

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 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-24)

Final Report of Reference Committee B

Dale Mandel, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2
3 **RECOMMENDED FOR ADOPTION**

- 4
5 1. Board of Trustees Report 02 — On-Site Physician Requirements for Emergency
6 Departments
7 2. Board of Trustees Report 06 — Health Technology Accessibility for Aging
8 Patients
9 3. Board of Trustees Report 09 — Corporate Practice of Medicine Prohibition
10 4. Resolution 205 — Native American Medical Debt
11 5. Resolution 218 — Time Sensitive Credentialing of New Providers with an
12 Insurance Carrier

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14 **RECOMMENDED FOR ADOPTION AS AMENDED**

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16 6. Board of Trustees Report 01 — Assessing the Intersection Between AI and
17 Health Care
18 7. Board of Trustees Report 04 — Addressing Work Requirements for J-1 Visa
19 Waiver Physicians
20 8. Resolution 202 — Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis
21 9. Resolution 203 — Alternative Pathways for International Medical Graduates
22 10. Resolution 204 — Support for Physician-Supervised Community Paramedicine
23 Programs
24 11. Resolution 206 — Protect Infant and Young Child Feeding
25 12. Resolution 207 — Accountability for G-605.009: Requesting A Task Force to
26 Preserve the Patient-Physician Relationship Task Force Update and Guidance
27 13. Resolution 208 — Medicare Part B Enrollment and Penalty Awareness
28 14. Resolution 210 — Laser Surgery
29 15. Resolution 211 — Water Bead Injuries
30 16. Resolution 212 — Addressing the Unregulated Body Brokerage Industry
31 17. Resolution 213 — Sustainable Long-term Funding for Child Psychiatry Access
32 Programs
33 18. Resolution 214 — Advocating for Evidence-Based Strategies to Improve Rural
34 Obstetric Health Care and Access
35 19. Resolution 216 — Clearing Federal Obstacles for Supervised Injection Sites
36 20. Resolution 222 — Rollback on Physician Performance Measures
37 21. Resolution 229 — Supporting Penalties on Insurers Who Fail to Pay Doctors

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RECOMMENDED FOR ADOPTION IN LIEU OF

- 22. Resolution 201 — Boarding Patients in the Emergency Room
- Resolution 230 — Addressing and Reducing Patient Boarding in Emergency Departments

RECOMMENDED FOR REFERRAL

- 23. Board of Trustees Report 03 — Reforming Stark Law's Blanket Self-Referral Ban
- 24. Resolution 226 — Information Blocking Rule

RECOMMENDED FOR REFERRAL FOR DECISION

- 25. Resolution 228 — Codification of the Chevron Deference Doctrine

RECOMMENDED FOR NOT ADOPTION

- 26. Resolution 221 — Medicare Coverage for Non-PAR Physicians

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- 27. Resolution 215 — Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
- 28. Resolution 217 — Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
- 29. Resolution 219 — Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
- 30. Resolution 220 — MIPS Reform
- 31. Resolution 223 — Mandated Economic Escalators in Insurance Contracts
- 32. Resolution 225 — Elimination of Medicare 14-Day Rule
- 33. Resolution 227 — Medicare Payment Parity for Telemedicine Services
- 34. Resolution 231 — Establish Pregnancy as a Federal Qualifying Life Event Triggering a Special Enrollment Period

Amendments:

If you wish to propose an amendment to an item of business, click here: [Submit New Amendment](#)

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 02 — ON-SITE
PHYSICIAN REQUIREMENTS FOR EMERGENCY
DEPARTMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 2 be adopted and the remainder of the Report be filed.

**HOD ACTION: Recommendations in Board of Trustees
Report 2 adopted and the remainder of the Report filed.**

The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed:

1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open. (New HOD Policy)
2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care. (New HOD Policy)

Your Reference Committee heard mixed but mostly supportive testimony for the recommendations in Board of Trustees Report 2. Your Reference Committee heard two amendments. First, an amendment to the second recommendation would specify that an appropriate rural exception requires that a physician be available by phone at all times and in person within 30 minutes. Your Reference Committee feels that the language of the original recommendation is not incompatible with this proposed amendment and allows states more flexibility in crafting limited rural exceptions that meet their unique needs while still preserving physician-led care. Your Reference Committee also heard an amendment that would remove reference to AMA's potential support of federal legislation that might require a hospital with an ED to have a physician on-site and on duty who is primarily responsible for the emergency department at all times. Because the 24/7 physical presence of a physician is the preferred model of emergency care, and recognizing the value of federal legislation governing emergency departments, your

1 Reference Committee feels it is appropriate that AMA be free to support potential federal
2 legislation to that end. Therefore, your Reference Committee recommends that Board of
3 Trustees Report 2 be adopted, and that the remainder of the Report be filed.

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6 (2) BOARD OF TRUSTEES REPORT 06 — HEALTH
7 TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS

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9 RECOMMENDATION:

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11 Madam Speaker, your Reference Committee recommends
12 that Board of Trustees Report 6 be adopted and the
13 remainder of the Report be filed.

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15 **HOD ACTION: Recommendations in Board of Trustees**
16 **Report 6 adopted and the remainder of the Report filed.**

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18 The Board of Trustees recommends that the following recommendations be adopted in
19 lieu of Resolution 213-I-23, and the remainder of the report be filed.:

20
21 That our American Medical Association amend Policy H-480-937 by addition and the title
22 be changed by addition.

23
24 Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH
25 TECHNOLOGY

- 26
27 1. Our American Medical Association recognizes access to broadband internet as a
28 social 6 determinant of health.
- 29 2. Our AMA encourages initiatives to measure and strengthen digital literacy, with
30 appropriate education programs, and with an emphasis on programs designed with
31 and for historically marginalized and minoritized populations.
- 32 3. Our AMA encourages telehealth solution and service providers to implement
33 design functionality, content, user interface, and service access best practices with
34 and for historically minoritized and marginalized communities, including
35 addressing culture, language, technology accessibility, and digital literacy within
36 these populations.
- 37 4. Our AMA supports efforts to design and to improve the usability of existing
38 electronic health record (EHR) and telehealth technology, including voice-
39 activated technology, with and for those with difficulty accessing technology, such
40 as older adults, individuals with vision impairment and individuals with other mental
41 or physical disabilities.
- 42 5. Our AMA encourages hospitals, health systems and health plans to invest in
43 initiatives aimed at designing access to care via telehealth with and for historically
44 marginalized and minoritized communities, including improving physician and non-
45 physician provider diversity, offering training and technology support for equity-
46 centered participatory design, and launching new and innovative outreach
47 campaigns to inform and educate communities about telehealth.
- 48 6. Our AMA supports expanding physician practice eligibility for programs that assist
49 qualifying health care entities, including physician practices, in purchasing
50 necessary services and equipment in order to provide telehealth services to

- 1 augment the broadband infrastructure for, and increase connected device use
 2 among historically marginalized, minoritized and underserved populations.
- 3 7. Our AMA supports efforts to ensure payers allow all contracted physicians to
 4 provide care via telehealth.
- 5 8. Our AMA opposes efforts by health plans to use cost-sharing as a means to
 6 incentivize or require the use of telehealth or in-person care or incentivize care
 7 from a separate or preferred telehealth network over the patient's current
 8 physicians.
- 9 9. Our AMA will advocate that physician payments should be fair and equitable,
 10 regardless of whether the service is performed via audio-only, two-way audio-
 11 video, or in-person.
- 12 10. Our AMA encourages the development of improved solutions to incorporate
 13 structured advance care planning (ACP) documentation standards that best meet
 14 the requisite needs for patients and physicians to easily store and access in the
 15 EHR complete and accurate ACP documentation that maintains the flexibility to
 16 capture unique, patient-centered details.
- 17 11. Our AMA encourages hospitals, health systems, and physician practices to
 18 provide a method other than electronic communication for patients who are without
 19 technological proficiency or access. (Modify Current HOD Policy)

20
 21 Your Reference Committee heard testimony in support of Board of Trustees Report 6.
 22 Your Reference Committee heard that the recommendations in the Report amplify the
 23 message and recognition that equity in telehealth should expand beyond the population
 24 of older adults. Testimony reflected that the Report is a meaningful update to current AMA
 25 policy and reflects the increasing use of health technology and its impact on aging
 26 patients. Testimony specifically cited that, as the demographic of those over age 85 is
 27 rising due to medical advances prolonging life, ensuring those patients can interact with
 28 their physicians and other care givers is crucial. Testimony also supported the addition of
 29 electronic advanced care planning as a substantive addition to existing policy. Therefore,
 30 Your Reference Committee recommends that Board of Trustees Report 6 be adopted,
 31 and that the remainder of the Report be filed.

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 34 (3) BOARD OF TRUSTEES REPORT 09 — CORPORATE
 35 PRACTICE OF MEDICINE PROHIBITION

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 37 RECOMMENDATION:

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 39 Madam Speaker, your Reference Committee recommends
 40 that Board of Trustees Report 9 be adopted and the
 41 remainder of the Report be filed.

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 43 **HOD ACTION: Recommendations in Board of Trustees**
 44 **Report 9 adopted and the remainder of the Report filed.**

45
 46 The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA
 47 Policy H-215.981 entitled, "Corporate Practice of Medicine," be amended by addition and
 48 the remainder of the report be filed:

- 1 1. Our American Medical Association vigorously opposes any effort to pass federal
2 legislation or regulation preempting state laws prohibiting the corporate practice of
3 medicine. (Reaffirm HOD Policy)
4
- 5 2. Our AMA vigorously opposes any effort to pass legislation or regulation that
6 removes or weakens state laws prohibiting the corporate practice of medicine.
7 (New HOD Policy)
8
- 9 3. Our AMA opposes the corporate practice of medicine and supports the restriction
10 of ownership and operational authority of physician medical practices to physicians
11 or physician-owned groups. (New HOD Policy)
12
- 13 4. At the request of state medical associations, our AMA will provide guidance,
14 consultation, and model legislation regarding the corporate practice of medicine,
15 to ensure the autonomy of hospital medical staffs, employed physicians in non-
16 hospital settings, and physicians contracting with corporately owned management
17 service organizations. (Reaffirm HOD Policy)
18
- 19 5. Our AMA will continue to monitor the evolving corporate practice of medicine with
20 respect to its effect on the patient-physician relationship, financial conflicts of
21 interest, patient centered care and other relevant issues. (Directive to take action)
22
- 23 6. Our AMA will work with interested state medical associations, the federal
24 government, and other interested parties to develop and advocate for regulations
25 and appropriate legislation pertaining to corporate control of practices in the
26 healthcare sector such that physician clinical autonomy in clinical care and
27 operational authority is are preserved and protected. (Modify Current HOD Policy)
28
- 29 7. Our AMA will create a state corporate practice of medicine template to assist state
30 medical associations and national medical specialty societies as they navigate the
31 intricacies of corporate investment in physician practices and health care generally
32 at the state level and develop the most effective means of prohibiting the corporate
33 practice of medicine in ways that are not detrimental to the sustainability of
34 physician practices. (New HOD Policy)
35

36 Your Reference Committee heard testimony uniformly in favor of adopting Board of
37 Trustees Report 9. Testimony expressed concern about the detrimental impact that
38 corporate investment has had on physician practices and health care generally, and thus
39 noted that our AMA should do more to oppose the corporate practice of medicine.
40 Testimony also highlighted that the Report should be adopted because, by not calling for
41 a complete prohibition on corporate investment in physician practices, physicians wanting
42 to pursue a partnership with a corporate investor are not prohibited from doing so.
43 Testimony stressed that physicians must always maintain control of practice operations
44 and clinical decision-making and emphasized the value of additional resources on the
45 corporate practice of medicine doctrine to be developed by our AMA. Therefore, your
46 Reference Committee recommends that Board of Trustees Report 9 be adopted, and that
47 the remainder of the Report be filed.

1 (4) RESOLUTION 205 — NATIVE AMERICAN MEDICAL
2 DEBT

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4 RECOMMENDATION:

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6 Madam Speaker, your Reference Committee recommends
7 that Resolution 205 be adopted.

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9 **HOD ACTION: Resolution 205 adopted.**

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11 RESOLVED, that our American Medical Association support federal legislation requiring
12 credit reporting agencies to remove information on the credit reports of Indian Health
13 Service (IHS) beneficiaries that relate to debts or collections activities for medical services
14 that should have been paid by the IHS. (New HOD Policy)

15 Your Reference Committee heard overwhelming testimony in favor of Resolution 205, with
16 only one comment against adoption. Your Reference Committee heard that Resolution
17 205 would call on our AMA to advocate for federal legislation that would protect Native
18 American patients from credit report penalties arising from unpaid medical bills that should
19 have been covered by the Indian Health Service (IHS). Testimony noted that Native
20 Americans are disproportionately affected by medical debt, which negatively impacts their
21 credit scores and leads to increased reliance on high-risk loans. Your Reference
22 Committee also heard that the IHS Purchased and Referred Care (PRC) program often
23 fails to pay medical bills on time, leaving IHS patients burdened with medical debt that the
24 agency is responsible for covering. This issue forces Indigenous patients to cover costs
25 that should be federally funded, leading to both personal and financial harm. Further
26 testimony highlighted that supporting policy changes for IHS beneficiaries would align with
27 protections currently provided to veterans receiving care through the Department of
28 Veterans Affairs, thereby fostering greater equity in credit reporting practices. Therefore,
29 your Reference Committee recommends that Resolution 205 be adopted.

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32 (5) RESOLUTION 218 — TIME SENSITIVE
33 CREDENTIALING OF NEW PROVIDERS WITH AN
34 INSURANCE CARRIER

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36 RECOMMENDATION:

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38 Madam Speaker, your Reference Committee recommends
39 that Resolution 218 be adopted.

