Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
E&B	003	Support	Artificial Intelligence to Bolster Physician-Led Team-Based Care	Adopted	RESOLVED, that our American Medical Association make efforts to educate physicians on evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-physician clinicians through improved interdisciplinary communication, decision support, and workflow integration (Directive to Take Action); and be it further RESOLVED, that our AMA support the development and dissemination of best practices for AI integration into physician-led care teams, with emphasis on safety monitoring, transparency, cyber hygiene, and preserving physician leadership in clinical decision making (New HOD Policy); and be it further RESOLVED, that our AMA encourage further research on AI interventions that demonstrate how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk perception, and improve coordination of care. (New HOD Policy)
A	103	Support	Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel. RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should ensure that when a patient is using their insurance benefits, they cannot be charged more than the lowest publicly available cash price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon9 based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel. RESOLVED, that our AMA advocate that patients and prescribing physicians receive transparent point-of-sale disclosure of the patient's expected out-of-pocket cost through the insurance benefit and any lower lawful cash or direct-purchase price available for the prescribed medication.
A	108	Support	Ensuring Physician Input in the Development of CMMI Models	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association seek meaningful and transparent involvement of actively practicing physicians, nominated by relevant national specialty societies, in the development of Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation.
A	109	Support	Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy	Adopted	RESOLVED, that our American Medical Association advocate for insurance coverage of intracranial neuromodulation as an acceptable treatment for appropriate pediatric patients with drug-resistant epilepsy (Directive to Take Action) RESOLVED, that our AMA advocate for insurance coverage of chronic pain neuromodulation therapies such as intracranial, spinal cord and peripheral stimulation, as acceptable treatment for appropriate pediatric patients with chronic refractory pain. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
A	115	Support	Patient Continuity Protections During Payer, PBM Changes	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including treatment location, physician/non-physician provider, prior authorizations, utilization management strategies, and formulary status, must be honored without interruption and that patients be notified of any changes in a clear and timely manner; and be it further RESOLVED, that our AMA advocate that 90-day transition-of-care protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care.
A	116	Support	Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, That our American Medical Association study and report back to the HOD at A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including: • The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs. • Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models. • The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration. • Whether Medicaid managed care arrangements result in increased payments to physicians, including achievement of Medicare-to-Medicaid payment parity. • Whether Medicaid managed care impacts patient access to care, including in rural areas
A	117	Support	Universal Out of Network Benefits	Reaffirmed in lieu of	Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H13 180.952, D-165.989, and H-285.908 reaffirmed in lieu of Resolution 117
B	BOT 08	Support	Council on Legislation Sunset Review of 2016 House Policies	Adopted as amended and the reminder of the Report filed	ADOPTED LANGUAGE: Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979 1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians (MD,DO, or Foreign equivalent) by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented. 2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led (MD,DO, or Foreign equivalent) health care teams or to mandate that the VA adopt policy regarding the same. 3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and other non-physicians (non34 MD,DO, or Foreign equivalent) in unsupervised practice. 4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the VA expanding the role of APRNs and other nonphysicians (non- MD,DO, or Foreign equivalent) within the VA in unsupervised practice.

