executive leadership are able to respond to issues in a flexible manner, and it is not clear how a rapid response framework would affect this.

Furthermore, our AMA does maintain relevant existing policy and has taken action to respond to misinformation pursuant to these policies in the past. Our AMA is particularly active in promoting evidence-based information in the area of vaccines and infectious diseases, and has issued swift responses to actions and statements by public officials in the past. For example, when the Administration issued an executive order in August changing the childhood vaccine schedule without following standard scientific review procedures, our AMA responded on the same day, warning that "[a]ltering a proven vaccination schedule without credible evidence risks weakening public confidence and putting children's health at risk." Our AMA also collaborates with organizations like the Vaccine Integrity Project and the American Academy of Pediatrics to develop and promote high-quality resources with public health information, many of which can be found on the AMA-maintained website SpreadTheFacts.org.

Your Reference Committee also heard that our AMA's current approach has been effective. The American public has confidence in our AMA, with one survey finding that 73 percent of Americans trusted information from our AMA, compared to only 43 percent who felt they could trust public health communications from the leaders of federal agencies. There is a significant risk that the framework's effect on how our AMA responds to issues could erode this confidence.

In light of the mixed testimony heard on Resolution 202, the strong and timely actions taken by our AMA in responding to public health misinformation, and the high level of public trust in our AMA as a source of information, your Reference Committee believes that reaffirming existing policies is preferable to adopting Resolution 202. Therefore, your Reference Committee recommends that existing AMA policies D-440.905 and D-440.922 be reaffirmed in lieu of Resolution 202.

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

1. Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
2. Our AMA assertively and publicly leads the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922

1. Our American Medical Association will champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes.
2. Our AMA will develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.
3. Our AMA will work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials.
4. Our AMA will advocate for
    a. consistent, sustainable funding to support our public health infrastructure.
    b. incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff.
    c. public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health.
    d. efforts to ensure equitable access to public health funding and programs.

(41) RESOLUTION 210 — REQUIRING PHYSICIAN OVERSIGHT FOR ARTIFICIAL INTELLIGENCE TOOLS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-480.931 and D-480.947 be reaffirmed in lieu of Resolution 210.

HOD ACTION: Existing AMA policies H-480.931 and D-480.947 are reaffirmed in lieu of Resolution 210.

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

Your Reference Committee heard support for the spirit of Resolution 210 but mixed testimony regarding its implementation. Testimony highlighted support for physician

oversight of artificial intelligence (AI), along with caution and concern about how that oversight should be defined in policy. Testimony broadly agreed that physicians must remain central to clinical decision-making when AI tools are used in patient care and noted that AI should support, but never replace, physician judgment. However, testimony also emphasized concerns that Resolution 210 could increase liability exposure for physicians when they are engaging with AI-enabled technologies in clinical care. Your Reference Committee heard that mandating that physicians review, interpret, and communicate any AI-generated diagnosis or treatment recommendations ensures that physicians will remain accountable for any resulting outcome, including any patient harm that results from an AI performance error. Testimony highlighted that the Resolution's mandate for physician interpretation of all AI-enabled outputs is challenging, given that physicians will never fully be able to interpret the results from an opaque, black-box algorithm especially since there are currently no transparency mandates that would require certain information regarding an AI technology to be made available to physicians.

Accordingly, your Reference Committee heard substantial testimony in favor of reaffirming existing AMA policy. Testimony noted that AMA policy states that AI should be used under the direction of a treating physician and integrated as part of the care team, solidifying AMA's position that AI should not perform clinical functions outside the oversight of a licensed clinician. Testimony highlighted that our AMA submitted testimony to this effect for a Congressional hearing on AI in health care. Your Reference Committee heard that additional policy would only support the creation of additional mandates on physicians that could be used against physicians to demonstrate that clinical outcomes resulting from an AI-enabled encounter were under the sole control of the treating physician and render the physician solely responsible for any resulting harm. Therefore, your Reference Committee recommends that existing AMA policies H-480.931 and D-480.947 be reaffirmed in lieu of Resolution 210.

Assessing the Intersection Between AI and Health Care H-480.931

2. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the

overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]

f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.

g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.

h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.

i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

3. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care

    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.

        i. AI disclosure should align and meet ethical standards or norms.

        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.

        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their

caregiver to request additional review from a licensed clinician should be made available upon request.

iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.

d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

4. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

i. Regulatory approval status.

ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.

iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.

iv. Intended population and intended practice setting.

v. Clear description of any limitations or risks for use, including possible disparate impact.

vi. Description of how impacted populations were engaged during the AI lifecycle.

vii. Detailed information regarding data used to train the model:

1. Data provenance.
2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:

1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.

2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:
1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

5. Generative Augmented Intelligence

a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).

b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:

i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.

ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.

iii. Lack of regulatory or clinical oversight to ensure performance of the tool.

iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.

v. Data privacy.
vi. Cybersecurity.
vii. Physician liability associated with the use of generative AI tools.

c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]

d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

6. Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]

i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

7. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
    b. User Education:
        i. Users should be provided with training specifically on generative AI. Education should address:
            1. Legal, ethical, and equity considerations.
            2. Risks such as data breaches and re-identification.
            3. Potential pitfalls of inputting sensitive and personal data.
            4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

8. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role

in mitigating threats and reporting suspicious AI behavior or outputs.

9. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
10. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on

particular patient care needs and not base decisions on algorithms developed on “similar” or “like” patients.

c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.

d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system’s accuracy measured against the outcomes of patients and the validity of the system’s predictions.

e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.

f. Individuals impacted by a payor’s automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems’ approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

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

1. 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
2. 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.

(42) RESOLUTION 216 — COMPREHENSIVE REFORM OF THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-285.955, D-285.957, and D-230.981 be reaffirmed in lieu of Resolution 216.

HOD ACTION: Existing AMA policies D-285.955, D-285.957, and D-230.981 are reaffirmed in lieu of Resolution 216.

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)

Your Reference Committee heard significant concern, caution, and divided testimony regarding Resolution 216's proposal to advocate for comprehensive reform of the independent dispute resolution process under the No Surprises Act (NSA). Overall, the testimony reflected broad agreement that the dispute resolution system needs improvement, but serious doubts were raised over whether Resolution 216's specific policy prescriptions are the right vehicle for achieving that goal, with multiple testifiers urging caution and recommending reaffirmation of existing policies in lieu of adoption.

Your Reference Committee heard broad testimony noting that the current dispute resolution system faces serious problems, including eligibility disputes, delayed payment of awards, inaccurate payment calculations, and insurer noncompliance. Some testified to the need to protect both patients and fair physician reimbursement through reforms to the NSA. Amendments were offered that would add specific enforcement mechanisms, including a private cause of action and financial penalties for failure to pay awards within 30 days, and replace the reference to caps on physician offers with safeguards against outlier billing practices. Supporters emphasized the need for meaningful enforcement and for physicians to address concerns about the effect of IDR on health care costs.

At the same time, the clear majority of the testimony spoke against adopting the Resolution as written, arguing that existing policy already gives our AMA sufficient authority to advocate for targeted reforms while preserving flexibility in a sensitive legislative environment. Testimony highlighted substantial concern centered on language supporting caps on physician Independent Dispute Resolution (IDR) offers, with testimony warning that such an approach could weaken physicians' negotiating position, create harmful benchmarks, and be used by payers to justify lower reimbursement. Significant testimony supported striking this provision from the Resolution.

Additional testimony was heard in support of reaffirmation on the grounds that our AMA should not adopt policy that essentially makes concessions and binds our AMA to specific statutory constructs during an active legislative negotiation process. Furthermore, existing policy already allows our AMA to advocate for improvements. Since the enactment of the NSA, and in accordance with existing policies, our AMA has been supportive of efforts to improve the law. For example, our AMA led sign-on letters calling for passage of the NSA Enforcement Act and highlighting the ways insurance plans are not abiding by the NSA.

As health plans pressure Congress to revise the NSA, our AMA must be able to counter their proposals with policies that protect patients and physicians. To do this effectively, our AMA must maintain policies that allow for a flexible response and should not cede ground before debate even begins. Existing AMA policy allows for this flexibility. Therefore, your Reference Committee recommends that existing AMA policies D-285.955, D-285.957, and D-230.981 be reaffirmed in lieu of Resolution 216.

Supporting Penalties on Insurers Who Fail to Pay Doctors D-285.955

Our American Medical Association advocates for passage of legislation that imposes penalties on insurers that fail to pay doctors within 30 days when doctors win for a claim brought to the federal Independent Dispute Resolution (IDR) process.

Addressing the Failed Implementation of the No Surprises Act Independent Dispute Resolution Process D-285.957

1. Our American Medical Association will advocate for the federal departments to immediately and correctly implement the fair and timely Independent Dispute Resolution (IDR) process as stipulated by the No Suprises Act including advocating specifically for the following:
    a. Specific requirements for insurers: Insurers must be required to make IDR loss payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and be prohibited from falsely claiming ineligibility due to network status or incorrect venue claims.
    b. Operational improvements in the IDR process: IDR entities must not close claims based on unverified insurer claims, an adequate number of IDR entities must be certified, and a structured timeline must be set for IDR entity selection and payment process.

Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation D-230.981

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies,

if an out of network physician is involved in the treatment or care of a patient at that hospital.

2. Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation.

(43) RESOLUTION 217 — STRENGTHENING THE PATIENTS FIRST ACT AND MEDICARE PHYSICIAN PAYMENT REFORM

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies D-390.921, D-390.946, H-390.849, H-385.905, D-400.982, D-395.999, H-165.838, D-390.922, D-400.981, and D-390.963 be reaffirmed in lieu of Resolution 217.

HOD ACTION: Existing AMA policies D-390.921, D-390.946, H-390.849, H-385.905, D-400.982, D-395.999, H-165.838, D-390.922, D-400.981, and D-390.963 are reaffirmed in lieu of Resolution 217.