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41 **HOD ACTION: Resolution 218 adopted.**

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43 RESOLVED, that our American Medical Association urge the US Department of Labor to
44 establish uniform provider credentialing standards for Third Party Administrator's (TPA's)
45 serving ERISA Plans to include the following : that when a credentialing application is
46 submitted, the insurance carrier must respond in writing within five business days whether
47 the application is complete and acceptable, and if incomplete the carrier must send notice
48 to the provider indicating what additional information is needed for completion of the
49 process, and acknowledge the completion of a successfully completed application within
50 ten business (Directive to Take Action); and be it further

1 RESOLVED, that our AMA urge the US Department of Labor to require Third Party
2 Administrators to send a written notice to applicants within 45 days, regarding their
3 credentialing decision and after 45 days, an applicant is deemed to have been
4 automatically credentialled and enrolled to be eligible for payment of services, even if the
5 payer fails to acknowledge the applicant. (Directive to Take Action)

6
7 Your Reference Committee heard unanimous support for Resolution 218. Testimony
8 highlighted the need for timely, uniform credentialing processes as described in the
9 resolution. Your Reference Committee heard testimony that highlighted arbitrary and
10 variable standards imposed by insurance companies, evidenced by delays of up to 9
11 months despite timely submission of all required documents. Your Reference Committee
12 heard that current delays from varied carrier policies are detrimental to private practice
13 viability and patient care. Testimony also emphasized the importance of credentialing for
14 providers to establish a financial relationship with insurance carriers. Therefore, your
15 Reference Committee recommends that Resolution 218 be adopted.

1 **RECOMMENDED FOR ADOPTION AS AMENDED**

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3 (6) BOARD OF TRUSTEES REPORT 01 — AUGMENTED
4 INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND
5 USE IN HEALTH CARE

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7 RECOMMENDATION A:

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9 Madam Speaker, your Reference Committee recommends
10 that Section “1) a)” be amended by addition and deletion to
11 read as follows:

12
13 a) Health care AI must be designed, developed, and
14 deployed in a manner which is ethical, equitable,
15 responsible, accurate, ~~and~~ transparent, and evidence-
16 based.

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18 RECOMMENDATION B:

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20 Madam Speaker, your Reference Committee recommends
21 that Section “1) g)” be amended by addition to read as
22 follows:

23
24 g) Clinical decisions influenced by AI must be made with
25 specified qualified human intervention points during the
26 decision-making process. A qualified human is defined as a
27 licensed physician with the necessary qualifications and
28 training to independently provide the same medical service
29 without the aid of AI. As the potential for patient harm
30 increases, the point in time when a physician should utilize
31 their clinical judgment to interpret or act on an AI
32 recommendation should occur earlier in the care plan. With
33 few exceptions, there generally should be a qualified human
34 in the loop when it comes to medical decision making
35 capable of intervening or overriding the output of an AI
36 model.

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38 RECOMMENDATION C:

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40 Madam Speaker, your Reference Committee recommends
41 that Section “4) d)” be amended by addition to read as
42 follows:

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

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9 RECOMMENDATION D:

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11 Madam Speaker, your Reference Committee recommends
12 that Section 5 be amended by addition to read as follows:

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14 c) Liability protections for physicians using AI-enabled
15 technologies should align with both current and future AMA
16 medical liability reform policies.

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18 RECOMMENDATION E:

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20 Madam Speaker, your Reference Committee recommends
21 that Board of Trustees Report 01 be adopted as amended
22 and the remainder of the Report be filed.

23
24 **HOD ACTION: Section 4(f) referred for decision and the**
25 **remainder of the recommendations in Board of Trustees**
26 **Report 01 adopted as amended and the remainder of the**
27 **Report filed.**
28

The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

1. General Governance

- a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent.
- 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 human intervention points during the decision-making process. 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 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)]
2. 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.
- 3. 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]
4. 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 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 (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
 - f. Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
 - g. 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.
5. 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.
6. 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)]

7. 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.

8. 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 data. 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.
9. 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.

(New HOD Policy)

1
2 Your Reference Committee heard testimony largely in support of Board of Trustees Report
3 01. Testimony covered the report's comprehensive focus areas, including healthcare AI
4 governance, transparency in AI applications, oversight of generative AI tools, physician
5 liability, and AI-related privacy and security issues. Your Reference Committee has
6 considered that this is a highly vetted report and includes amendments made in response
7 to previous comments and concerns from prior AMA meetings. Several amendments were
8 proposed, most of which your Reference Committee believes are consistent with the
9 recommendations in the report and would provide additional clarity. These include
10 amendments that would clarify that: clinical decisions influenced by AI must be made with
11 a specified human who is qualified; the deployment of AI tools be evidence-based; and
12 healthcare organizations, in addition to physicians, should engage with generative AI tools
13 only when adequate information regarding the product is provided by the developers of
14 those tools. In addition, your Reference Committee recommends including an amendment
15 that would provide greater focus on addressing additional liability protections for
16 physicians using AI-enabled technologies, as well as an amendment that would modify
17 Recommendation B in the Preliminary Report to clarify the definition of "qualified human,"
18 per testimony received. While additional testimony was heard regarding disclosure to
19 patients and physicians when AI is used in medical decision making, the use of
20 confidential or proprietary information as prompts, and advocacy for the development of
21 expert consensus guidelines, your Reference Committee recommends deferring to the
22 language in the report at this time given that the current language has been well vetted.
23 In making this recommendation, your Reference Committee considered that our AMA
24 House of Delegates adopted Policy G-615.998 at the 2024 Annual Meeting, and that under

1 this policy a task force is being formed that will focus on digital health, technology,
2 informatics, and augmented/artificial intelligence. This task force, along with our AMA
3 Councils, will be well positioned to consider these and other evolving and complex issues
4 regarding AI and propose to the HOD revised or new policy as necessary to ensure that
5 our AMA's advocacy on behalf of physicians and our patients remains impactful.
6 Therefore, your Reference Committee recommends that Board of Trustees Report 01 be
7 adopted as amended and that the remainder of the Report be filed.
8
9

10 (7) BOARD OF TRUSTEES REPORT 04 — ADDRESSING
11 WORK REQUIREMENTS FOR J-1 VISA WAIVER
12 PHYSICIANS
13

14 RECOMMENDATION A:
15

16 Madam Speaker, your Reference Committee recommends
17 that Board of Trustees Report 4 be amended by addition
18 and deletion to read as follows:
19

20 Our American Medical Association ~~supports~~ advocates for
21 federal visa and visa waiver policies ~~that to include time for~~
22 administrative tasks, professional development
23 opportunities, and other professional responsibilities within
24 the federally mandated work week requirements for direct
25 patient care, ~~administrative tasks, professional development~~
26 ~~opportunities, and other professional responsibilities.~~
27

28 RECOMMENDATION B:
29

30 Madam Speaker, your Reference Committee recommends
31 that Board of Trustees Report 4 be adopted as amended
32 and the remainder of the Report be filed.
33

34 **HOD ACTION: Recommendation in Board of Trustees**
35 **Report 4 adopted as amended and the remainder of the**
36 **Report filed.**
37

38 The Board of Trustees recommends that the following policy be adopted in lieu of
39 Resolution 217-I-23, and the remainder of the report be filed:
40

41 Our American Medical Association supports federal visa and visa waiver policies that
42 include time within the federally mandated work week requirements for direct patient care,
43 administrative tasks, professional development opportunities, and other professional
44 responsibilities. (New HOD Policy)
45

46 Your Reference Committee heard supportive testimony on Board of Trustees Report 4.
47 Your Reference Committee heard that International Medical Graduates (IMGs) are
48 working significant hours to ensure that they can provide patient care as well as gain
49 professional development. Testimony noted that it was very difficult for IMGs to find
50 enough time to accomplish all the personal and professional goals that they have due to

1 their work hour requirements. Your Reference Committee heard that the work hour
2 requirements that apply to J-1 waivers vary by state, regional commission, and federal
3 agency. An amendment was provided and was supported by some commentors.
4 However, testimony from the Board of Trustees emphasized the importance of maintaining
5 the term support in this resolution. Testimony stated that maintaining the word support will
6 provide staff with the ability to strategically advocate on this topic when the time is ripe to
7 ensure that we do not negatively impact the passage of the Conrad 30 legislation, which
8 must be renewed yearly. Therefore, the Reference Committee recommends that Board of
9 Trustees Report 4 be adopted as amended, and that the remainder of the Report be
10 filed.

1 (8) RESOLUTION 202 — ILLICIT DRUGS: CALLING FOR A
2 MULTIFACETED APPROACH TO THE “FENTANYL”
3 CRISIS
4

5 RECOMMENDATION A:
6

7 Madam Speaker, your Reference Committee recommends
8 that the first resolve of Resolution 202 be amended by
9 addition and deletion to read as follows:

10
11 RESOLVED, that our American Medical Association
12 continue to support ~~advocate for~~ public education and
13 awareness about the rapidly evolving US illicit drug
14 epidemic crisis due to dangers of illegally made fentanyl and
15 other toxic substances ~~carfentanil-laced products (Directive~~
16 ~~to Take Action)~~; and be it further
17

18 RECOMMENDATION B:
19

20 Madam Speaker, your Reference Committee recommends
21 that the second resolve of Resolution 202 be amended by
22 addition and deletion to read as follows:
23

24 RESOLVED, that our AMA continue to support efforts by
25 ~~advocate that~~ federal, state and local government officials
26 and agencies ~~implement measures~~ to curb and/or stop the
27 manufacturing, importation, and distribution of illicit drugs
28 and related chemical compounds (Directive to Take
29 Action); ~~and be it further~~
30

31 RECOMMENDATION C:
32

33 Madam Speaker, your Reference Committee recommends
34 that Resolves three through six of Resolution 202 be
35 deleted.
36

37 ~~RESOLVED, that our AMA support federal legislation that~~
38 ~~would help Customs and Border Protection (CBP) stop the~~
39 ~~flow of illicit goods, including fentanyl and counterfeit~~
40 ~~medications (New HOD Policy); and be it further~~
41

42 ~~RESOLVED, that our AMA, based on the Public Health~~
43 ~~Security and Bioterrorism Preparedness and Response Act~~
44 ~~of 2002 (which criminalizes the use of a biological agents to~~
45 ~~cause death, disease, or other harm), request our~~
46 ~~government to determine if expansion should include illicit~~
47 ~~chemicals and drugs such as fentanyl, carfentanil, 3-~~
48 ~~methylfentanyl, Xylazine, etc. (Directive to Take Action);~~
49 ~~and be it further~~

1 ~~RESOLVED, that our AMA encourage our government to~~
2 ~~clarify if, and in what circumstances, these types of illicit~~
3 ~~drugs (e.g. fentanyl, carfentanil, etc.), or their precursors,~~
4 ~~should be considered chemical weapons as defined by The~~
5 ~~Chemical Weapons Convention and/or a WMD as defined~~
6 ~~by the DHS (New HOD Policy); and be it further~~
7

8 ~~RESOLVED, that our AMA assess the likelihood that illicit~~
9 ~~drugs such as carfentanil may be used as a WMD and what~~
10 ~~steps healthcare workers, hospital systems and first-~~
11 ~~responders should take to prepare for such an event.~~
12 ~~(Directive to Take Action)~~
13

14 RECOMMENDATION D:

15
16 Madam Speaker, your Reference Committee recommends
17 that Resolution 202 be adopted as amended.

18
19 RECOMMENDATION E:

20
21 Madam Speaker, your Reference Committee recommends
22 that the title of Resolution 202 be changed to read as
23 follows:
24

25 **CALLING FOR A MULTIFACETED APPROACH TO THE**
26 **ILLCIT FENTANYL CRISIS**

27
28 **HOD ACTION: The second resolve of Resolution 202**
29 **referred and the remainder of Resolution 202 adopted as**
30 **amended with a change of title.**
31

32 **CALLING FOR A MULTIFACETED APPROACH TO THE**
33 **ILLCIT FENTANYL CRISIS**
34

35 RESOLVED, that our American Medical Association advocate for public education and
36 awareness about the rapidly evolving US illicit drug crisis due to dangers of fentanyl and
37 carfentanil-laced products (Directive to Take Action); and be it further
38

39 RESOLVED, that our AMA advocate that federal, state and local government officials and
40 agencies implement measures to curb and/or stop the manufacturing, importation, and
41 distribution of illicit drugs and related chemical compounds (Directive to Take Action); and
42 be it further
43

44 RESOLVED, that our AMA support federal legislation that would help Customs and Border
45 Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit
46 medications (New HOD Policy); and be it further
47

48 RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism
49 Preparedness and Response Act of 2002 (which criminalizes the use of a biological
50 agents to cause death, disease, or other harm), request our government to determine if

1 expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-
2 methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further

3
4 RESOLVED, that our AMA encourage our government to clarify if, and in what
5 circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their
6 precursors, should be considered chemical weapons as defined by The Chemical
7 Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it
8 further

9 RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may
10 be used as a WMD and what steps healthcare workers, hospital systems and first-
11 responders should take to prepare for such an event. (Directive to Take Action)

12
13 Your Reference Committee heard mixed testimony on Resolution 202. Your Reference
14 Committee heard that our AMA has considerable, existing policy advocating for a public
15 health focus to combat the drug overdose and death epidemic, including strong support
16 for increased education, research, prevention, treatment, harm reduction efforts, and
17 removing the stigma associated with drug use and substance use disorders (SUDs).
18 Testimony highlighted the need for our AMA to take a public health approach to this
19 Resolution to avoid stigmatizing drug use and to increase support for harm reduction
20 initiatives such as naloxone access. Testimony emphasized that our AMA's most
21 appropriate role is to support public health efforts and that law enforcement should be left
22 to law enforcement. Testimony also noted the ongoing nature of the epidemic, including
23 how there are multiple, toxic substances in the nation's illicit drug supply. Testimony noted
24 that AMA advocacy is incredibly broad and effectively addresses the polysubstance nature
25 of the epidemic without having to name every new substance. Therefore, your Reference
26 Committee recommends that Resolution 202 be adopted as amended.