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	BOT 14	Support	Binding Arbitration in Health Insurance Contracts	Adopted as amended and the reminder of the Report filed	ADOPTED LANGUAGE: The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed: 1. That our American Medical Association Policy D-435.967, "Binding Arbitration in Health Insurance Contracts," be rescinded having been accomplished by this report. (Rescind HOD Policy) 2. That our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians can identify the advantages and disadvantages that may be present in those agreements. Resources shall include, but not be limited to: (1) developing model arbitration language that protects physicians when such clauses are used; (2) establishing fairness principles or standards for arbitration provisions in physician-insurer contracts that include but are not limited to clear timelines, enforcement mechanisms, reasonable limits on arbitration costs, neutral arbitrator selection, and safeguards against venue manipulation; (3) identifying specific contract red flags such as venue restrictions that physicians should be aware of when reviewing arbitration clauses; and (4) encouraging greater transparency or reporting around arbitration outcomes. (New HOD Policy) 3. That our AMA (1) opposes requiring mandatory binding arbitration as a condition of participation in an insurance company's provider network; (2) supports a physician's right to choose between arbitration and the public court system after a dispute arises, rather than being forced to waive their right to a jury trial; (3) believes that no physician should be required to participate in an arbitration or mediation process that is not the result of meaningful mutual agreement between the physician and health insurer; (4) advocates that all arbitration awards involving physician-payer disputes be reported to a centralized de-identified database to ensure transparency and to identify patterns of frequent bad-faith claims settlement practices by insurers. (New HOD Policy)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	BOT 15	Support	Protecting the Prescriptive Authority of Plenary Licensed Physicians	Adopted as amended and the reminder of the Report filed	ADOPTED LANGUAGE: 1. That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas, with report back at A-27. (Directive to Take Action) 2. That our AMA work with pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. (Directive to Take Action). 3. That our AMA Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be reaffirmed. (Reaffirm HOD Policy) 4. That Policy D-120.920 "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be amended by deletion of the first item to read as follows: Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment. Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment. 1. Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment. 2. Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists. 3. Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician. 4. Our AMA encourages interprofessional collaboration to clarify scope2 of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care. (Modify Current HOD Policy)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	BOT 19	Support	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	Adopted as amended and the reminder of the Report filed	ADOPTED LANGUAGE: The Board of Trustees recommends the following be adopted and the remainder of this report be filed: 1. That our AMA reaffirm the following policies: a. H-330.932, “Cuts in Medicare and Medicaid Reimbursement”; b. H-400.957, “Medicare Reimbursement of Office-Based Procedures”; c. H-390.879, “Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service”; d. D-330.902, “The Site-of-Service Differential”; e. H-240.958, “Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service”; f. D-240.994, “Payment Variations Across Outpatient Sites of Service”; D-330.997, “Appropriate Payment Level Differences by Place and Type of Service”; g. D-400.990, “Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule”; h. H-385.921, “Health Care Access for Medicaid Patients”; i. D-160.907, “Health System Consolidation”; j. D-215.984, “Health System Consolidation”; k. H-180.947, “Maintaining Freedom of Choice with Insurance Products”; l. D-160.906, “Strengthening Efforts Against Horizontal & Vertical Consolidation”; m. D-160.908, “Vertical Consolidation in Health Care – Markets or Monopolies”; n. D-385.940, “Stark Law Self-Referral Ban”; o. H-215.960, “Hospital Consolidation”; p. H-215.969, “Hospital Merger Study”; q. D-225.995, “Hospital Merger Study”; r. H-383.988, “Physicians' Ability to Negotiate and Undergo Practice Consolidation”; s. H-160.885, “Impact of Integration and Consolidation on Patients and Physicians”; t. H-160.960, “Corporate Ownership of Established Private Medical Practices”; u. D-405.988, “The Preservation of the Private Practice of Medicine”; v. D-160.909, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations”; w. D-330.909, “Study the Costs of Administrative and Regulatory Burdens”;