RESOLVED, that our American Medical Association advocate that Medicare physician payment reform proposals, including the Patients First Act of 2026, provide annual physician payment updates no less than the full MEI (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for preservation and advancement of Medicare Physician Fee Schedule reforms that improve payment stability, including appropriate reforms to budget neutrality, utilization estimates, conversion factor volatility, and regular updating of physician practice expense inputs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that any replacement or reform of the Merit-based Incentive Payment System, including the proposed Patient Outcome Improvement National Tabulation System (POINTS), meaningfully reduce administrative burden; utilize clinically relevant measures that appropriately account for differences among medical specialties, practice settings, and patient populations; provide meaningful representation and input from affected specialties and practicing physicians in the development and review of such measures; and provide appropriate transition protections for existing clinically valid MIPS and Qualified Clinical Data Registry (QCDR) measures. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 217, with many commenters expressing frustration with the pace and direction of Medicare physician payment reform. Testimony differed, however, on the best approach to accomplish policy goals like permanent inflation-based updates, meaningful budget neutrality reform, greater payment stability, and a reporting system that truly reduces burdens on physicians and reflects clinically relevant measures.

Your Reference Committee heard some testimony that pushed for adoption, arguing that the Resolution goes beyond existing policy by providing specific, timely direction for advocacy on the Patients First Act of 2026. Supporters of adoption spoke to the need for

more aggressive advocacy on issues such as scope creep, reforming or replacing the Merit-based Incentive Payment System (MIPS), and tying physician payment updates to the full Medicare Economic Index (MEI).

On the other hand, strong testimony was also heard in favor of reaffirming existing AMA policy in lieu of adoption. Multiple commenters pointed to our AMA's extensive body of existing policy on Medicare payment reform, which includes policies that support physician payment updates at least equal to the full MEI (D-385.945), reducing the burden of MIPS reporting (H-385.905), and budget neutrality reform (D-390.946). Testimony noted that, pursuant to existing policies, our AMA is actively working towards achieving these goals, including by supporting bills such as the Strengthening Medicare for Patients and Providers Act (H.R. 6160), a bipartisan bill currently under consideration in the House of Representatives that provides physicians with a permanent, annual update equal to the full MEI.

Supporters of reaffirmation also expressed well-founded concerns that adopting Resolution 217 would be immensely damaging to our AMA's ongoing advocacy efforts on Medicare physician payment. While our AMA will continue to advocate for physician payment updates that are equal to full MEI, our advocacy should also be flexible enough to support the highest possible physician payment updates, even if they (for now) fall short of full MEI. Your Reference Committee heard that the Patients First Act of 2026 (H.R. 9693) is a heavily negotiated piece of legislation that was developed by the co-chairs of both the Republican and Democratic Doctors Caucuses, and the culmination of years of advocacy by our AMA and the Federation. It provides for a permanent, annual, inflation-based update equal to MEI minus one percentage point. Although tying physician payment updates to the full MEI was thoroughly debated by the bill's sponsors, practical considerations, including a cost that congressional staff estimate could already exceed $150 billion over ten years, led them to settle on MEI minus one percentage point.

Your Reference Committee agrees that full MEI is preferable to MEI minus one percentage point. Even so, securing a permanent, annual, inflation-based physician payment update would be a significant achievement. In fact, this policy change would mark the first time that physician payment updates would be tied to any measure of inflation in any federal statute. Testimony also noted that, under current law, the cumulative update for most physicians from 2026 to 2036 would be essentially flat, at just 0.03 percent, while under H.R. 9693 it would grow by 7.7 percent, with those gains compounding in every year that follows. Accordingly, our AMA, alongside state medical associations from every state and the District of Columbia, strongly supports H.R. 9693, as do national medical specialty societies and patient and caregiver organizations. Our AMA's support for the Patients First Act is grounded in existing policy D-390.921, which directs our AMA to "work towards achieving the highest sustainable annual Medicare payment increases possible." Additionally, the provisions of H.R. 9693 are consistent with the Characteristics of a Rational Medicare Physician Payment System, endorsed by over 120 national medical specialty societies and state medical associations. Likewise, H.R. 9693 reflects the budget neutrality and MIPS reform concepts in the second and third resolve clauses of Resolution 217 (which are also reflected in existing AMA policies such as H-390.849 and H-450.947).

Your Reference Committee is persuaded by the strong testimony in favor of reaffirmation. As testimony made clear, Resolution 217 does not present a choice between the Patients First Act and a better version of it. With end-of-year government funding legislation

expected in December, our AMA must advocate strongly that any legislative package include annual, inflation-based physician payment updates, budget neutrality reforms, and MIPS reform. H.R. 9693, which has strong bipartisan support within Congress, is by far the most comprehensive vehicle for accomplishing these goals. However, adopting Resolution 217 would require our AMA to abandon its support for the bill because it does not provide for an annual physician payment update that is at least equal to full MEI. Adopting Resolution 217 and pulling our AMA's support for the bill at such a crucial juncture would waste the extensive political capital our AMA has invested in H.R. 9693, jeopardize the enactment of any automatic inflation-based physician payment update (along with every other reform the bill carries, including the very budget neutrality and MIPS reforms the Resolution seeks), alienate partner organizations and members of Congress, and hamstring our AMA's advocacy on physician payment issues in the future. It would also signal to the bill's champions that organized medicine does not stand behind the legislation it urged them to write; at the very moment physicians need to speak with one voice.