1 (9) RESOLUTION 203 — ALTERNATIVE PATHWAYS FOR
2 INTERNATIONAL MEDICAL GRADUATES

3
4 RECOMMENDATION A:

5
6 Madam Speaker, your Reference Committee recommends
7 that the first resolve of Resolution 203 be amended by
8 addition and deletion to read as follows:

9
10 RESOLVED, that our American Medical Association
11 provides an informational report about the ongoing work
12 around alternate licensing pathways and currently
13 introduced laws and regulations being introduced around
14 the country and their status during the ~~A-25-I-25~~ meeting
15 (Directive to Take Action); and be it further

16
17 RECOMMENDATION B:

18
19 Madam Speaker, your Reference Committee recommends
20 that the second resolve of Resolution 203 be amended by
21 addition and deletion to read as follows:

22
23 RESOLVED, that, following the conclusion of the work of the
24 Advisory Commission on Alternate Licensing Models, our
25 AMA develop educational resources related to alternate
26 licensing models for the AMA HOD and other interested
27 parties stakeholders (Directive to Take Action); and be it
28 further

29
30 RECOMMENDATION C:

31
32 Madam Speaker, your Reference Committee recommends
33 that the third resolve of Resolution 203 be amended by
34 deletion to read as follows:

35
36 RESOLVED, that our AMA widely distribute the
37 Commission's report and relevant educational content to all
38 AMA members ~~and other interested stakeholders~~ (Directive
39 to Take Action); ~~and be it further~~

40 RECOMMENDATION D:

41
42 Madam Speaker, your Reference Committee recommends
43 that the fourth resolve of Resolution 203 be deleted.

1 ~~RESOLVED, that, following the conclusion of the work of the~~
2 ~~Advisory Commission on Alternate Licensing Models, our~~
3 ~~AMA study our existing policy pertaining to state licensure~~
4 ~~processes, including alternate licensing pathways, and~~
5 ~~recommend updates to such policies, as appropriate, to~~
6 ~~help inform advocacy efforts by state medical societies.~~
7 ~~(Directive to Take Action)~~

8
9 RECOMMENDATION E:

10
11 Madam Speaker, your Reference Committee recommends
12 that Resolution 203 be adopted as amended.

13
14 **HOD ACTION: Resolution 203 adopted as amended.**

15
16 RESOLVED, that our American Medical Association provides an informational report
17 about the ongoing work around alternate licensing pathways and currently introduced laws
18 and regulations being introduced around the country and their status during the A-25
19 meeting (Directive to Take Action); and be it further

20
21 RESOLVED, that, following the conclusion of the work of the Advisory Commission on
22 Alternate Licensing Models, our AMA develop educational resources related to alternate
23 licensing models for the AMA HOD and other interested stakeholders (Directive to Take
24 Action); and be it further

25
26 RESOLVED, that our AMA widely distribute the Commission's report and relevant
27 educational content to all AMA members and other interested stakeholders (Directive to
28 Take Action); and be it further

29
30 RESOLVED, that, following the conclusion of the work of the Advisory Commission on
31 Alternate Licensing Models, our AMA study our existing policy pertaining to state licensure
32 processes, including alternate licensing pathways, and recommend updates to such
33 policies, as appropriate, to help inform advocacy efforts by state medical societies.
34 (Directive to Take Action)

35
36 Your Reference Committee heard about the importance of the Advisory Commission on
37 Additional Licensing Models and the work that it is undertaking to try and unify and ease
38 the licensure pathway for international medical graduates (IMGs). Testimony noted how
39 difficult it can be for IMGs to receive a license to practice medicine in the United States,
40 even if they have already received extensive training abroad. Testimony also noted the
41 importance of a more uniform approach to this licensure pathway among the states.
42 However, your Reference Committee also heard that it is the undertaking of the
43 Commission to provide information about the Commission and its ongoing work to
44 interested parties and states. Moreover, testimony noted that since the recommendations
45 of the Commission are not complete and will continue to be developed over the course of
46 multiple years, our AMA should not commit to changing our existing policies based on the
47 work of the Commission. Further testimony noted that due to the ongoing work of the
48 Commission, an informational report would be more beneficial to our House if it were
49 presented at the Interim 2025 meeting of the House of Delegates to provide more time for
50 the Commission to develop their recommendations and for staff to appropriately review

1 the work of the Commission in alignment with our existing AMA policy. Therefore, your
2 Reference Committee recommends that Resolution 203 be adopted as amended.

3
4
5 (10) RESOLUTION 204 — SUPPORT FOR PHYSICIAN-
6 SUPERVISED COMMUNITY PARAMEDICINE
7 PROGRAMS

8
9 RECOMMENDATION A:

10
11 Madam Speaker, your Reference Committee recommends
12 that Resolution 204 be amended by addition and deletion to
13 read as follows:

14
15 RESOLVED, that our American Medical Association
16 support federal and state efforts to strengthen ~~establish,~~
17 ~~expand,~~ and provide coverage for community paramedicine
18 programs ~~supervised by physicians~~, especially in rural or
19 underserved areas, so long as these programs do not
20 decrease funding for physician payment. (New HOD Policy)

21
22 RECOMMENDATION B:

23
24 Madam Speaker, your Reference Committee recommends
25 that Resolution 204 be amended by addition of a second
26 resolve clause to read as follows:

27
28 RESOLVED, that our American Medical Association only
29 support community paramedicine programs that preserve
30 physician-led team-based care.

31
32 RECOMMENDATION C:

33
34 Madam Speaker, your Reference Committee recommends
35 that Resolution 204 be adopted as amended.

36
37 **HOD ACTION: Resolution 204 adopted as amended.**

38
39 RESOLVED, that our American Medical Association support federal and state efforts to
40 establish, expand, and provide coverage for community paramedicine programs
41 supervised by physicians, especially in rural areas. (New HOD Policy)

42
43 Your Reference Committee heard unanimous testimony in support of Resolution 204.
44 Your Reference Committee received testimony that highlighted the important role of
45 community paramedicine programs in improving access to care and limiting unnecessary
46 trips to emergency departments. However, some testimony highlighted the need to
47 preserve physician-led teams in these programs. Additionally, amendments were
48 proffered to ensure that funding for physician payment was not decreased because of the
49 establishment of these programs. Further testimony noted the importance of guaranteeing

1 that other underserved communities were included in this advocacy work. Therefore, your
2 Reference Committee recommends that Resolution 204 be adopted as amended.

3
4
5 (11) RESOLUTION 206 — PROTECT INFANT AND YOUNG
6 CHILD FEEDING

7
8 RECOMMENDATION A:

9
10 Madam Speaker, your Reference Committee recommends
11 that the first Resolve of Resolution 206 be amended by
12 addition to read as follows:

13
14 RESOLVED, that our American Medical Association
15 support public and private payer coverage of medically
16 necessary donor human breast milk (New HOD Policy); and
17 be it further

18
19 RECOMMENDATION B:

20
21 Madam Speaker, your Reference Committee recommends
22 that Resolution 206 be adopted as amended.

23
24 **HOD ACTION: Resolution 206 adopted as amended.**

25
26 RESOLVED, that our American Medical Association support Medicaid coverage of donor
27 human breast milk (New HOD Policy); and be it further

28
29 RESOLVED, that our AMA advocate for an adequate supply and consistent sources of
30 infant milk formula. (Directive to Take Action)

31
32 Your Reference Committee heard overwhelming testimony in support of Resolution 206,
33 with no opposing testimony offered. Your Reference Committee heard that AMA policy
34 recognizes that breastfeeding is the optimal form of nutrition for most infants and promotes
35 strategies to increase breastfeeding, and further, that in alignment with this policy, the
36 American Academy of Pediatrics supports the use of donor human milk for high-risk
37 infants and calls for policies to provide high-risk infants access to donor human milk based
38 on medical necessity, not financial status. Your Reference Committee further heard that
39 in 2011, the U.S. Surgeon General called for strategies to address obstacles to the
40 availability of safe, banked, donor human milk for fragile infants. Your Reference
41 Committee heard support for having mechanisms in place that allow for the accessibility
42 of safe and sufficient nutrition for infants and that our AMA should advocate for such a
43 supply. An amendment was offered to support coverage of donor human milk only in cases
44 of medical necessity. Testimony noted that this was an important addition due to supplier
45 concerns. Additional testimony emphasized the importance of requiring this benefit from
46 all payers. Therefore, your Reference Committee recommends that Resolution 206 be
47 adopted as amended.

1 (12) RESOLUTION 207 — ACCOUNTABILITY FOR G-
2 605.009: REQUESTING A TASK FORCE TO PRESERVE
3 THE PATIENT-PHYSICIAN RELATIONSHIP TASK
4 FORCE UPDATE AND GUIDANCE
5

6 RECOMMENDATION A:

7
8 Madam Speaker, your Reference Committee recommends
9 that the second resolve of Resolution 207 be deleted.

10
11 ~~RESOLVED, that our AMA's work on the Task Force~~
12 ~~continues for a minimum of three years with reevaluation of~~
13 ~~need and relevance at I-29 (Directive to Take Action); and~~
14 ~~be it further~~

15
16 RECOMMENDATION B:

17
18 Madam Speaker, your Reference Committee recommends
19 that the third Resolve of Resolution 207 be amended by
20 addition and deletion to read as follows:

21
22 2h. Work with interested parties to encourage the
23 development of institution-level guidance and protection
24 publish public-facing guidance for what is medically
25 allowable for physicians practicing in states with restrictions
26 potentially ~~impeding on~~ interfering with the patient-physician
27 relationship. (Modify Current HOD Policy)

28
29 RECOMMENDATION C:

30
31 Madam Speaker, your Reference Committee recommends
32 that Resolution 207 be adopted as amended.

33
34 **HOD ACTION: Resolution 207 adopted as amended.**

35
36 RESOLVED, that our American Medical Association's Task Force to Preserve the Patient-
37 Physician Relationship will present annual updates on their findings at AMA Annual
38 Meetings until the objectives have been completed (Directive to Take Action); and be it
39 further

40
41 RESOLVED, that our AMA's work on the Task Force continues for a minimum of three
42 years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it
43 further

44
45 RESOLVED, that our AMA amend G-605.009 with the addition of text as follows:

46
47 2h. Work with interested parties to publish public-facing guidance for what is medically
48 allowable for physicians practicing in states with restrictions potentially impeding on the
49 patient-physician relationship. (Modify Current HOD Policy)

1 Your Reference Committee heard testimony that was overall supportive of the Task Force
2 to Preserve the Patient-Physician Relationship and of efforts to protect the patient-
3 physician relationship from laws that restrict medical care. Your Reference Committee
4 heard testimony in support of the Reference Committee recommendation to require the
5 Task Force to report annually on its progress and in support of an amendment to direct
6 the Task Force to encourage the development of institution-level guidance for physicians
7 practicing in states that restrict medical care.
8

9 Your Reference Committee also heard testimony that provided information on the Task
10 Force activities. For example, your Reference Committee heard about [informational report](#)
11 (BOT 21-I-24) that has been provided to this House. [Informational report](#) (BOT 09-I-23)
12 was also provided at last year's Interim Meeting, and – as directed by policy – updates will
13 be provided annually. As outlined in its report, the Task Force has been working diligently
14 to carry out the directives adopted by this House. The Task Force has met virtually and
15 in-person and has tapped national experts and government officials to help examine key
16 issues for the Task Force to focus its efforts on – including legal issues, EMTALA, shield
17 laws, workforce, and education issues, and more.
18

19 In addition, testimony noted existing resources, including "[Know your State's Abortion](#)
20 [Laws](#)" guides for medical providers from the Abortion Defense Network. These guides
21 align with the ask in Resolution 207 that our AMA publish state specific guidance about
22 the legal boundaries of state abortion laws. Our AMA has supported the development of
23 these resources and a hotline for medical professionals to ask additional questions about
24 the current state of the law, seek individualized legal advice, or find representation in civil
25 or criminal cases. Our AMA is also in the process of conducting research and producing
26 resources on the impact of abortion laws on the physician workforce and on strategy and
27 message development. The Task Force is in the process of developing additional
28 deliverables as well.
29

30 Your Reference Committee heard testimony that opposed requiring the Task Force to
31 operate for a certain number of years and an amendment was offered to strike the second
32 resolved clause accordingly. The testimony emphasized that it would be premature to
33 extend the Task Force mandate to 2029 and that such a directive would be overly
34 prescriptive. Your Reference Committee agrees that the Task Force should be able to
35 continue its important work and that a timeline for the Task Force should be evaluated at
36 a later time after the Task Force has reported on its progress. Therefore, your Reference
37 Committee recommends that Resolution 207 be adopted as amended.

1 (13) RESOLUTION 208 — MEDICARE PART B
2 ENROLLMENT AND PENALTY AWARENESS

3
4 RECOMMENDATION A:

5
6 Madam Speaker, your Reference Committee recommends
7 that the fourth resolve of Resolution 208 be deleted.

8
9 ~~RESOLVED, that our AMA explore with AARP and other~~
10 ~~interested organizations a mechanism for auto enrollment in~~
11 ~~Medicare Part B for those who take Social Security benefits~~
12 ~~before age 65 that would include additional premium~~
13 ~~support for those making less than \$1,000 in monthly Social~~
14 ~~Security benefits. (Directive to Take Action)~~

15
16 RECOMMENDATION B:

17
18 Madam Speaker, your Reference Committee recommends
19 that Resolution 208 be adopted as amended.

20
21 **HOD ACTION: Resolution 208 adopted as amended.**

22
23 RESOLVED, that our American Medical Association review the current penalties for
24 declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services
25 (CMS), and advocate for changes to improve awareness of the risk and financial burdens
26 associated with discontinuing coverage before reaching age 65 (Directive to Take Action);
27 and be it further

28
29 RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist
30 for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in
31 insurance coverage or permanent increases in Part B premiums (Directive to Take Action);
32 and be it further

33
34 RESOLVED, that our AMA advocate for enhanced public awareness regarding the risks
35 of not enrolling in Medicare Part B, and support making information about these risks more
36 accessible and widely available to prevent lifetime penalties (Directive to Take Action);
37 and be it further

38
39 RESOLVED, that our AMA explore with AARP and other interested organizations a
40 mechanism for auto enrollment in Medicare Part B for those who take Social Security
41 benefits before age 65 that would include additional premium support for those making
42 less than \$1,000 in monthly Social Security benefits. (Directive to Take Action)

43
44 Your Reference Committee heard mostly supportive testimony on Resolution 208. Your
45 Reference Committee heard testimony that emphasized the need to increase awareness
46 and simplify Medicare Part B enrollment to prevent lifelong penalties and support for
47 seniors receiving necessary healthcare coverage. Testimony noted that the current
48 Medicare enrollment process is complex and that penalties for late enrollment can place
49 significant financial strain on seniors, especially those with limited incomes. An
50 amendment was offered stemming from concerns about the legal and logistical

1 complexities of auto-enrolling individuals in a program that requires premium payments,
2 as this could unintentionally impact financial autonomy and create additional costs for
3 those not wishing to participate. Your Reference Committee heard that our AMA's
4 framework for auto-enrollment advocacy has historically been aligned with Medicaid
5 programs, where individuals are auto-enrolled only if they are eligible for coverage options
6 that come at no cost to them after the application of subsidies, as exemplified in AMA
7 Policy H-165.823, Options to Maximize Coverage under the AMA Proposal for Reform.
8 Therefore, your Reference Committee recommends that Resolution 208 be adopted as
9 amended.