B	BOT 19	Support	Root Cause Analysis of the Causes of the Decline of Private Medical Practice (continued)	Adopted as amended and the reminder of the Report filed	x. H-110.985, "340B Drug Discount Program"; and y. H-155.976, “Administrative Costs and Access to Health Care” (Reaffirm HOD Policy) 2. Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions. (New HOD Policy) 3. That consistent with Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice” our AMA further study and report back on the role of physician non-compete agreements and other physician employment restrictions as potential contributors to the decline of private medical practice, including their impact on physician mobility, the ability of physicians to establish or re-establish independent practices, patient access and continuity of care, and the maintenance of market power by dominant health systems. (Modify HOD Policy)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	BOT 21	Support	Abolishing Venue Shopping	Adopted and the remainder of the Report filed	The Board of Trustees recommends that the following recommendations be adopted, and the remainder of the report be filed: 1. That our American Medical Association amend Policy D-438.968, "Abolishing Venue Shopping" by deletion of clause 2 as it has been accomplished by this report: 1. Our American Medical Association (AMA) opposes venue shopping in medical professional liability actions. ~~2. Our AMA will study avenues to most effectively combat venue shopping in state and federal medical professional liability actions with report back at A-26.~~ (Modify Current Policy) 2. That our AMA will work with interested medical society partners, to combat venue shopping in medical liability lawsuits. (New HOD Policy) 3. That our AMA opposes any efforts to move venue to jurisdictions that may apply a standard of care not reflecting specific resource constraints, available technology/equipment and community standards of the location where the patient's clinical care was actually delivered. (New HOD Policy)
B	BOT 28	Support	Accountability in the Use of Augmented Intelligence for Prior Authorization	Adopted as amended and the remaider of the Report filed	ADOPTED LANGUAGE: 1) Our American Medical Association (AMA) will: 1. Advance federal advocacy to ensure that insurer use of AI in prior authorization and claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines derived from national medical specialty societies and peer-reviewed literature. 2. Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to appeal and to review by a physician (a) possessing a current and valid non34 restricted license to practice medicine in the state in which the proposed services would be provided, (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request, and (c) who are not incentivized to deny coverage for care, and to ensure that automated systems do not supplant individualized clinical judgment. 3. Support and seek advancement of federal legislation to promote transparency in all prior authorization programs, including public reporting of AI and automated decision-making use. 4. Advocate for enhanced transparency and accountability in insurer use of AI, including clear disclosure when AI is used in coverage determinations and meaningful access for patients and physicians to the criteria, clinical guidelines, and data underlying those determinations. 5. Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI-generated recommendations without direct review of the patient record by 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 and (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request. 6. Support development and adoption of state-level guardrails that limit reliance on automated systems as the sole basis for medical necessity enials and promote clinician oversight, audit authority, and protections against algorithmic discrimination. 7. Engage in national AI technical standards discussions to strengthen transparency regarding whether human review occurred in coverage determinations and to facilitate identification of reviewer specialty. (Directive to Take Action) 2) That item two of Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," be rescinded as having been accomplished by this report. (Modify Current HOD Policy)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	201	Support	Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety	Alternate Resolution 201 adopted in lieu of Resolutions 201 and 233	ADOPTED LANGUAGE: PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY RESOLVED, that our American Medical Association our AMA amend policy H31 95.903 Regulate Kratom and Ban Over-The-Counter Sales, by addition to read: 1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed. 2. Our AMA recommends individuals who are currently using kratom, and its derivatives, for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed. 3. Our AMA recommends individuals who are using kratom, and its derivatives, only for personal use should not face criminal consequences. 4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition; (Modify Current HOD Policy); and be it further RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action) RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom products as adulterated or misbranded when sold in child-appealing forms, prohibit their availability in physical retail stores and online platforms accessible to minors (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for public education campaigns by physicians warning parents and youth of 7-OH kratom risks, including adverse cutaneous effects, and support research into pediatric exposures and optimal regulatory frameworks. (Directive to Take Action)
B	202	Support	Using and Defining “Unsupervised Practice of Medicine”	Referred	RESOLVED, that our American Medical Association use the term “Unsupervised Practice of Medicine” (UPM) when describing statutory or regulatory efforts that allow nonphysician practitioners to diagnose, treat, and prescribe without physician oversight, and reaffirm that physician-led, team-based care with appropriate physician supervision remains the gold standard for patient safety and quality care (New HOD Policy); RESOLVED, that our AMA incorporate the term “Unsupervised Practice of Medicine” in its advocacy materials, public communications, testimony, and educational resources, where appropriate, to clarify the distinction between physician licensure and nonphysician scope expansion (Directive to Take Action); RESOLVED, that our AMA continue to advocate for truth in advertising, transparency in professional identification, and clear communication to patients regarding differences in education, training, and licensure between physicians and nonphysician practitioners. (Directive to Take Action)