Reaffirmation of existing policies will allow our AMA's advocacy team, in collaboration with the Board of Trustees and the Council on Legislation, to continue to advocate effectively on physician payment issues, including full MEI annual payment updates, without tying our AMA's hands or undermining parallel efforts to achieve a positive outcome for physicians. Therefore, your Reference Committee strongly recommends that existing AMA policies D-390.921, D-390.946, H-390.849, H-385.905, D-400.982, D-395.999, H-165.838, D-390.922, D-400.981, and D-390.963 be reaffirmed in lieu of Resolution 217.

Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program D-390.921

1. Our American Medical Association will prioritize preventing the imminent 3.4% Medicare payment cut from taking effect by any means available.
2. Our AMA will continue to prioritize reforming the Medicare payment system to ensure the continued economic viability of medical practice.
3. Our AMA will work towards achieving the highest sustainable annual Medicare payment increases possible, whether tied to the MEI, the CPI, or some other relevant measure of inflation that is sufficient to ensure that Medicare beneficiaries can receive robust access to care and that medical practices do not continue to encounter economic challenges as a result of insufficient payment updates.
4. Our AMA will immediately create and disseminate, in major news outlets, a press release outlining the current problems within the Medicare system and how it will affect access to care with a call to action to help those with Medicare keep their physicians and the high-quality care they deserve.

Sequestration D-390.946

a. Our American Medical Association will continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022.
b. Our AMA will seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs;

c. Our AMA will ensure Medicare physician payments are sufficient to safeguard beneficiary access to care.
d. Our AMA will work towards the elimination of budget neutrality requirements within Medicare Part B.
e. Our AMA will eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments.
f. Our AMA will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.
g. Our AMA will advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

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.

Merit-based Incentive Payment System (MIPS) Update H-385.905

Our American Medical Association supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in (MIPS) with incentive payments, or implements positive annual physician payment updates.

AMA Efforts on Medicare Payment Reform D-400.982

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.
5. Our AMA will report back on a biannual basis to AMA members via open forum on Medicare Payment Reform initiatives and advocacy on Medicaid.

Reducing MIPS Reporting Burden D-395.999

Our American Medical Association will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician’s choosing) within the calendar year.

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health

system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans.
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps.
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.
d. Investments and incentives for quality improvement and prevention and wellness initiatives.
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care.
f. Implementation of medical liability reforms to reduce the cost of defensive medicine.
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

2. Our AMA advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our AMA House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our AMA supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
    a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services.
    b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system.

c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted.
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate.
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another.
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
14. Our AMA will continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing.

Physician Payment Reform and Equity D-390.922

Our American Medical Association will implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

Increasing Transparency of AMA Medicare Payment Reform Strategy D-400.981

1. Our American Medical Association will provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily

focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.

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

Improving the Medicare Economic Index D-390.963

Our American Medical Association will urge the Centers for Medicare and Medicaid Services and the Medicare Payment Advisory Commission to review the Medicare Economic Index productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice.

(44) RESOLUTION 218 — FIREARM MANUFACTURER ACCOUNTABILITY FOR THE COST OF GUN VIOLENCE

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-145.985 and H-145.997 be reaffirmed in lieu of Resolution 218.

HOD ACTION: Resolution 218 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association supports legislative, regulatory, and national advocacy efforts that 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 injury prevention and to support people and communities affected by firearm-related injury. (Directive to Take Action)

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)

Your Reference Committee heard mixed testimony on Resolution 218, with supporters describing the proposal as a needed expansion on existing policy that would support legislative proposals to hold firearm manufacturers financially accountable for the harms associated with gun violence and opponents arguing that existing policy is sufficient and the proposed new policy is unworkably vague.

Testimony in support of adoption emphasized the enormous human, financial, and community burden of firearm-related harm, and argued that manufacturers should bear financial responsibility for the costs of these harms. Some supporters noted that this responsibility should extend to the full spectrum of firearm injuries, including suicide and unintentional injury as well as interpersonal violence. Supporters of adoption acknowledged that existing policy does support some forms of financial accountability for firearm manufacturers, but noted that the proposed policy would call for our AMA to support legislation imposing new forms of financial accountability on firearm manufacturers.

On the other hand, testimony that supported reaffirmation noted that key terms in the proposed policy are unclear, making implementation difficult. For example, testimony highlighted concerns with how to define the scope of manufacturer liability under the proposed policy, as well as how to quantify the public costs associated with firearm injuries and deaths. This testimony noted that, without greater clarity on these issues, it would be difficult to determine whether a piece of legislation or regulation is reasonable or sufficient under the proposed policy.