10
11
12 (14) RESOLUTION 210 — LASER SURGERY

13
14 RECOMMENDATION A:

15
16 Madam Speaker, your Reference Committee recommends
17 that the first resolve of Resolution 210 be amended by
18 addition and deletion to read as follows:

19
20 RESOLVED, that our American Medical Association amend
21 policy H-475.989, "Laser Surgery" to read that laser surgery
22 should be performed only by individuals licensed to practice
23 medicine and surgery or by those categories of practitioners
24 appropriately trained licensed physicians or by individuals
25 who are appropriately trained, under the supervision of a
26 physician. and currently licensed by the state to perform
27 surgical services (Modify Current HOD Policy); and be it
28 further

29
30 RECOMMENDATION B:

31
32 Madam Speaker, your Reference Committee recommends
33 that Resolution 210 be adopted as amended.

34
35 **HOD ACTION: Resolution 210 referred.**

36
37 RESOLVED, that our American Medical Association amend policy H-475.989, "Laser
38 Surgery" to read that laser surgery should be performed only by individuals licensed to
39 practice medicine and surgery or by those categories of practitioners appropriately trained
40 and currently licensed by the state to perform surgical services (Modify Current HOD
41 Policy); and be it further

42
43 RESOLVED, that our AMA amend policy H-475.980 Addressing Surgery Performed by
44 Optometrists to read:

- 45
46 1. Our AMA will support legislation prohibiting optometrists from performing surgical
47 procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-
48 475.989 H-475.988, "Laser Surgery."
49

1 2. Our AMA encourages state medical associations to support state legislation and
 2 rulemaking prohibiting optometrists from performing surgical procedures as
 3 defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-~~
 4 ~~475.988~~, "Laser Surgery". (Modify Current HOD Policy)
 5

6 Your Reference Committee heard testimony in support of Resolution 210, however
 7 several amendments were offered. One amendment aimed to clarify that only licensed
 8 physicians are considered appropriately trained clinicians licensed by the state to perform
 9 surgical services. Your Reference Committee believes that this amendment creates
 10 redundancy within policy H-475.989, which already specifies that "laser surgery should be
 11 performed only by individuals licensed to practice medicine and surgery." Another
 12 amendment, recognizing that Resolution 210 was proposed with ophthalmology in mind,
 13 suggested specifying that policy H-475.989 only applies to laser surgery "of the eyeball."
 14 However, because policy H-475.989 was crafted to apply to all forms of laser surgery,
 15 your Reference Committee believes that this amendment would inappropriately narrow its
 16 scope. A final amendment proposed specifying that laser surgery may be performed by
 17 "appropriately trained licensed physicians or individuals appropriately trained and under
 18 the supervision of a physician." Your Reference Committee understands that laser surgery
 19 is used by many different medical specialties and that some non-physicians practicing on
 20 physician-led teams within certain specialties may be trained to perform laser surgery
 21 under the supervision of a physician. This amendment avoids redundancy and aligns with
 22 the intent of the existing policy while creating safeguards to ensure and clarify that AMA
 23 can only support laser surgery done by non-physicians if the individual is appropriately
 24 trained and practicing on a physician-led team. Therefore, your Reference Committee
 25 recommends that Resolution 210 be adopted as amended.
 26
 27

28 (15) RESOLUTION 211 — WATER BEAD INJURIES

29
 30 RECOMMENDATION A:

31
 32 Madam Speaker, your Reference Committee recommends
 33 that the second resolve of Resolution 211 be amended by
 34 deletion to read as follows:
 35

36 RESOLVED, that our AMA ~~continue to~~ urge Congress to
 37 enact legislation to classify water bead products as banned
 38 hazardous items to protect consumers, particularly children,
 39 from associated risks (New HOD Policy); and be it further
 40

41 RECOMMENDATION B:

42
 43 Madam Speaker, your Reference Committee recommends
 44 that Resolution 211 be adopted as amended.
 45

46 **HOD ACTION: Resolution 211 adopted as amended.**

47
 48 RESOLVED, that our American Medical Association urge the U.S. Consumer Product
 49 Safety Commission (CPSC) to promptly promulgate and enforce stringent performance

1 and labeling requirements for water bead toys and toys containing water beads to
2 effectively mitigate associated health hazards (New HOD Policy); and be it further

3
4 RESOLVED, that our AMA continue to urge Congress to enact legislation to classify water
5 bead products as banned hazardous items to protect consumers, particularly children,
6 from associated risks (New HOD Policy); and be it further

7
8 RESOLVED, that our AMA encourage businesses that sell gel blasters to make
9 appropriate and safe protective eye wear available and encourage its use to their
10 customers and to distribute educational materials on the safe use of gel guns (New HOD
11 Policy); and be it further

12
13 RESOLVED, that our AMA advocate for the development of national safety standards for
14 gel blasters that include requirements for product design modifications such as lower
15 velocity limits, safer projectile designs, or integrated safety mechanisms to reduce the risk
16 of eye injuries. (Directive to Take Action)

17
18 Your Reference Committee heard strong testimony in support of Resolution 211. Your
19 Reference Committee heard that water beads can be dangerous for children and have the
20 potential to cause significant damage if they expand inside the body after ingestion,
21 inhalation or insertion into ears, and can cause potential bowel obstruction, choking, or
22 other injuries. Testimony also noted the significant dangers associated with water beads
23 being used as projectiles, including eye injuries. Your Reference Committee heard that
24 adoption of Resolution 211 would be a welcome addition to our AMA's broad range of
25 public health policies, especially with respect to protecting children and young adults. An
26 amendment was proposed to correct a misstatement in the second resolve with respect
27 to our AMA continuing to support pending legislation in Congress that would classify water
28 bead products as banned hazardous items, but our AMA has not supported such
29 legislation; your Reference Committee agrees with this amendment. Therefore, your
30 Reference Committee recommends that Resolution 211 be adopted as amended.

1 (16) RESOLUTION 212 — ADDRESSING THE
2 UNREGULATED BODY BROKERAGE INDUSTRY
3

4 RECOMMENDATION A:
5

6 Madam Speaker, your Reference Committee recommends
7 that Resolution 212 be amended by addition and deletion
8 read as follows:
9

10 Our AMA: (1) recognizes the need for ethical, transparent,
11 and consistent body and body part donation regulations; (2)
12 will support collaborate with interested organizations to
13 actively advocate for the passage of federal legislation to
14 provide necessary minimum standards, oversight, and
15 authority over body broker entities that receive donated
16 human bodies and body parts for education and research;
17 (3) will develop model state legislation to provide necessary
18 minimum standards, oversight, and authority over body
19 broker entities that receive donated human bodies and body
20 parts for education and research; and (4) encourages state
21 medical societies to advocate for legislation or regulations
22 in their state that are consistent with the AMA model state
23 legislation. (Modify Current HOD Policy)
24

25 RECOMMENDATION B:
26

27 Madam Speaker, your Reference Committee recommends
28 that Resolution 212 be adopted as amended.
29

30 **HOD ACTION: Resolution 212 referred.**
31

32 RESOLVED, that our American Medical Association amend existing policy H-460.890,
33 "Improving Body Donation Regulation," by addition to read as follows:
34

35 Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body
36 part donation regulations-; (2) will collaborate with interested organizations to actively
37 advocate for the passage of federal legislation to provide necessary minimum standards,
38 oversight, and authority over body broker entities that receive donated human bodies and
39 body parts for education and research; (3) will develop model state legislation to provide
40 necessary minimum standards, oversight, and authority over body broker entities that
41 receive donated human bodies and body parts for education and research; and (4)
42 encourages state medical societies to advocate legislation or regulations in their state that
43 are consistent with the AMA model state legislation. (Modify Current HOD Policy)
44

45 Your Reference Committee heard strong supportive testimony on Resolution 212.
46 Testimony highlighted current gaps in federal and state oversight that allow body brokers
47 to operate with minimal accountability, raising significant ethical concerns and public
48 health risks. Testimony strongly supported our AMA's role in aiding states in enforcing
49 minimum standards that would prevent the misuse and exploitation of donor bodies.
50 Testimony particularly addressed the unregulated practices of non-living tissue body

1 banks. A minor amendment was offered to support the passage of federal legislation to
2 broaden our AMA's advocacy on this issue. Therefore, your Reference Committee
3 recommends that Resolution 212 be adopted as amended.

4
5
6 (17) RESOLUTION 213 — SUSTAINABLE LONG-TERM
7 FUNDING FOR CHILD PSYCHIATRY ACCESS
8 PROGRAMS

9
10 RECOMMENDATION A:

11
12 Madam Speaker, your Reference Committee recommends
13 that Resolution 213 be amended by addition and deletion to
14 read as follows:

15
16 RESOLVED, that our American Medical Association
17 advocate that the federal government work to achieve
18 adequate and sustained funding for of access to child
19 psychiatry consultation programs, ~~such as Child Psychiatry~~
20 ~~Access Programs and Pediatric Mental Health Care Access~~
21 ~~Program.~~ (Directive to Take Action)

22
23 RECOMMENDATION B:

24
25 Madam Speaker, your Reference Committee recommends
26 that Resolution 213 be adopted as amended.

27
28 **HOD ACTION: Resolution 213 adopted as amended.**

29
30 RESOLVED, that our American Medical Association advocate that the federal government
31 work to achieve adequate sustained funding of child psychiatry consultation programs,
32 such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access
33 Program. (Directive to Take Action)

34
35 Your Reference Committee heard testimony in support of Resolution 213. Your Reference
36 Committee heard that the Child Psychiatry Access Programs (CPAP) model helps to meet
37 the needs of, and support primary care providers in, managing pediatric patients with
38 psychiatric illnesses. Testimony noted that despite strong efforts to increase the number
39 of child and adolescent psychiatrists, the demand exceeds the supply. Your Reference
40 Committee heard that due to the success of CPAPs, Health Resources and Services
41 Administration (HRSA) issued several grants for states to develop and implement these
42 programs, however, it was noted that funding will run out for many states in 2026. Your
43 Reference Committee also heard that Resolution 213 should be adopted with an
44 amendment to delete reference to specific programs funded under discretionary
45 appropriations and to make the language broader to provide flexibility to support more
46 comprehensive physician workforce policy and to prevent conflicts with efforts to increase
47 residency slots in mental health. Your Reference Committee agrees that the proffered
48 amendment would provide more flexibility to AMA staff in working with Congress and
49 should be adopted. Therefore, your Reference Committee recommends that Resolution
50 213 be adopted as amended.

1 (18) RESOLUTION 214 — ADVOCATING FOR EVIDENCE-
2 BASED STRATEGIES TO IMPROVE RURAL
3 OBSTETRIC HEALTH CARE AND ACCESS
4

5 RECOMMENDATION A:
6

7 Madam Speaker, your Reference Committee recommends
8 that third resolve of Resolution 214 be amended by addition
9 and deletion to read as follows:
10

11 RESOLVED, that our AMA encourages academic medical
12 centers and health systems to actively participate in
13 obstetric telementoring/teleconsultation models to support
14 rural physicians and nonphysician practitioners who provide
15 obstetric care as part of a physician-led team advanced
16 practice providers and improve perinatal health outcomes in
17 rural communities (New HOD Policy); and be it further
18

19 RECOMMENDATION B:
20

21 Madam Speaker, your Reference Committee recommends
22 that Resolution 214 be adopted as amended.
23

24 **HOD ACTION: Resolution 214 adopted as amended.**
25

26 RESOLVED, that our American Medical Association strongly supports federal legislation
27 that provides funding for the creation and implementation of a national obstetric
28 emergency training program for rural health care facilities with and without a dedicated
29 labor and delivery unit (New HOD Policy); and be it further
30

31 RESOLVED, that our AMA supports the expansion and implementation of innovative
32 obstetric telementoring/teleconsultation models to address perinatal health disparities and
33 improve access to evidence-informed perinatal care in rural communities (New HOD
34 Policy); and be it further
35

36 RESOLVED, that our AMA encourages academic medical centers and health systems to
37 actively participate in obstetric telementoring/teleconsultation models to support rural
38 physicians and advanced practice providers and improve perinatal health outcomes in
39 rural communities (New HOD Policy); and be it further
40

41 RESOLVED, that our AMA supports ongoing research to evaluate the effectiveness of
42 national implementation of obstetric telementoring/teleconsultation models to improve
43 rural perinatal health outcomes and reduce rural-urban health disparities (New HOD
44 Policy).
45

46 Your Reference Committee heard strong supportive testimony in favor of Resolution 214.
47 Your Reference Committee heard that patients may seek obstetric care in a number of
48 non-obstetric settings and therefore, it is important to ensure that the larger physician
49 workforce, especially those physicians who are often required to provide prenatal and
50 postpartum care in rural facilities, are trained and prepared to provide this medical care.