B	206	Support	Overall Hospital Quality Star Ratings / CMS Star Ratings	Referred	RESOLVED, that our American Medical Association advocate to CMS that the Overall Hospital Quality Star Ratings (CMS Star Ratings) include a 6th measured group defined as Physician Experience which would include those physicians who have membership on the hospital medical staff. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	209	Support	Protecting Mental Health Treatment Privacy in Legal Proceedings	Referred	RESOLVED, that our American Medical Association develop model state legislation ensuring that mental health treatment records are protected from discoverability in civil and criminal trials, thereby fostering a safe and supportive environment for healthcare professionals to seek necessary mental health care. (Directive to Take Action)
B	211	Support	Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians	Referred	RESOLVED, that our American Medical Association advocate for the patients of any physician practicing in the same county (or equivalent region) that contains a covered 340B entity to receive reduced cost medications under the 340b program through the covered entity's contracted pharmacy. (Directive to Take Action)
B	213	Support	Prohibiting Pharmacy Benefit Managers from Owning Pharmacies	Adopted	RESOLVED, that our American Medical Association develop model state legislation empowering state insurance regulating bodies to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies. (Directive to Take Action)
B	215	Support	Oppose Medicare Efficiency Adjustments	Reaffirmed in lieu of	Existing AMA policies H-400. 972, H-390.849, and D-400.982 are reaffirmed in lieu of Resolution 215
B	218	Support	Opposing the Practice of Jury Anchoring in Medical Liability Cases	Adopted	RESOLVED, that our American Medical Association opposes the practice of jury anchoring in medical liability litigation, specifically as it related to non-economic damages. (New HOD Policy)
B	220	Support	Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians	Reaffirmed in lieu of	Existing AMA policies H-400.972, H-390.849, D-400.982, D-330.891, H14 385.916, and D-405.965 are reaffirmed in lieu of Resolution 220
B	222	Support	Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage	Alternate Resolution 222 adopted in lieu of Resolution 222	ADOPTED LANGUAGE: ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE RESOLVED, that our American Medical Association advocate for the development and maintenance of a centralized, official Medicare enrollment platform overseen by the Centers for Medicare & Medicaid Services that provides clear, neutral, accurate, and easily understandable comparisons of coverage options under Traditional Medicare, Medicare Advantage, and supplemental coverage, including information on provider networks, prior authorization requirements, benefits, and out-of-pocket costs (Directive to Take Action); and be it further RESOLVED, that existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	223	Support	Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations	Referred	RESOLVED, that our American Medical Association oppose the use of artificial intelligence, algorithms, or automated decision-making systems as the sole basis for any adverse health insurance determination, including denials, delays, or limitations of coverage and adverse eligibility, underwriting, or enrollment determinations affecting health insurance applicants or insured patients (New HOD Policy); and be it further RESOLVED, that our AMA advocate that when artificial intelligence or automated decision-making systems are used in adverse health insurance determinations, any required human review must be conducted through the independent judgment of a licensed physician in accordance with existing AMA peer review policy, and must not be overridden, dictated, or unduly influenced by the output of such systems (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for policies requiring that patients and physicians be provided a clear and accessible explanation when artificial intelligence or automated decision-making systems materially contributed to an adverse health insurance determination, including an explanation of the role of the system in the decision, in both coverage determinations and eligibility, underwriting, or enrollment decisions (Directive to Take Action); and be it further RESOLVED, that our AMA support and advocate for payer-specific regulatory standards governing the use of artificial intelligence and automated decision-making systems in adverse health insurance determinations, including requirements for auditable records of AI-assisted decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and oversight by appropriate regulatory bodies (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for the uniform application of safeguards governing artificial intelligence and automated decision-making systems across all payer types and markets, including commercial insurance, individual and small-group markets, employer-sponsored coverage, and government insurance, with particular attention to applicant-facing eligibility, underwriting, and enrollment decisions. (Directive to Take Action)