Your Reference Committee agrees that strong action in preventing firearm injuries is needed, but shares the concerns raised by the commenters who testified in favor of reaffirmation. By leaving important questions about the nature and scope of firearm manufacturer liability open, Resolution 218 would place our AMA in a difficult position when evaluating legislative or regulatory proposals to hold firearm manufacturers financially accountable. Our AMA would be required to assess the reasonableness and efficacy of proposed legislation without clear guidance.

Your Reference Committee also believes that Resolution 218's core concepts — holding firearm manufacturers financially accountable for the harms of gun violence and directing funds recovered from manufacturers to firearm violence prevention and education — are covered by existing policy. H-145.985 supports:

> "The imposition of federal and state surtaxes on manufacturers…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"

Additionally, H-145.997:

> "urges that a significant portion of any funds recovered from firearm manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention."

Through these policies, your Reference Committee believes that our AMA can effectively advocate for financial accountability for firearm manufacturers and that any funds collected from manufacturers be dedicated to firearm injury prevention and education efforts. Therefore, your Reference Committee recommends that existing AMA policies H-145.985 and H-145.997 be reaffirmed in lieu of Resolution 218.

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.

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:
    1. encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
    2. 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;
    3. urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
    4. 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;
    5. encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
    6. 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
    7. 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.

(45) RESOLUTION 222 — INCREASING LEGISLATIVE ADVOCACY AND DEDICATED NATIONAL EDUCATIONAL PROGRAMMING FOR INTERNATIONAL MEDICAL GRADUATES (IMGS)

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-255.988, D-255.969, D-255.991, and D-255.980 be reaffirmed in lieu of Resolution 222.

HOD ACTION: Existing AMA policies H-255.988, D-255.969, D-255.991, and D-255.980 are reaffirmed in lieu of Resolution 222.

RESOLVED, that our American Medical Association expand its federal and state advocacy efforts to actively educate legislators, administrative agencies, and health system policymakers on the critical role International Medical Graduates (IMGs) play in addressing national physician workforce shortages and improving healthcare access in underserved populations (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with the AMA International Medical Graduates Section (AMA-IMGS), state medical societies, and relevant specialty organizations to establish unique, dedicated events and educational programming, including legislative briefings, advocacy workshops, and policy panels focused on IMG workforce integration at national meetings such as the AMA National Advocacy Conference (Directive to Take Action); and be it further

RESOLVED, that our AMA develop educational materials and policy toolkits highlighting key IMG workforce issues (such as visa reauthorization, green card backlog relief, and licensing equity) for distribution to federal and state lawmakers to support targeted healthcare workforce legislation. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 222. Your Reference Committee heard that our international medical graduate (IMG) colleagues are essential to the physician workforce, particularly in rural, underserved, and historically marginalized communities. Testimony highlighted, that in recognition of our IMG colleagues and their immense importance, our AMA is already undertaking considerable work in this space in accordance with existing AMA policy. Your Reference Committee heard that our AMA's work includes, but is not limited to:

- Immigration issues: Visas and green cards: Work that our AMA has done surrounding International Medical Graduates.
- Submitted a Statement for the Record to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce." Our AMA commended the Subcommittee for focusing on the critically

important issue of physician immigration and workforce shortages and emphasized the importance of IMGs in addressing this shortage.

- Submitted a Statement for the Record to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled "Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System." Our AMA highlighted the need for additional Medicare-funded residency slots, the importance of IMGs in combating our current and projected physician shortage, and the need to prioritize IMGs during the visa process.
- Our AMA sent a letter strongly supporting H.R. 7961, the "H-1Bs for Physicians and the Healthcare Workforce Act." This legislation would exempt physicians and healthcare workers involved in direct patient care from the $100,000 fee implemented by the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers."
- Our AMA sent a letter to the Department of Health and Human Services (HHS) concerning the U.S. Exchange Visitor Program. The letter highlighted communications that our AMA received from physicians expressing their deep concern about the current HHS administrative hold and their projected inability to meet their contractually obligated start date.
- Our AMA sent a letter to the U.S. Department of Homeland Security and the U.S. Department of State urging for the exemption of physicians from the partial and complete suspension of entry into the U.S., as indicated in Proclamation 10998 entitled "Restricting and Limiting the Entry of Foreign Nationals to Protect the Security of the United States."
- Our AMA sent letters supporting S. 2759 and H.R. 5283, the "Healthcare Workforce Resilience Act. This bill would provide the ability to recapture 15,000 unused employment-based physician immigrant visas.
- Our AMA sent a letter expressing our support for H.R. 1201, the "Doctors in our Borders Act," which would expand the number of Conrad 30 waivers a state or regional commission can receive from 30 to 100.
- Our AMA sent a letter to both the House and Senate expressing our support for H.R. 1585/S. 709, the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize and make targeted improvements to the J-1 visa waiver program in a manner that helps alleviate the shortage of physicians, especially in rural and underserved areas, and promotes a more diversified workforce.