1 Testimony also noted that in many rural areas that lack regular and reliable access to
2 physician specialists and subspecialists, non-specialist physicians must manage this care
3 and thus need access to teleconsultations. Your Reference Committee also heard that
4 this Resolution aligns with ongoing AMA advocacy in this space and that our AMA put out
5 maternal health recommendations to Congress and the Administration acknowledging the
6 importance of increased training and access to teleconsultations within the context of a
7 physician led team. However, your Reference Committee also heard about the importance
8 of aligning the terminology that we use for nonphysician practitioners with our policy
9 compendium. Further testimony noted the importance of ensuring that this care takes
10 place as part of a physician led team. Therefore, your Reference Committee recommends
11 that Resolution 214 be adopted as amended.
12

13
14 (19) RESOLUTION 216 — CLEARING FEDERAL
15 OBSTACLES FOR SUPERVISED INJECTION SITES

16
17 RECOMMENDATION A:

18
19 Madam Speaker, your Reference Committee recommends
20 that Resolution 216 be amended by addition and deletion to
21 read as follows:
22

23 RESOLVED, that our American Medical Association
24 advocate for elimination of federal obstacles policies that
25 empower states to determine the legality of to the
26 development of overdose prevention sites supervised
27 injection facilities (SIFs).
28

29 RECOMMENDATION B:

30
31 Madam Speaker, your Reference Committee recommends
32 that Resolution 216 be adopted as amended.
33

34 RECOMMENDATION C:

35
36 Madam Speaker, your Reference Committee recommends
37 that the title of Resolution 216 be changed to read as
38 follows:
39

40 **CLEARING FEDERAL OBSTACLES FOR OVERDOSE**
41 **PREVENTION SITES**

42
43 **HOD ACTION: Resolution 216 adopted as amended with a**
44 **change of title.**
45

46 **CLEARING FEDERAL OBSTACLES FOR OVERDOSE**
47 **PREVENTION SITES**

1 RESOLVED, that our American Medical Association advocate for federal policies that
2 empower states to determine the legality of supervised injection facilities (SIFs). (Directive
3 to Take Action)
4

5 Your Reference Committee heard mixed testimony on Resolution 216. Your Reference
6 Committee heard that it is important to help remove barriers to more states being able to
7 implement a pilot overdose prevention site. Testimony noted that decisions about
8 overdose prevention sites should be left to the states and that the federal government
9 should not be able to dictate the existence of these sites. Additional testimony noted that
10 these sites are an important harm reduction measure, and that this resolution addresses
11 a gap in existing AMA policy. However, one commentator suggested that adopting the
12 resolution would create the appearance of AMA suggesting that illicit drug use can be
13 done safely. Nevertheless, significantly more testimony was in favor of the resolution.
14 Moreover, an amendment was offered that suggested a change in terminology from
15 “supervised injection facility” to “overdose prevention site.” Therefore, your Reference
16 Committee recommends that Resolution 216 be adopted as amended.
17

18
19 (20) RESOLUTION 222 — ROLLBACK ON PHYSICIAN
20 PERFORMANCE MEASURES

21
22 RECOMMENDATION A:

23
24 Madam Speaker, your Reference Committee recommends
25 that the first resolve of Resolution 222 be amended by
26 addition and deletion to read as follows:
27

28 RESOLVED, that our American Medical Association will
29 continue to advocate ~~make public statements calling for a~~
30 removal of any/all unproven outcomes measures and
31 associated mandates placed on physicians, practices,
32 licensed clinics, nursing homes, hospitals and other places
33 of healthcare (Directive to Take Action); and be it further
34

35 RECOMMENDATION B:

36
37 Madam Speaker, your Reference Committee recommends
38 that the second resolve of Resolution 222 be amended by
39 addition and deletion to read as follows:
40

41 RESOLVED, that our AMA will support ~~seek~~ legislation or
42 regulation removing any/all unproven outcomes measures
43 and associated mandates placed on physicians, practices,
44 licensed clinics, nursing homes, hospitals and other places
45 of healthcare (Directive to Take Action); and be it further

1 RECOMMENDATION C:
2

3 Madam Speaker, your Reference Committee recommends
4 that the third resolve of Resolution 222 be deleted.

5
6 ~~RESOLVED, that our AMA will include the following action~~
7 ~~on a national level, including but not limited to:~~

8
9 ~~-AMA statements calling for a removal of any/all unproven~~
10 ~~outcomes measures and associated mandates placed on~~
11 ~~physicians, practices, licensed clinics, nursing homes,~~
12 ~~hospitals and other places of healthcare; and legislation and~~
13 ~~regulation seeking the same, and~~

14
15 ~~-AMA seeking legislation or regulation mandating the~~
16 ~~removal of any/all unproven outcomes measures and~~
17 ~~associated mandates placed on physicians, practices,~~
18 ~~licensed clinics, nursing homes, hospitals and other places~~
19 ~~of healthcare. (Directive to Take Action)~~

20
21 RECOMMENDATION D:
22

23 Madam Speaker, your Reference Committee recommends
24 that Resolution 222 be adopted as amended.

25
26 **HOD ACTION: Resolution 222 adopted as amended.**
27

28 RESOLVED, that our American Medical Association will make public statements calling
29 for a removal of any/all unproven outcomes measures and associated mandates placed
30 on physicians, practices, licensed clinics, nursing homes, hospitals and other places of
31 healthcare (Directive to Take Action); and be it further

32
33 RESOLVED, that our AMA will seek legislation or regulation removing any/all unproven
34 outcomes measures and associated mandates placed on physicians, practices, licensed
35 clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action);
36 and be it further

37
38 RESOLVED, that our AMA will include the following action on a national level, including
39 but not limited to:

40
41 -AMA statements calling for a removal of any/all unproven outcomes measures and
42 associated mandates placed on physicians, practices, licensed clinics, nursing homes,
43 hospitals and other places of healthcare; and legislation and regulation seeking the same,
44 and

45
46 -AMA seeking legislation or regulation mandating the removal of any/all unproven
47 outcomes measures and associated mandates placed on physicians, practices, licensed
48 clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)

1 Your Reference Committee heard support for Resolution 222. Your Reference Committee
2 heard that many existing performance measures lack scientific validation and burden
3 physicians without improving patient care. Testimony argued that these mandates often
4 redirect resources away from patient interaction. Further testimony noted that many
5 current measures for quality reporting do not accurately capture the true quality of patient
6 care. An amendment was offered that provided a more focused and strategic approach to
7 addressing concerns regarding unproven performance measures that negatively impact
8 physicians. The amendment captures our AMA's ongoing role in supporting legislative
9 efforts that address unproven performance measures in the Merit-based Incentive
10 Payment System (MIPS) and includes significant reforms, such as freezing performance
11 thresholds, eliminating punitive payment penalties, requiring timely quarterly feedback
12 from the Centers for Medicaid and Medicare Services, and simplifying reporting processes
13 to reduce administrative burdens on physicians. Therefore, your Reference Committee
14 recommends that Resolution 222 be adopted as amended.
15

16
17 (21) RESOLUTION 229 - SUPPORTING PENALTIES ON
18 INSURERS WHO FAIL TO PAY DOCTORS

19
20 RECOMMENDATION A:

21
22 Madam Speaker, your Reference Committee recommends
23 that Resolution 229 be amended by deletion to read as
24 follows:
25

26 RESOLVED, that our American Medical Association will
27 advocate for passage of legislation that imposes penalties
28 on insurers that fail to pay doctors within 30 days when
29 doctors win for a claim brought to the federal Independent
30 Dispute Resolution (IDR) process (~~i.e. No Surprises
31 Enforcement Act that has currently been introduced to the
32 U.S. House of Representatives~~).

33
34 RECOMMENDATION B:

35
36 Madam Speaker, your Reference Committee recommends
37 that Resolution 229 be adopted as amended.
38

39 **HOD ACTION: Resolution 229 adopted as amended.**

40
41 RESOLVED, that our American Medical Association will advocate for passage of
42 legislation that imposes penalties on insurers that fail to pay doctors within 30 days when
43 doctors win for a claim brought to the federal Independent Dispute Resolution (IDR)
44 process (i.e. No Surprises Enforcement Act that has currently been introduced to the U.S.
45 House of Representatives)
46

47 Your Reference Committee heard support for Resolution 229. Your Reference Committee
48 heard about the need for both Congress and the Administration to ensure that the
49 Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA)
50 functions as Congress intended. However, your Reference Committee heard that the

1 reference to specific legislation should be removed since the legislation referenced in the
2 Resolution has already been changed to the Enhanced Enforcement of Health Coverage
3 Act. Therefore, your Reference Committee recommends that Resolution 229 be adopted
4 as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- 1
2
3 (22) RESOLUTION 201 — BOARDING PATIENTS IN THE
4 EMERGENCY ROOM
5 RESOLUTION 230 — ADDRESSING AND REDUCING
6 PATIENT BOARDING IN EMERGENCY DEPARTMENTS
7

8 RECOMMENDATION:
9

10 Madam Speaker, your Reference Committee recommends
11 that Alternate Resolution 201 be adopted in lieu of
12 Resolutions 201 and 230.
13

14 **ADDRESSING AND REDUCING PATIENT BOARDING IN**
15 **EMERGENCY DEPARTMENTS**
16

17 RESOLVED, that our American Medical Association (AMA)
18 collaborate with interested parties, such as hospitals,
19 insurance companies, the Centers for Medicare & Medicaid
20 Services (CMS), and accrediting bodies such as the Joint
21 Commission, to address and reduce emergency department
22 boarding and overcrowding (Directive to Take Action); and
23 be it further
24

25 RESOLVED, that our AMA support appropriate staffing and
26 standards of care for all patients admitted to the hospital or
27 awaiting transfer, including emergency department patients
28 and admitted patients physically located in the emergency
29 department, to mitigate patient harm and physician burnout
30 (Directive to Take Action); and be it further
31

32 RESOLVED, that our AMA advocate for increased state and
33 federal assistance to address the systemic factors
34 contributing to emergency department boarding (Directive
35 to Take Action); and be it further
36

37 RESOLVED, that our AMA support other medical societies,
38 hospital associations, accrediting organizations, and patient
39 advocacy groups to raise awareness of the impacts of
40 emergency department boarding and to identify and
41 propose solutions (Directive to Take Action); and be it
42 further
43

44 RESOLVED, that our AMA will continue to monitor the
45 development of CMS quality measures related to patient
46 boarding and work in collaboration with relevant medical
47 specialty associations to support improvements in quality
48 standards related to emergency department care (Directive
49 to Take Action).

1 RESOLVED, that our AMA will report back to the House of
2 Delegates at the 2025 Interim Meeting on progress
3 addressing and reducing patient boarding in emergency
4 departments (Directive to Take Action).
5

6 **HOD ACTION: Alternate Resolution 201 adopted in lieu of**
7 **Resolutions 201 and 230.**
8

9 **RESOLUTION 201**

10 RESOLVED, that our American Medical Association immediately collaborate with
11 stakeholders such as hospitals, insurance companies, CMS, and joint commission to
12 resolve this issue (Directive to Take Action); and be it further
13

14 RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and
15 appropriate care for patients and the emergency room and those admitted but still
16 physically located in the emergency room to decrease patient harm and physician and
17 nurse burnout. (Directive to Take Action)
18

19 **RESOLUTION 230**

20 RESOLVED, that our American Medical Association strongly advocate that hospitals and
21 health systems prioritize strategies to reduce emergency department boarding (Directive
22 to Take Action); and be it further
23

24 RESOLVED, that our AMA advocate for increased state and federal funding to address
25 the underlying causes of emergency department boarding (Directive to Take Action); and
26 be it further
27

28 RESOLVED, that our AMA collaborate with other medical societies, hospital associations,
29 accrediting organizations, and patient advocacy groups to raise awareness about the
30 negative impacts of emergency department boarding and propose solutions (Directive to
31 Take Action); and be it further
32

33 RESOLVED, that our AMA encourage the inclusion of emergency department boarding
34 metrics in hospital quality measures and accreditation standards (New HOD Policy); and
35 be it further
36

37 RESOLVED, that our AMA will report back to the House of Delegates at the 2025 Annual
38 Meeting on progress addressing and reducing patient boarding in emergency departments
39 (Directive to Take Action).
40
41

42
43
44 Your Reference Committee heard testimony in support of the spirit of Resolutions 201 and
45 230. Your Reference Committee heard that boarding patients in emergency rooms is a
46 systemic problem that has a detrimental impact on both patients and physicians. Multiple
47 amendments were offered. Additional testimony highlighted concerns about prescriptive
48 staffing ratios and offered amendments to negate this issue. Testimony stressed that
49 boarding patients in emergency rooms is an emergent problem that harms patients and
50 contributes to physician burnout. Testimony also supported the joint consideration of

1 Resolution 201 and Resolution 230 given their similarities and a well-supported Alternate
2 Resolution was offered that combined the content in both Resolutions. Therefore, your
3 Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of
4 Resolutions 201 and 230.

RECOMMENDED FOR REFERRAL

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

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 3 be referred.

HOD ACTION: Board of Trustees Report 3 referred.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed.

1. That our American Medical Association reaffirm AMA Policies H-140.861, “Physicians Self-Referral,” D-270.995, “Physician Ownership and Referral for Imaging Services,” and H-385.914, “Stark Law and Physician Compensation,” be reaffirmed. (Reaffirm HOD Policy)
2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 3. Your Reference Committee heard that the Stark law has contributed to creating an uneven playing field for physician practices who must go to great lengths to avoid violating the Stark law’s prohibition on self-referral. Other testimony noted that the Report should go further to remove burdens on physician practices that large, consolidated entities do not face. Testimony recommended referral for stronger support to eliminate the Stark law’s unfair barrier to competition on physician practices. Therefore, your Reference Committee recommends that Board of Trustees Report 3 be referred.

(24) RESOLUTION 226 — INFORMATION BLOCKING RULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 226 be referred.

HOD ACTION: Resolution 226 referred.

RESOLVED, that our American Medical Association supports the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy); and be it further

1 RESOLVED, that our AMA supports the requirement of review of report and result
2 information by the ordering physician or physician surrogate prior to release of medical
3 information to the patient (New HOD Policy); and be it further

4
5 RESOLVED, that our AMA supports expansion of the harm exception to the Information
6 Blocking Rule to include harassment or potential harm of medical staff or others (New
7 HOD Policy); and be it further

8
9 RESOLVED, that our AMA advocates for expansions to the harm exception to the
10 Information Blocking Rule and for the requirement of review by the ordering physician or
11 surrogate prior to the application of the Information Blocking Rule provisions. (Directive to
12 Take Action).