B	226	Support	Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System	Alternate Resolution 226 is adopted in lieu of Resolutions 226 and 230	ADOPTED LANGUAGE: EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES RESOLVED, that our AMA monitor and report on the impact of Presidential Proclamations restricting entry into the United States and how such policies affect International Medical Graduate participation, physician workforce supply, and patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action) RESOLVED, that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	229	Support	Physicians are not Providers	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term “physician” when discussing those with an MD or DO (Directive to Take Action); and be it further RESOLVED, that our AMA Oppose the use of the term “provider” when used to include physicians (New HOD Policy); and be it further RESOLVED, that our AMA believes that the use of the term “provider” when used to include physicians negatively impacts patient education and awareness, transparency and the ethical responsibilities of physicians to patient safety and professionalism (Directive to Take Action); and be it further RESOLVED, that our AMA refer the issue of “Physicians are not Providers” for possible consideration by the American Medical Association’s Council on Ethical and Judicial Affairs (CEJA). (Directive to Take Action)
B	230	Support	Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States	Alternate Resolution 226 is adopted in lieu of Resolutions 226 and 230	ADOPTED LANGUAGE: EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES RESOLVED, that our AMA monitor and report on the impact of Presidential Proclamations restricting entry into the United States and how such policies affect International Medical Graduate participation, physician workforce supply, and patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action) RESOLVED, that existing AMA policies D-255.967, D-255.991, H-255.961, D-255.980, D-255.966, H-255.988 be reaffirmed.
B	232	Support	Banning Flavored Cannabis E-Cigarettes	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling intoxicating hemp products (Directive to Take Action); and be it further RESOLVED, that our AMA pursue legislative changes supporting a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	233	Support	Banning Synthesized, Purified or Derivative Products from Kratom	Alternate Resolution 201 adopted in lieu of Resolutions 201 and 233	ADOPTED LANGUAGE: PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY RESOLVED, that our American Medical Association our AMA amend policy H31 95.903 Regulate Kratom and Ban Over-The-Counter Sales, by addition to read: 1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed. 2. Our AMA recommends individuals who are currently using kratom, and its derivatives, for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed. 3. Our AMA recommends individuals who are using kratom, and its derivatives, only for personal use should not face criminal consequences. 4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition; (Modify Current HOD Policy); and be it further RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market. (Directive to Take Action) RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom products as adulterated or misbranded when sold in child-appealing forms, prohibit their availability in physical retail stores and online platforms accessible to minors (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for public education campaigns by physicians warning parents and youth of 7-OH kratom risks, including adverse cutaneous effects, and support research into pediatric exposures and optimal regulatory frameworks. (Directive to Take Action)
B	234	Support	Physician Unity in Advocacy Regarding Physician Reimbursement	Referred	RESOLVED, that our American Medical Association reaffirm that physician payment reform should prioritize the sustainability of the entire physician workforce and the protection of patient access to care (New Hod Policy); and be it further RESOLVED, that our AMA adopt policy stating that physicians and physician organizations should refrain from advocating for reductions in reimbursement specifically targeted at other physician specialties or physician groups (Directive to Take Action); and be it further RESOLVED, that our AMA encourage physician organizations to pursue payment reform through approaches that improve overall fairness, adequacy, and stability of physician reimbursement rather than redistribution among physician specialties (Directive to Take Action); and be it further RESOLVED, that our AMA affirm that physicians should advocate collectively against reimbursement cuts affecting any group of physicians and support efforts to protect the financial sustainability of all physician practices in order to preserve patient access to care. (New HOD Policy)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	239	Support	Medicare Administrative Contractor Policy Modification	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder Engagement in Medicare Administrative Contractor Policy, by addition to read: 1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes. 2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process. 3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review. 4. Our AMA will advocate and work with CMS to require a minimum 90-day public comment period for new or revised LCDs. 5. Our AMA will advocate and work with CMS to require expedited reconsideration timelines for new or revised LCDs that involve patient access to an intervention that may preserve life and/or function. 6. Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA, LCD Reference Article, or Billing and Coding Article, and to require MACs to allow a 90-day public comment period after this explanation has been provided (Modify Current HOD Policy); and be it further 7. Our AMA will support federal legislation to improve the LCD process, including to make the LCD process more transparent and responsive to stakeholders such as providers with subject matter expertise so that patients can receive medically necessary and appropriate care. RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National Coverage Decisions (Reaffirm HOD Policy); and be it further RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage Determination Process. (Reaffirm HOD Policy)