Your Reference Committee also heard that, in accordance with the second resolve, our AMA currently offers events and programming that are specific to our IMGs. For example, testimony highlighted that our AMA has the AMA Distinguish Yourself IMG Summit which is an IMG-specific meeting that has educational sessions on leadership, research, advocacy, and preparing for the Match as an IMG. Testimony also noted that our AMA has International Medical Graduates (IMG) Recognition Week where our AMA honors and celebrates IMG physicians who are a vital component of the physician workforce and our AMA. Your Reference Committee also heard that our AMA has advocated for the passage of the Conrad State 30 and Physician Access Reauthorization Act at our Medical Student Advocacy Conference, and had educational sessions surrounding the importance of IMGs. Your Reference Committee believes that our AMA offers ample programming on IMG issues and is concerned that calling for specific programming at a specific AMA event is overly prescriptive.

Your Reference Committee also heard that, in accordance with the requests contained in the third resolve clause, our AMA has created significant resources discussing issues surrounding immigration and IMGs. For example:

- International Medical Graduates (IMG) Toolkit: Introduction: The AMA IMG Physician Toolkit provides comprehensive, timely guidance for various topics.
- International Medical Graduates (IMG): General IMG AMA information about some ongoing work and programs.
- International Medical Graduates (IMG) toolkit: Types of visas & FAQs: Everything you need to know about the U.S. visa system for practicing physicians.
- International Medical Graduates (IMGs) as Physician Leaders: Continuing Medical Education program.
- GME Leaders Collaborate on Toolkit for Transition to Residency
- Compendium of Graduate Medical Education Initiatives: Has a section on IMGs beginning on page 15.

Testimony also highlighted that other leaders in this space have created educational materials including the ECFMG Publication on J-1 certification, sponsorship, and more. In alignment with the significant ongoing work in this space, your Reference Committee recommends that existing AMA Policies H-255.988, D-255.969, D-255.991, and D-255.980 be reaffirmed in lieu of Resolution 222.

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.

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

1. Our American Medical Association publicly advocates to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates.
2. Our AMA will issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other

relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates.

3. Our AME will collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability.
4. Our AMA will work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States.

Visa Complications for IMGs in GME D-255.991

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

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

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(46) RESOLUTION 230 — DUE PROCESS, TRANSPARENCY, AND ACCOUNTABILITY FOR DELEGATED THIRD-PARTY PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT ENTITIES

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policies H-285.939 and H-320.939 be reaffirmed in lieu of Resolution 230.

HOD ACTION: Existing AMA policies H-285.939 and H-320.939 are reaffirmed in lieu of Resolution 230.

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)

Your Reference Committee heard supportive testimony for the spirit of Resolution 230, but significant testimony noted that our AMA already has strong existing policy in this space. Your Reference heard supportive testimony for the Resolution's goals, particularly increased transparency, meaningful clinical review, and accountability when health plans delegate prior authorization or utilization management decisions to third-party vendors. However, testimony noted that our AMA's existing policy already addresses the core of this Resolution. Your Reference Committee heard that Policy H-285.939 establishes that utilization review decisions to deny payment for medically necessary care are the practice of medicine. Testimony noted that this policy supports holding medical directors of insurance entities accountable and liable for those decisions and subjecting them to state licensure and medical board review. Testimony also highlighted that a health plan's choice to delegate that review to a vendor does not change the nature of the decision or the plan's responsibility for it. Your Reference Committee also heard that Policy H-320.939 directs our AMA to continue its widespread prior authorization advocacy. Testimony highlighted that this policy also calls for adverse determinations to be based on direct review by a physician of the same specialty or subspecialty as the ordering physician. Your Reference Committee also heard that our AMA is actively advancing these principles through its federal, state, and payer-facing prior authorization advocacy. Therefore, your Reference Committee recommends that existing AMA Policies H-285.939 and H-320.939 be reaffirmed in lieu of Resolution 230.

Managed Care Medical Director Liability H-285.939

Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine.

1. 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.
2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations.
3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.
4. Our AMA will seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA), and allow for accountability should the decision be called into question.
5. Our AMA will seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction and therefore, accountable to appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions.

Prior Authorization and Utilization Management Reform H-320.939

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA 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.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

(47) RESOLUTION 233 — MEDICAID PROTECTIONS & CONTINUOUS COVERAGE FOR ACTIVE CANCER CARE

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy D-290.969 be reaffirmed in lieu of Resolution 233.

HOD ACTION: Resolution 233 is adopted.

RESOLVED, that our American Medical Association advocate for federal and state policies that require Medicaid medical frailty exemptions for individuals under active treatment for cancer or other medically complex chronic conditions and their caregivers remain in continuous effect throughout treatment and survivorship follow-up and prohibit mid-treatment disenrollment or procedural terminations. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 233, which relates to medical frailty exemptions and Medicaid work requirements. Your Reference Committee heard some testimony that supported adoption while others testified in support of reaffirmation or offered amendments. However, all of the testimony expressed grave concerns with the implementation of Medicaid work requirements.

Supporters of adopting the Resolution believed that existing AMA policy is insufficient because it does not explicitly advocate for the continuation of medical frailty exemptions throughout the treatment, recovery, or survivorship follow-up phases of treatments for

cancer and other medically complex conditions, nor does it provide for the application of medical frailty exemptions for caretakers.