13
14 Your Reference Committee heard mixed testimony on Resolution 226. Testimony
15 indicated that any limits on patients' access to their medical records must be undertaken
16 only at the request of the patient to avoid violation of the HIPAA patient right of access
17 and the Information Blocking Rules. However, testimony also noted that requiring
18 physician review of every result would unnecessarily increase physician burden.
19 Testimony emphasized the need to differentiate between delay of normal results versus
20 abnormal results with serious implications. Some testimony opposed the delay of results
21 only when directed by a patient. Your Reference Committee believes that given the level
22 of complexity and variety of concerns heard throughout testimony, further study is the
23 most appropriate course of action to sufficiently address this issue. Therefore, your
24 Reference Committee recommends that Resolution 226 be referred.

1 **RECOMMENDED FOR REFERRAL FOR DECISION**

2
3 (25) **RESOLUTION 228 – CODIFICATION OF THE CHEVRON**
4 **DEFERENCE DOCTRINE**

5
6 **RECOMMENDATION:**

7
8 Madam Speaker, your Reference Committee recommends
9 that Resolution 228 be referred for decision.

10
11 **HOD ACTION: Resolution 228 referred.**

12
13 **RESOLVED**, that our American Medical Association support codification of the Chevron
14 deference doctrine at the federal and state levels, which would:

- 15
16 a. generally leave reasonable interpretation of ambiguous regulatory statutes to the
17 purview of the executive branch, including agencies comprised of scientific and medical
18 experts evaluating robust evidence and
19
20 b. generally prioritize legislative oversight and modification of ambiguous regulatory
21 statutes and agency rules, instead of deferring to the judicial branch for this function.

22
23 Your Reference Committee heard mixed testimony on Resolution 228. In support, your
24 Reference Committee heard that in June 2024, the U.S. Supreme Court overturned the
25 40-year-old Chevron Deference Doctrine, under which courts would defer to Agency
26 interpretation of ambiguous legislation. Moreover, your Reference Committee heard that
27 healthcare, public health, scientific, and technological regulations are best left to subject-
28 matter and technical experts within the Agencies. Further testimony was heard that noted
29 that the demise of Chevron sets a dangerous precedent for the gradual erosion of
30 regulations governing environmental, healthcare, public health, and civil rights policy.
31 Testimony noted that this legal change could threaten our AMA’s advocacy on a myriad
32 of healthcare and public health priorities.

33
34 However, your Reference Committee also heard that this resolution could have negative
35 consequences for our AMA’s advocacy efforts. Your Reference Committee heard that the
36 Supreme Court’s decision may present opportunities for our AMA to challenge certain
37 regulations, especially under Medicare, that negatively impact physician payment. Further
38 testimony noted that our AMA is currently examining various regulations where legal
39 challenges might be possible. Your Reference Committee heard that calling for the
40 codification of the Chevron Deference Doctrine is too vague since Chevron deference is
41 a judicial doctrine, not a legislative mandate, and codifying “deference” itself seems to
42 contradict its purpose. . Your Reference Committee also heard concerns that establishing
43 a statutory requirement that ambiguous statutes should always be decided by Executive
44 Branch Agencies could result in unchecked Executive authority, which might not align with
45 our AMA’s advocacy in opposition to certain Agency interpretations or implementation of
46 rules.

47
48 Your Reference Committee considered testimony that offered alternative language than
49 what is in the resolution, as well as testimony raising concerns that adopting Resolution
50 228 would have significant implications for our AMA’s advocacy agenda and strategy.

1 Your Reference Committee agrees with testimony that our Board is in a better position to
2 weigh the pros and cons of this resolution and should be referred for study or referred for
3 decision. Having heard testimony that this issue is urgent, your Reference Committee
4 recommends that a referral for decision would be a more expedient way to address this
5 matter. Therefore, your Reference Committee recommends that Resolution 228 be
6 referred for decision.

RECOMMENDED FOR NOT ADOPTION

(26) RESOLUTION 221 — MEDICARE COVERAGE FOR
NON-PAR PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that Resolution 221 not be adopted.

HOD ACTION: Resolution 221 not adopted.

RESOLVED, that our American Medical Association support federal legislation that would provide Medicare enrollees with the ability to receive partial reimbursement towards the cost of receiving treatment from the physician of their choice, regardless of whether that physician participates in Medicare. (New HOD Policy)

Your Reference Committee heard considerable testimony in opposition to Resolution 221. Your Reference Committee heard support for the intent to increase patient choice, but testimony raised concerns about potential redundancy with existing policies. Additional testimony noted that our AMA already has policies supporting patient choice, including the Medicare Patient Empowerment Act, and recommended that our AMA continue our advocacy with our existing policies rather than adopting new ones. Further testimony expressed opposition based on Medicare's current allowances for non-participating providers, and noted concerns that the resolution may not reflect current Medicare rules and limits around non-PAR physician reimbursement, as outlined by CMS. For additional information on this issue please see our AMA's [Medicare Participation Options Toolkit](#) and our AMA's [Medicare Participation Guide](#), and our AMA's [Frequently Asked Questions Regarding Medicare Participation Options](#). Therefore, your Reference Committee recommends that Resolution 221 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(27) RESOLUTION 215 — ADVOCATING FOR FEDERAL
AND STATE INCENTIVES FOR RECRUITMENT AND
RETENTION OF PHYSICIANS TO PRACTICE IN RURAL
AREAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that AMA policies H-465.988, H-465.981, H-305.925, and
D-305.958 be reaffirmed in lieu of Resolution 215.

**HOD ACTION: AMA policies H-465.988, H-465.981, H-
305.925, and D-305.958 reaffirmed in lieu of Resolution 215.**

RESOLVED, that our American Medical Association advocate for increased federal and
state funding for loan forgiveness for physicians who commit to practice and reside in rural
and underserved areas for a meaningful period of time (Directive to Take Action); and be
it further

RESOLVED, that our AMA urge Congress and State legislatures to establish retention
bonus programs for physicians who maintain practice in rural areas for extended periods,
with increasing bonuses for longer commitments (Directive to Take Action); and be it
further

RESOLVED, that our AMA advocate for the expansion and sustainable funding of
residency and graduate medical education slots in rural areas, as well as opportunities for
exposure to rural health care such as through clinical rotations in rural areas, to increase
the likelihood of physicians practicing in these communities after training. (Directive to
Take Action)

Your Reference Committee heard mixed testimony on Resolution 215. Your Reference
Committee heard that it is extremely important to ensure that physicians who work in rural
and underserved communities are properly supported and provided with the resources
necessary to practice in these communities. Testimony noted the cost of medical school
and the importance of loan forgiveness programs as well as the need to ensure that
medical students and residents are provided rotations and residency positions in rural
communities to help build a connection to the work and ensure that these areas have
access to physicians. However, your Reference Committee also heard that our AMA has
consistently advocated for additional loan forgiveness avenues and increased funding for
residency slots. Testimony also highlighted that our AMA is consistently advocating for
sustainable working environments for physicians across the board, including those that
practice in rural areas. This advocacy includes requests for proper payment, access to
needed resources, pipeline programs and more. Additionally, your Reference Committee
heard that more providers are needed in the Indian Health Service and notes that our AMA
recently passed policy that addresses helping to create sustainable pipelines for
physicians in the Indian Health Service. Your Reference Committee also notes that our
AMA has actively worked on this issue and has sent multiple advocacy letters out on this
topic. (See some of our AMA advocacy work on this topic [here](#), [here](#), [here](#), [here](#), [here](#),

1 [here](#), [here](#), and [here](#)). Further testimony noted that Resolution 215 is already abundantly
2 covered by existing AMA policy and advocacy work. Therefore, your Reference
3 Committee recommends that existing AMA policies H-465.988, H-465.981, H-305.925,
4 and D-305.958 be reaffirmed in lieu of Resolution 215.

5
6 [H-465.988 - Educational Strategies for Meeting Rural Health Physician Shortage](#)

7
8 1. In light of the data available from the current literature as well as ongoing studies
9 being conducted by staff, our American Medical Association recommends that:

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

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

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

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

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

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

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

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

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

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

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

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

48 2. Our AMA will work with state and specialty societies, medical schools, teaching
49 hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the
50 Centers for Medicare and Medicaid Services (CMS) and other interested

1 stakeholders to identify, encourage and incentivize qualified rural physicians to
2 serve as preceptors and volunteer faculty for rural rotations in residency.

3 3. Our AMA will:

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

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

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

13 5. Our AMA will encourage adding educational webinars, workshops and other
14 didactics via remote learning formats to enhance the educational needs of smaller
15 training programs.

16
17 [H-465.981 - Enhancing Rural Physician Practices](#)

18
19 1. Our American Medical Association supports legislation to extend the 10%
20 Medicare payment bonus to physicians practicing in rural counties and other areas
21 where the poverty rate exceeds a certain threshold, regardless of the areas' Health
22 Professional Shortage Area (HPSA) status.

23 2. Our AMA encourages federal and state governments to make available low
24 interest loans and other financial assistance to assist physicians with shortage
25 area practices in defraying their costs of compliance with requirements of the
26 Occupational Safety and Health Administration, Americans with Disabilities Act
27 and other national or state regulatory requirements.

28 3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory
29 changes necessary to establish a waiver process through which shortage area
30 practices can seek exemption from specific elements of regulatory requirements
31 when improved access, without significant detriment to quality, will result.

32 4. Our AMA supports legislation that would allow shortage area physician practices
33 to qualify as Rural Health Clinics without the need to employ one or more physician
34 extenders.

35 5. Our AMA will undertake a study of structural urbanism, federal payment policies,
36 and the impact on rural workforce disparities.

37
38 [H-305.925 - Principles of and Actions to Address Medical Education Costs and](#)
39 [Student Debt](#)

40
41 The costs of medical education should never be a barrier to the pursuit of a career
42 in medicine nor to the decision to practice in a given specialty. To help address
43 this issue, our American Medical Association (AMA) will:

44 1. Collaborate with members of the Federation and the medical education
45 community, and with other interested organizations, to address the cost of medical
46 education and medical student debt through public- and private-sector advocacy.

47 2. Vigorously advocate for and support expansion of and adequate funding for
48 federal scholarship and loan repayment programs--such as those from the
49 National Health Service Corps, Indian Health Service, Armed Forces, and
50 Department of Veterans Affairs, and for comparable programs from states and the

- 1 private sector--to promote practice in underserved areas, the military, and
2 academic medicine or clinical research.
- 3 3. Encourage the expansion of National Institutes of Health programs that provide
4 loan repayment in exchange for a commitment to conduct targeted research.
- 5 4. Advocate for increased funding for the National Health Service Corps Loan
6 Repayment Program to assure adequate funding of primary care within the
7 National Health Service Corps, as well as to permit:
 - 8 a. inclusion of all medical specialties in need, and
 - 9 b. service in clinical settings that care for the underserved but are not
10 necessarily located in health professions shortage areas.
- 11 5. Encourage the National Health Service Corps to have repayment policies that
12 are consistent with other federal loan forgiveness programs, thereby decreasing
13 the amount of loans in default and increasing the number of physicians practicing
14 in underserved areas.
- 15 6. Work to reinstate the economic hardship deferment qualification criterion known
16 as the "20/220 pathway," and support alternate mechanisms that better address
17 the financial needs of trainees with educational debt.
- 18 7. Advocate for federal legislation to support the creation of student loan savings
19 accounts that allow for pre-tax dollars to be used to pay for student loans.
- 20 8. Work with other concerned organizations to advocate for legislation and
21 regulation that would result in favorable terms and conditions for borrowing and for
22 loan repayment, and would permit 100% tax deductibility of interest on student
23 loans and elimination of taxes on aid from service-based programs.
- 24 9. Encourage the creation of private-sector financial aid programs with favorable
25 interest rates or service obligations (such as community- or institution-based loan
26 repayment programs or state medical society loan programs).
- 27 10. Support stable funding for medical education programs to limit excessive tuition
28 increases, and collect and disseminate information on medical school programs
29 that cap medical education debt, including the types of debt management
30 education that are provided.
- 31 11. Work with state medical societies to advocate for the creation of either tuition
32 caps or, if caps are not feasible, pre-defined tuition increases, so that medical
33 students will be aware of their tuition and fee costs for the total period of their
34 enrollment.
- 35 12. Encourage medical schools to:
 - 36 a. study the costs and benefits associated with non-traditional instructional
37 formats (such as online and distance learning, and combined
38 baccalaureate/MD or DO programs) to determine if cost savings to medical
39 schools and to medical students could be realized without jeopardizing the
40 quality of medical education;
 - 41 b. engage in fundraising activities to increase the availability of scholarship
42 support, with the support of the Federation, medical schools, and state and
43 specialty medical societies, and develop or enhance financial aid
44 opportunities for medical students, such as self-managed, low-interest loan
45 programs;
 - 46 c. cooperate with postsecondary institutions to establish collaborative debt
47 counseling for entering first-year medical students;
 - 48 d. allow for flexible scheduling for medical students who encounter financial
49 difficulties that can be remedied only by employment, and consider creating
50 opportunities for paid employment for medical students;

- 1 e. counsel individual medical student borrowers on the status of their
- 2 indebtedness and payment schedules prior to their graduation;
- 3 f. inform students of all government loan opportunities and disclose the
- 4 reasons that preferred lenders were chosen;
- 5 g. ensure that all medical student fees are earmarked for specific and well-
- 6 defined purposes, and avoid charging any overly broad and ill-defined fees,
- 7 such as but not limited to professional fees;
- 8 h. use their collective purchasing power to obtain discounts for their
- 9 students on necessary medical equipment, textbooks, and other
- 10 educational supplies;
- 11 i. work to ensure stable funding, to eliminate the need for increases in
- 12 tuition and fees to compensate for unanticipated decreases in other
- 13 sources of revenue; mid-year and retroactive tuition increases should be
- 14 opposed.
- 15 13. Support and encourage state medical societies to support further expansion of
- 16 state loan repayment programs, particularly those that encompass physicians in
- 17 non-primary care specialties.
- 18 14. Take an active advocacy role during reauthorization of the Higher Education
- 19 Act and similar legislation, to achieve the following goals:
- 20 a. Eliminating the single holder rule.
- 21 b. Making the availability of loan deferment more flexible, including
- 22 broadening the definition of economic hardship and expanding the period
- 23 for loan deferment to include the entire length of residency and fellowship
- 24 training.
- 25 c. Retaining the option of loan forbearance for residents ineligible for loan
- 26 deferment.
- 27 d. Including, explicitly, dependent care expenses in the definition of the
- 28 "cost of attendance".
- 29 e. Including room and board expenses in the definition of tax-exempt
- 30 scholarship income.
- 31 f. Continuing the federal Direct Loan Consolidation program, including the
- 32 ability to "lock in" a fixed interest rate, and giving consideration to grace
- 33 periods in renewals of federal loan programs.
- 34 g. Adding the ability to refinance Federal Consolidation Loans.
- 35 h. Eliminating the cap on the student loan interest deduction.
- 36 i. Increasing the income limits for taking the interest deduction.
- 37 j. Making permanent the education tax incentives that our AMA
- 38 successfully lobbied for as part of Economic Growth and Tax Relief
- 39 Reconciliation Act of 2001.
- 40 k. Ensuring that loan repayment programs do not place greater burdens
- 41 upon married couples than for similarly situated couples who are
- 42 cohabitating.
- 43 l. Increasing efforts to collect overdue debts from the present medical
- 44 student loan programs in a manner that would not interfere with the
- 45 provision of future loan funds to medical students.
- 46 15. Continue to work with state and county medical societies to advocate for
- 47 adequate levels of medical school funding and to oppose legislative or regulatory
- 48 provisions that would result in significant or unplanned tuition increases.
- 49 16. Continue to study medical education financing, so as to identify long-term
- 50 strategies to mitigate the debt burden of medical students, and monitor the short-

1 and long-term impact of the economic environment on the availability of
2 institutional and external sources of financial aid for medical students, as well as
3 on choice of specialty and practice location.

4 17. Collect and disseminate information on successful strategies used by medical
5 schools to cap or reduce tuition.

6 18. Continue to monitor the availability of and encourage medical schools and
7 residency/fellowship programs to:

8 a. provide financial aid opportunities and financial planning/debt
9 management counseling to medical students and resident/fellow
10 physicians;

11 b. work with key stakeholders to develop and disseminate standardized
12 information on these topics for use by medical students, resident/fellow
13 physicians, and young physicians; and

14 c. share innovative approaches with the medical education community.

15 19. Seek federal legislation or rule changes that would stop Medicare and Medicaid
16 decertification of physicians due to unpaid student loan debt. Our AMA believes
17 that it is improper for physicians not to repay their educational loans, but assistance
18 should be available to those physicians who are experiencing hardship in meeting
19 their obligations.

20 20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA
21 supports increased medical student and physician participation in the program,
22 and will:

23 a. Advocate that all resident/fellow physicians have access to PSLF during
24 their training years.

25 b. Advocate against a monetary cap on PSLF and other federal loan
26 forgiveness programs.

27 c. Work with the United States Department of Education to ensure that any
28 cap on loan forgiveness under PSLF be at least equal to the principal
29 amount borrowed.

30 d. Ask the United States Department of Education to include all terms of
31 PSLF in the contractual obligations of the Master Promissory Note.

32 e. Encourage the Accreditation Council for Graduate Medical Education
33 (ACGME) to require residency/fellowship programs to include within the
34 terms, conditions, and benefits of program appointment information on the
35 employer's PSLF program qualifying status.

36 f. Advocate that the profit status of a physician's training institution not be
37 a factor for PSLF eligibility,

38 g. Encourage medical school financial advisors to counsel wise borrowing
39 by medical students, in the event that the PSLF program is eliminated or
40 severely curtailed.

41 h. Encourage medical school financial advisors to increase medical student
42 engagement in service-based loan repayment options, and other federal
43 and military programs, as an attractive alternative to the PSLF in terms of
44 financial prospects as well as providing the opportunity to provide care in
45 medically underserved areas.

46 i. Strongly advocate that the terms of the PSLF that existed at the time of
47 the agreement remain unchanged for any program participant in the event
48 of any future restrictive changes.

49 j. Monitor the denial rates for physician applicants to the PSLF.

1 k. Undertake expanded federal advocacy, in the event denial rates for
2 physician applicants are unexpectedly high, to encourage release of
3 information on the basis for the high denial rates, increased transparency
4 and streamlining of program requirements, consistent and accurate
5 communication between loan servicers and borrowers, and clear
6 expectations regarding oversight and accountability of the loan servicers
7 responsible for the program.

8 l. Work with the United States Department of Education to ensure that
9 applicants to the PSLF and its supplemental extensions, such as
10 Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are
11 provided with the necessary information to successfully complete the
12 program(s) in a timely manner.

13 m. Work with the United States Department of Education to ensure that
14 individuals who would otherwise qualify for PSLF and its supplemental
15 extensions, such as TEPSLF, are not disqualified from the program(s).

16 21. Advocate for continued funding of programs including Income-Driven
17 Repayment plans for the benefit of reducing medical student load burden.

18 22. Strongly advocate for the passage of legislation to allow medical students,
19 residents and fellows who have education loans to qualify for interest-free
20 deferment on their student loans while serving in a medical internship, residency,
21 or fellowship program, as well as permitting the conversion of currently
22 unsubsidized Stafford and Graduate Plus loans to interest free status for the
23 duration of undergraduate and graduate medical education.

24 23. Continue to monitor opportunities to reduce additional expense burden upon
25 medical students including reduced-cost or free programs for residency
26 applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed
27 at reducing non-educational debt.

28 24. Encourage medical students, residents, fellows and physicians in practice to
29 take advantage of available loan forgiveness programs and grants and
30 scholarships that have been historically underutilized, as well as financial
31 information and resources available through the Association of American Medical
32 Colleges and American Association of Colleges of Osteopathic Medicine, as
33 required by the Liaison Committee on Medical Education and Commission on
34 Osteopathic College Accreditation, and resources available at the federal, state
35 and local levels.

36 25. Support federal efforts to forgive debt incurred during medical school and other
37 higher education by physicians and medical students, including educational and
38 cost of attendance debt.

39 26. Support that residency and fellowship application services grant fee assistance
40 to applicants who previously received fee assistance from medical school
41 application services or are determined to have financial need through another
42 formal mechanism.

43
44 [D-305.958 - Increasing Graduate Medical Education Positions as a Component to](#)
45 [any Federal Health Care Reform Policy](#)

46
47 1. Our American Medical Association will ensure that actions to bolster the
48 physician workforce must be part of any comprehensive federal health care reform.

1 2. Our AMA will work with the Centers for Medicare and Medicaid Services to
2 explore ways to increase graduate medical education slots to accommodate the
3 need for more physicians in the US.

4 3. Our AMA will work actively and in collaboration with the Association of American
5 Medical Colleges and other interested stakeholders to rescind funding caps for
6 GME imposed by the Balanced Budget Act of 1997.

7 4. Our AMA will actively advocate for expanded funding for entry and continued
8 training positions in specialties and geographic regions with documented medical
9 workforce shortages.

10 5. Our AMA will lobby Congress to find ways to increase graduate medical
11 education funding to accommodate the projected need for more physicians.

12 6. Our AMA will work with key organizations, such as the US Health Resources
13 and Services Administration, the Robert Graham Center, and the Cecil G. Sheps
14 Center for Health Services Research, to:

15 a. Support development of reports on the economic multiplier effect of each
16 residency slot by geographic region and specialty.

17 b. Investigate the impact of GME funding on each state and its impact on
18 that state's health care workforce and health outcomes.

19
20
21 (28) RESOLUTION 217 — EXPAND ACCESS TO SKILLED
22 NURSING FACILITY SERVICES FOR PATIENTS WITH
23 OPIOID USE DISORDER

24
25 RECOMMENDATION:

26
27 Madam Speaker, your Reference Committee recommends
28 that AMA policy D-95.955 be reaffirmed in lieu of Resolution
29 217.

30
31 **HOD ACTION: AMA policy D-95.955 reaffirmed in lieu of**
32 **Resolution 217.**

33
34 RESOLVED, that our American Medical Association advocate for legislative and
35 regulatory action to ensure patients are not being denied appropriate admission to skilled
36 nursing facilities based on practices of denying admission solely on the diagnosis of opioid
37 use disorder or prescriptions for active medications for opioid use disorder (Directive to
38 Take Action); and be it further

39
40 RESOLVED, that our AMA advocate for and support legislation and regulatory action to
41 ensure adequate reimbursement of skilled nursing facilities that recognizes the complexity
42 of care, treatment and resources required for opioid use disorder treatment (Directive to
43 Take Action); and be it further

44
45 RESOLVED, that our AMA advocate for increased access to medications for opioid use
46 disorder in long-term care pharmacies and address the barriers to access to methadone
47 in long-term care for use in the treatment of opioid use disorder. (Directive to Take Action)

48
49 Minimal but mixed testimony was received for Resolution 217. Your Reference Committee
50 heard that there has been a consistent struggle for patients with opioid use disorder (OUD)

1 when admission to a skilled nursing facility (SNF) is recommended. Testimony noted that
2 a history of OUD or being prescribed appropriate medical treatment for OUD should not
3 be a barrier to receiving necessary care at a SNF. Further testimony highlighted the fact
4 that denying admission to these facilities based solely on an OUD diagnosis, or actively
5 taking medications for OUD, exacerbates the stigma surrounding addiction and denies
6 patients access to the comprehensive care they need. Your Reference Committee
7 received one suggestion to refer this resolution for further study however, opposing
8 testimony noted that this issue does not need to be studied and noted that not accepting
9 a patient needing physical rehabilitation services because they are on medication for OUD
10 is discrimination. Further testimony noted that our AMA already has existing policy that
11 addresses caring for individual with OUD in SNFs. Therefore, your Reference Committee
12 recommends that existing AMA policy D-95.955 be reaffirmed in lieu of Resolution 217.

13
14 [Improving Access to Post-Acute Medical Care for Patients with Substance Use](#)
15 [Disorder \(SUD\) D-95.955](#)

- 16
17 1. Our American Medical Association advocates to ensure that patients who
18 require a post-acute medical care setting are not discriminated against because of
19 their history of substance use disorder.
20 2. Our AMA advocates that our federal, state, and local governments remove
21 barriers to evidence-based treatment for substance use disorders, including
22 medications for opioid use disorder, at skilled nursing facilities.
23 3. Our AMA advocates that Medicare and Medicaid, including managed care
24 organizations, remove barriers to coverage and treatment for substance use and
25 opioid use disorder, including medications for opioid use disorder, in skilled nursing
26 facilities.

27
28
29 (29) RESOLUTION 219 — ADVOCATE TO CONTINUE
30 REIMBURSEMENT FOR TELEHEALTH / TELEMEDICINE
31 VISITS PERMANENTLY

32
33 RECOMMENDATION:

34
35 Madam Speaker, your Reference Committee recommends
36 that AMA policies D-480.965 and D-480.963 be reaffirmed
37 in lieu of Resolution 219.

38
39 **HOD ACTION: AMA policies D-480.965 and D-480.963**
40 **reaffirmed in lieu of Resolution 219.**

41
42 RESOLVED, that our American Medical Association advocate for making telehealth
43 reimbursement permanent for Medicare and for all health insurance providers. (Directive
44 to Take Action)

45
46 Your Reference Committee heard testimony in support of the spirit of Resolution 219. Your
47 Reference Committee heard testimony that emphasized telehealth's role in improving
48 access to care, particularly for rural and underserved communities, and highlighted its
49 sustained value since the COVID-19 pandemic. Testimony also reflected the increasing
50 importance of advocating for a permanent telehealth solution for Medicare beneficiaries

1 and patients with private insurance plans, as the COVID-19 telehealth waivers are set to
2 expire on December 31st of this year. However, strong testimony, that was supported by
3 others, recommended reaffirmation of existing AMA policy. This testimony noted that our
4 AMA already has policy that directly addresses the concerns raised by Resolution 219
5 concerning access and reimbursement for telehealth. Your Reference Committee also
6 heard about our AMA's tireless advocacy efforts in this realm in the form of supporting bi-
7 partisan legislation and commenting, when appropriate, through the regulatory rule
8 making process. Therefore, Your Reference Committee recommends that existing AMA
9 Policies D-480.965 and D-480.963 be reaffirmed in lieu of Resolution 219.