On the other hand, significant testimony spoke in favor of reaffirming existing policy, arguing that our AMA has strong, carefully crafted policy on medical frailty exemptions and is currently engaged in a robust campaign to maximize the protection afforded to patients through this exemption that includes the development of patient-facing resources and educational materials for physicians and advocates, strong engagement with the Centers for Medicare & Medicaid Services (CMS) on the issue, and support for litigation challenging the medical frailty provisions of CMS's regulations implementing Medicaid work requirements. This testimony noted that our AMA has policy opposing work requirements as a condition of Medicaid eligibility altogether (H-290.961), as well as policy calling for medical frailty exemptions that:

> "encompass the full range of serious and complex conditions, including conditions associated with functional impairment, that are life-threatening, chronic, episodic, relapsing, co-occurring, not yet diagnosed but evidenced by significant healthcare utilization, or that require significant, ongoing interaction with the health care system" (D-290.969).

Supporters of reaffirmation testified that this existing AMA policy on medical frailty is broad enough to encompass the principal objectives of Resolution 233, including protecting patients with cancer and other medically complex conditions from the administrative burdens and risk of procedural disenrollment associated with work requirements.

Your Reference Committee shares the concerns raised in testimony regarding implementation of Medicaid work requirements. Without strong medical frailty exemptions, many patients with serious and complex medical conditions, such as cancer, could lose coverage, and with it, access to needed care. However, your Reference Committee also found the testimony supporting reaffirmation of existing policy persuasive. D-290.969, our AMA's current policy on medical frailty exemptions, was adopted at the most recent Annual Meeting of the House of Delegates (HOD) following thoughtful deliberation by the HOD. Although existing policy is less explicit in calling for medical frailty exemptions that remain in continuous effect throughout treatment and survivorship follow-up, your Reference Committee agrees with the testimony that D-290.969 is responsive to the requests made by Resolution 233. By supporting policies that encompass the "full range" of serious and complex conditions, including those that are "life-threatening," "chronic," or "episodic," or that require "significant, ongoing interaction with the health care system," D-290.969 already provides our AMA with the basis to support the types of medical frailty exemptions requested by Resolution 233.

At the same time, the breadth of existing policy is an advantage because it allows our AMA to advocate strategically. Under CMS's current interpretation of the medical frailty exemption — which, as discussed above, our AMA is challenging on multiple fronts — many of the exemptions described in Resolution 233 would be rejected out of hand. Before our AMA can effectively advocate for these exemptions (which current policy would allow), it must first succeed in advocating for CMS to modify its current regulations. Prematurely pursuing these exemptions would expend resources in an effort that is very unlikely to succeed and risks undermining our AMA's broader efforts to mitigate the harmful effects of Medicaid work requirements on patients and physicians.

Your Reference Committee believes that existing policy allows our AMA to advocate for the medical frailty exemptions described in Resolution 233 while preserving the ability to advance an advocacy strategy that is appropriate to the current moment. Therefore, your Reference Committee recommends that existing AMA policy D-290.969 be reaffirmed in lieu of Resolution 233.

Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions D-290.969

1. Our American Medical Association will work with the Centers for Medicare & Medicaid Services, state Medicaid agencies, and state and specialty medical associations to establish medical frailty exemptions from Medicaid work and community engagement requirements, that are clinically grounded and protective of all individuals who are medically frail, while preserving state flexibility to build upon federal definitions and to design clinically appropriate, accessible, and locally tailored exemption processes.
2. Our AMA advocates for automatic exemptions from community engagement and work requirements for patients and primary caregivers of patients with complex medical conditions, existing data to ensure treatment adherence and continuity of care.
3. Our AMA advocates for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians.
4. Our AMA urges policymakers, in defining and operationalizing medical frailty exemptions, to adopt policies that encompass the full range of serious and complex conditions, including conditions associated with functional impairment, that are life-threatening, chronic, episodic, relapsing, co-occurring, not yet diagnosed but evidenced by significant healthcare utilization, or that require significant, ongoing interaction with the health care system.

(48) RESOLUTION 242 — OPPOSING REIMBURSEMENT CUTS TO MODIFIER 25

RECOMMENDATION:

Your Reference Committee recommends that existing AMA policy D-385.956 be reaffirmed in lieu of Resolution 242.

HOD ACTION: Resolution 242 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association immediately and aggressively advocate, through all available regulatory, legislative, and legal means, against the Modifier 25 payment reduction finalized in the CY 2027 Medicare Physician Fee Schedule final rule; and be it further

RESOLVED, that our AMA oppose any reduction in payment for a significant, separately identifiable evaluation and management service appropriately reported with Modifier 25 by any and all payers; and be it further

RESOLVED, that our AMA advocate for legislation at the state and federal level that blocks or reverses Modifier 25 payment reductions and prohibits the Centers for Medicare & Medicaid Services from reducing payment for a significant, separately identifiable evaluation and management service appropriately reported with Modifier 25.