10
11 [D-480.965 - Reimbursement for Telehealth](#)
12

13 Our American Medical Association will work with third-party payers, the Centers
14 for Medicare and Medicaid Services, Congress and interested state medical
15 associations to provide coverage and reimbursement for telehealth to ensure
16 increased access and use of these services by patients and physicians.
17

18 [D-480.963 -COVID-19 Emergency and Expanded Telemedicine Regulations](#)
19

- 20 1. Our American Medical Association will continue to advocate for the widespread
21 adoption of telehealth services in the practice of medicine for physicians and
22 physician-led teams post SARS-COV-2.
23 2. Our AMA will advocate that the Federal government, including the Centers for
24 Medicare & Medicaid Services (CMS) and other agencies, state governments and
25 state agencies, and the health insurance industry, adopt clear and uniform laws,
26 rules, regulations, and policies relating to telehealth services that:
27 a. Provide equitable coverage that allows patients to access telehealth
28 services wherever they are located.
29 b. Provide for the use of accessible devices and technologies, with
30 appropriate privacy and security protections, for connecting physicians and
31 patients.
32 3. Our AMA will advocate for equitable access to telehealth services, especially for
33 at-risk and under-resourced patient populations and communities, including but
34 not limited to supporting increased funding and planning for telehealth
35 infrastructure such as broadband and internet-connected devices for both
36 physician practices and patients.
37 4. Our AMA supports the use of telehealth to reduce health disparities and promote
38 access to health care.
39

40
41 (30) RESOLUTION 220 — MIPS REFORM
42

43 RECOMMENDATION:
44

45 Madam Speaker, your Reference Committee recommends
46 that AMA policies D-400.982, H-385.905, and D-395.999 be
47 reaffirmed in lieu of Resolution 220.
48

49 **HOD ACTION: AMA policies D-400.982, H-385.905, and D-**
50 **395.999 reaffirmed in lieu of Resolution 220.**

1 RESOLVED, that our American Medical Association advocate for the repeal of the
2 Medicare Merit-Based Incentive Payment System (MIPS) and replacement with 1) a
3 practicing physician-designed program that has far less administrative burdens and 2) only
4 adopts measures that have been shown to measurably improve patient outcomes.
5 (Directive to Take Action)
6

7 Your Reference Committee heard mixed testimony on Resolution 220. Your Reference
8 Committee heard that MIPS has become overly complex, placing excessive administrative
9 demands on physicians and detracting from direct patient care. Testimony noted that the
10 existing Surgical Care MIPS Value Pathway (MVP) demonstrates the system's flaws, as
11 it groups unrelated specialties together and lacks relevant, clinically meaningful measures.
12 However, your Reference Committee also heard strong testimony noting that our AMA
13 already has policy that addresses the concerns raised in this resolution. Existing AMA
14 policy already focuses on securing sufficient Medicare physician payment to ensure
15 access to care and emphasizes reducing the financial and reporting burdens that MIPS
16 places on physicians. These existing AMA policies advocate for reforms such as positive
17 payment updates, eliminating budget neutrality, and reducing the administrative load
18 associated with MIPS reporting. Your Reference Committee also heard that our AMA is
19 actively advocating in this area. For example, our AMA, in collaboration with 50 state
20 medical associations, the District of Columbia, and 76 national medical specialty societies,
21 has developed legislation to replace key elements of MIPS with a new Data-Driven
22 Performance Payment System (DPPS). This includes freezing performance thresholds,
23 eliminating the tournament model, and simplifying reporting to reduce the negative
24 impacts on small and rural practices (see [here](#) and [here](#)). Therefore, your Reference
25 Committee recommends that existing AMA policies D-400.982, H-385.905, and D-
26 395.999 be reaffirmed in lieu of Resolution 220.
27

28 [D-400.982 – AMA Efforts on Medicare Payment Reform](#)

29

- 30 1. Our American Medical Association will increase media awareness around the
31 2024 AMA Annual meeting about the need for Medicare Payment Reform,
32 eliminating budget neutrality reductions, and instituting annual cost of living
33 increases.
- 34 2. Our AMA will step up its public relations campaign to get more buy-in from the
35 general public about the need for Medicare payment reform.
- 36 3. Our AMA will increase awareness to all physicians about the efforts of our AMA
37 on Medicare Payment Reform.
- 38 4. Our AMA will advocate for abolition of all MIPS penalties in light of the current
39 inadequacies of Medicare payments.
40

41 [H-385.905 - Merit-based Incentive Payment System \(MIPS\)](#)

42

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

1 [D-395.999 - Reducing MIPS Reporting Burden](#)

2
3 Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to
4 advocate for improvements to Merit-Based Incentive Payment System (MIPS) that
5 have significant input from practicing physicians and reduce regulatory and
6 paperwork burdens on physicians. In the interim, our AMA will work with CMS to
7 shorten the yearly MIPS data reporting period from one-year to a minimum of 90-
8 days (of the physician's choosing) within the calendar year.
9

10
11 (31) RESOLUTION 223 — MANDATED ECONOMIC
12 ESCALATORS IN INSURANCE CONTRACTS

13
14 RECOMMENDATION:

15
16 Madam Speaker, your Reference Committee recommends
17 that AMA policy D-400.990 be reaffirmed in lieu of
18 Resolution 223.
19

20 **HOD ACTION: AMA policy D-400.990 reaffirmed in lieu of**
21 **Resolution 223.**

22
23 RESOLVED, that our American Medical Association advocates through legislation or
24 regulation for the mandatory insertion of an economic escalator provision in all commercial
25 insurance contracts to account for economic inflation or a decline in Medicare Physician
26 Fee Schedule (PFS). (Directive to Take Action)
27

28 Your Reference Committee heard mixed testimony on Resolution 223. Your Reference
29 Committee heard that linking commercial reimbursement to Medicare's declining rates
30 without adjustments for inflation creates financial strain for physician practices, particularly
31 as operational costs continue to rise. Additional testimony argued that economic
32 escalators could perpetuate unsustainable cost-shifting and fail to address underlying
33 reimbursement issues and recommended that instead innovative reimbursement models
34 such as value-based care and bundled payments, which align payments with patient
35 outcomes, should be promoted. Your Reference Committee also heard strong testimony
36 in favor of reaffirming existing AMA policy. This testimony noted that existing AMA policy
37 already supports uncoupling commercial fee schedules from Medicare's declining
38 payment rates and advocates for inflation-based adjustments to ensure physician
39 payment schedules reflect both the rising costs of care and the value of services provided.
40 Testimony also highlighted the work that our AMA is already doing in this space including
41 advocating to ensure that commercial payers adopt payment models that better align with
42 the costs and value of care, rather than relying solely on Medicare's outdated fee structure.
43 Therefore, your Reference Committee recommends that existing AMA Policy D-400.990
44 be reaffirmed in lieu of Resolution 223.
45

46 [D-400.990 - Uncoupling Commercial Fee Schedules from the Medicare Physician](#)
47 [Payment Schedule](#)

48
49 1. Our American Medical Association shall use every means available to convince
50 health insurance companies and managed care organizations to immediately

1 uncouple fee schedules from the Medicare Physician Payment Schedule and to
2 maintain a level of payment that is sustainable, reflects the full cost of practice,
3 and the value of the care provided, and includes inflation-based updates.

4 2. Our AMA will seek legislation and/or regulation to prevent managed care
5 companies from utilizing a physician payment schedule below the updated
6 Medicare Physician Payment Schedule.

7
8
9 (32) RESOLUTION 225 — ELIMINATION OF MEDICARE 14-
10 DAY RULE

11
12 RECOMMENDATION:

13
14 Madam Speaker, your Reference Committee recommends
15 that AMA policy D-330.903 be reaffirmed in lieu of
16 Resolution 225.

17
18 **HOD ACTION: Resolution 225 adopted.**

19
20 RESOLVED, that our American Medical Association actively lobby the federal government
21 to readdress and change laboratory date of service rules under Medicare, e.g. the
22 Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that
23 complex laboratory services performed on pathologic specimens collected from an
24 inpatient hospital procedure be paid separately from inpatient bundled payments,
25 consistent with Outpatient rules. (Directive to Take Action).

26
27 Your Reference Committee heard minimal but mixed testimony on Resolution 225. Your
28 Reference Committee heard testimony in support of reaffirming existing policy. Testimony
29 reflected that existing policy on this subject accomplishes the spirit of this resolution and
30 the testimony noted that the resolution's slightly modified language does not provide any
31 substantive changes to our existing policy. Your Reference Committee would like to
32 encourage interested parties to contact our AMA staff who would be happy to help state
33 or specialty societies address this issue. Therefore, your Reference Committee
34 recommends that existing AMA policy D-330.903 be reaffirmed in lieu of Resolution 225.

35
36 [D-330.903 - Elimination of Laboratory 14-Day Rules Under Medicare](#)

37
38 Our AMA will actively lobby the federal government to change laboratory Date of
39 Service rules under Medicare such that complex diagnostic laboratory services
40 performed on pathologic specimens collected from a hospital procedure be paid
41 separately from inpatient and outpatient bundled payments.

1 (33) RESOLUTION 227 — MEDICARE PAYMENT PARITY
2 FOR TELEMEDICINE SERVICES
3

4 RECOMMENDATION:
5

6 Madam Speaker, your Reference Committee recommends
7 that AMA policies D-480.969 and D-480.965 be reaffirmed
8 in lieu of Resolution 227.
9

10 **HOD ACTION: AMA policies D-480.969 and D-480.965**
11 **reaffirmed in lieu of Resolution 227.**
12

13 RESOLVED, that our American Medical Association advocate for Medicare to reimburse
14 providers for telemedicine-provided services at an equal rate as if the services were
15 provided in-person. (Directive to Take Action)
16

17 Your Reference Committee heard testimony in support of the spirit of Resolution 227. Your
18 Reference Committee heard about telemedicine's role in expanding access to care and
19 promoting continuity across various care settings. Testimony noted that Medicare
20 payment parity is essential for sustaining telemedicine services and fairly compensating
21 physicians. However, additional testimony suggested exploring flexible reimbursement
22 models to account for telemedicine's unique cost structure while still recognizing the value
23 of physician expertise and time. Your Reference Committee also heard testimony that
24 clarified that the value of telehealth services paid for by Medicare is something that cannot
25 be advocated for by AMA staff since discussions related to the value of those codes occur
26 at the AMA/Specialty Society RVS Update Committee (RUC) meetings following
27 deliberations by the various specialty society members that utilize those services.
28 Testimony further noted the strong existing policy that our AMA already has that
29 addresses the heart of Resolution 227. Therefore, your Reference Committee
30 recommends that existing AMA Policies D-480.969 and D-480.965 be reaffirmed in lieu of
31 Resolution 227.
32

33 [D-480.969 - Insurance Coverage Parity for Telemedicine Service](#)
34

- 35 1. Our American Medical Association will advocate for telemedicine parity laws that
36 require private insurers to cover telemedicine-provided services comparable to
37 that of in-person services, and not limit coverage only to services provided by
38 select corporate telemedicine providers.
39 2. Our AMA will develop model legislation to support states' efforts to achieve parity
40 in telemedicine coverage policies.
41 3. Our AMA will work with the Federation of State Medical Boards to draft model
42 state legislation to ensure telemedicine is appropriately defined in each state's
43 medical practice statutes and its regulation falls under the jurisdiction of the state
44 medical board.
45

46 [D-480.965 - Reimbursement for Telehealth](#)
47

48 Our American Medical Association will work with third-party payers, the Centers
49 for Medicare and Medicaid Services, Congress and interested state medical

1 associations to provide coverage and reimbursement for telehealth to ensure
2 increased access and use of these services by patients and physicians.

3
4
5 (34) RESOLUTION 231 - ESTABLISH PREGNANCY AS A
6 FEDERAL QUALIFYING LIFE EVENT TRIGGERING A
7 SPECIAL ENROLLMENT PERIOD

8
9 RECOMMENDATION:

10
11 Madam Speaker, your Reference Committee recommends
12 that AMA policy H-165.828 be reaffirmed in lieu of
13 Resolution 231.

14
15 **HOD ACTION: Resolution 231 adopted.**

16
17 RESOLVED, that our American Medical Association actively advocate that the United
18 States Department of Health and Human Services and Congress establish pregnancy as
19 a qualifying life event for a Special Enrollment Period in the Affordable Care Act
20 Marketplace. (Directive to Take Action)

21
22 Your Reference Committee heard strong testimony in favor of adoption of Resolution 231.
23 Your Reference Committee heard that in light of the U.S.'s high maternal mortality rate
24 and the gaps in access to maternal care, a woman needs immediate access to pregnancy
25 care when she becomes pregnant, but the U.S. Department of Health and Human
26 Services (HHS) has declined to change current regulations to allow this, and that active
27 advocacy efforts by our AMA are needed. However, your Reference Committee also heard
28 testimony that Resolution 231 should not be adopted because our AMA already has policy
29 supporting inclusion of pregnancy as a qualifying life event for special enrollment in the
30 health insurance marketplace. Your Reference Committee heard that this policy was
31 adopted in 2021 and is included in policy H-165.828 as subparagraph 8. Your Reference
32 Committee notes that this existing AMA policy is broader and more flexible because it
33 allows for appropriate advocacy to take place across a range of entities instead of
34 restricting this advocacy to HHS. Further, your Reference Committee heard that our AMA
35 has actively advocated for this policy. For example, in a [2023 letter](#) to the Administrator of
36 the Centers for Medicare & Medicaid, our AMA stated that pregnancy should be a
37 qualifying life event. In addition, your Reference Committee heard that in a [2022 letter](#), our
38 AMA stated that "our AMA supports the inclusion of pregnancy as a qualifying life event
39 for special enrollment in the health insurance marketplace." While acknowledging the
40 importance of this issue, in light of existing policy H-165.828 and the actions to implement
41 this policy that our AMA has already taken, your Reference Committee recommends that
42 existing AMA policy H-165.828 be reaffirmed in lieu of Resolution 231.

43
44 [Health Insurance Affordability H-165.828](#)

- 45
46 1. Our American Medical Association supports modifying the eligibility criteria for
47 premium credits and cost-sharing subsidies for those offered employer-sponsored
48 coverage by lowering the threshold that determines whether an employee's
49 premium contribution is affordable to the level at which premiums are capped for

- 1 individuals with the highest incomes eligible for subsidized coverage in Affordable
2 Care Act (ACA) marketplaces.
- 3 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's
4 "family glitch," thus determining the eligibility of family members of workers for
5 premium tax credits and cost-sharing reductions based on the affordability of family
6 employer-sponsored coverage and household income.
- 7 3. Our AMA encourages the development of demonstration projects to allow
8 individuals eligible for cost-sharing subsidies, who forego these subsidies by
9 enrolling in a bronze plan, to have access to a health savings account (HSA)
10 partially funded by an amount determined to be equivalent to the cost-sharing
11 subsidy.
- 12 4. Our AMA supports capping the tax exclusion for employment-based health
13 insurance as a funding stream to improve health insurance affordability, including
14 for individuals impacted by the inconsistency in affordability definitions, individuals
15 impacted by the "family glitch," and individuals who forego cost-sharing subsidies
16 despite being eligible.
- 17 5. Our AMA supports additional education regarding deductibles and cost-sharing at
18 the time of health plan enrollment, including through the use of online prompts and
19 the provision of examples of patient cost-sharing responsibilities for common
20 procedures and services.
- 21 6. Our AMA supports efforts to ensure clear and meaningful differences between
22 plans offered on health insurance exchanges.
- 23 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired
24 with a Health Savings Account (HSA) with information on how to set up an HSA.
- 25 8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special
26 enrollment in the health insurance marketplace.

1 Madam Speaker, this concludes the report of Reference Committee B. I would
2 like to thank Rachel Kylo, MD, Robert Dannenhoffer, MD, Anuradha Reddy, MD,
3 Michael Medlock, MD, Deborah Fuller, MD, Rebekah Bernard, MD, and all those
4 who testified before the Committee.
5
6

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