RESOLVED, that our AMA immediately consider pursing a preliminary injunction or emergency stay to prevent implementation of the CMS CPT Modifier-25 payment reduction scheduled to take effect January 1, 2027, on the grounds that CMS failed to adequately consider the impact on patient access to care; and be it further

RESOLVED, that if the Modifier-25 payment reduction takes effect on January 1, 2027, our AMA pursue, if appropriate, additional legal action, including litigation, to challenge the policy, and report back to the House of Delegates at A-27 on actions taken and outcomes achieved.

RESOLVED, that our American Medical Association immediately and aggressively advocate, through all available regulatory, legislative, and legal means, against the Modifier 25 payment reduction finalized in the CY 2027 Medicare Physician Fee Schedule final rule; and be it further

RESOLVED, that our AMA oppose any reduction in payment for a significant, separately identifiable evaluation and management service appropriately reported with Modifier 25 by any and all payers; and be it further

RESOLVED, that our AMA advocate for legislation at the state and federal level that blocks or reverses Modifier 25 payment reductions and prohibits the Centers for Medicare & Medicaid Services from reducing payment for a significant, separately identifiable evaluation and management service appropriately reported with Modifier 25.

Your Reference Committee heard strong support for the spirit of Resolution 242, which responds to the 20 percent payment reduction for evaluation and management (E/M) services reported with Modifier 25 on the same day as a procedure with a 0-day global period, as finalized in the CY 2027 Medicare Physician Fee Schedule. Testimony emphasized that Modifier 25 by definition identifies a significant, separately identifiable service, and offered examples ranging from identifying a new skin cancer during a visit for complex medical dermatology to goals-of-care discussions in palliative care. Commenters warned that the reduction will fall hardest on independent, small, and rural practices, may force patients to return for additional visits, and is likely to be adopted by commercial payers. Testimony also noted that our AMA has strongly opposed this policy.

Our AMA deeply understands the important concerns that our House raised during testimony and has undertaken numerous federal regulatory and legislative efforts to mitigate these concerns in accordance with existing Policy D-385.956, which states:

> Our American Medical Association will aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate.

For example, our AMA met numerous times with key staff at the Centers for Medicare & Medicaid Services (CMS) and the Office of Management and Budget (OMB) in opposition to this policy and staunchly opposed the Modifier 25 multiple procedure payment reduction (MPPR) policy within its comment letter on the CY27 Medicare Physician Fee Schedule Proposed Rule. These combined advocacy actions resulted in CMS reducing a proposed 50 percent cut down to 20 percent and narrowing the policy so it only affects 0-day global payments, as opposed to 10- and 90-day global payments.

Complementing AMA's regulatory actions was an October 1st letter to CMS Administrator Mehmet Oz, MD, cosigned by a bipartisan group of almost 80 Members of the House of Representatives opposing the implementation of the Modifier 25 MPPR. The Chairs of the GOP and Democratic Doctors Caucuses, specifically Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC), and Kim Schrier, MD (D-WA), spearheaded this letter. AMA also led an August 2026 Federation letter to CMS Administrator Oz in opposition to the implementation of this policy.

In addition, prior to the start of the 2026 Interim Meeting, AMA shared a new Federation sign-on letter to U.S. House and Senate Leadership outlining our four principal legislative requests for the lame duck session of the 119th Congress. In addition to requesting the reversal of impending conversion factor cuts, enactment of budget neutrality reforms, and mitigation of the negative impacts of the MIPS program, this letter urges Congress to pass legislation implementing a one-year moratorium on the implementation of the Modifier 25

MPPR policy. Numerous national medical specialty societies, including those most affected by this policy, already agreed to cosign this important letter. Our AMA wants to strengthen the potential for securing the one-year moratorium of the MPPR policy, which will give our AMA more time to advocate on this issue and mitigate the cut.

Your Reference Committee believes that our strong existing AMA policy in this space should be reaffirmed. This policy is almost identical to Resolution 242 but includes a few key differences that, unlike Resolution 242, provide our AMA with the flexibility needed for the strongest possible advocacy on this topic. In particular, as testimony noted, the third Resolve of Resolution 242 is damaging to our AMA's advocacy efforts because it could prevent our AMA from supporting short-term relief, such as a temporary moratorium of the MPPR policy, that Congress may consider during the lame duck session.

Additionally, your Reference Committee notes that the Medicare statute largely bars administrative and judicial review of relative value determinations, making it unclear what impact Resolution 242's call for legal action would have.

Moreover, existing Policy D-385.956 already directs our AMA to pursue any legal means possible, including litigation, should circumstances warrant.

Your Reference Committee agrees that the payment reduction is unjustified and must be reversed. However, your Reference Committee believes our AMA's efforts are best focused on the regulatory and legislative relief currently under consideration. Therefore, your Reference Committee recommends that existing AMA policy D-385.956 be reaffirmed in lieu of Resolution 242.

Opposition to Reduced Payment for the 25 Modifier D-385.956

Our American Medical Association will aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate.

This concludes the report of Reference Committee B. I would like to thank Shawn Baca, MD, Mary Campagnolo, MD, Robert Emmick, MD, Matthew Gold, MD, Amit Ghose, MD, Tashera Perry, MD, and all those who testified before the Committee.

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