B	240	Support	Ending Private Equity Dividend Recapitalization in Healthcare	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors that permit any non-physician licensed entities to exercise control over the practice of medicine (Directive to Take Action); and be it further RESOLVED, that our AMA will develop model state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
B	244	Support	Eliminate Administrative Barriers to Appeal Wrongful Denials	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal denials without requiring plan-specific forms (Directive to Take Action); and be it further RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded ERISA plans once the patient has assigned benefits to the physician. (Directive to Take Action)
B	245	Support	State Regulation of Non-Preempted "Non-Central Matters" of ERISA Plans—Rutledge v. PCMA	Not adopted	RESOLVED, that our American Medical Association will examine the strategic and operational opportunities physicians should consider under the U.S. Supreme Court holding in Rutledge v. PCMA as they pertain to the Employment Retirement Income Security Act (ERISA) with a report back at the Annual 2027 meeting with recommendations for operational best practices (Directive to Take Action); and be it further RESOLVED, that our AMA will explore and, as appropriate, provide related educational programming at Interim and/or Annual Meetings and through other appropriate venues, including potential educational modules, regarding ERISA and its practical implications for private practice physicians (Directive to Take Action); and be it further RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways that can eliminate problems that some independent physicians experience, including: 1. Interest payments on overdue "clean" health insurance claims not otherwise addressed by ERISA's statutory mandate; 2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources; 3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan; 4. Payment for the administrative burden of prior authorization and successful denial appeals; 5. Parity for telehealth-delivered services; 6. Timely payment of "clean claims" when the insurer's obligation to pay the claim is reasonably distinct from timely determination of claims; 7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies; 8. Requiring that when health plan payment recovery or recoupment is due to coordination of benefit failure, the health plan shall seek recovery from the patient and/or the correct payor. (Directive to Take Action)
C	302	Support	Excessive Cost of Multi-State DEA Licensure	Adopted	RESOLVED, that our American Medical Association continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies, "One Fee One Number D-100.975" and "One Fee, One Number D-100.980." (Reaffirm HOD Policy)
C	303	Support	Allowing Options for Certification Maintenance	Not adopted	RESOLVED, that our American Medical Association encourage all hospitals and insurance programs in the United States to end the monopoly of MOC and accept NBPAS to accomplish any MOC requirements (New HOD Policy); and be it further RESOLVED, that our AMA request that the Accreditation Council for Graduate Medical Education (ACGME), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA) accept this alternative route for MOC for all teachers of medical students and physicians in order to maintain quality and experienced instruction in residency programs and medical schools in this era of physician shortages. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
C	305	Support	Leadership by Physicians for Physicians in Graduate Medical Education (GME)	Adopted as amended	Adopted language: RESOLVED, that our American Medical Association encourage the ACGME to examine minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs.
C	306	Support	Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows	Adopted	RESOLVED, that our American Medical Association amend D-295.318 "Competency-Based Portfolio Assessment of Medical Students" by addition and deletion to read as follows: 1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student and trainee evaluations, including competency-based portfolio assessment; and be it further 2. Our AMA will work with the NRMP, ACGME and ~~the 11 schools in the AMA's Accelerating Change in Medical Education consortium~~ medical schools to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency and fellowship match process ~~and off-cycle entry into residency programs,~~ and transitions across the UME-GME practice continuum; including off-cycle entry pathways. (Modify Current HOD Policy); and be it further
	306	Support	Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows (continued)	Adopted	RESOLVED, that our AMA amend H-65.951 "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions" by addition to read as follows: Our American Medical Association recognizes that implicit biases in evaluations, including those related to gender, race, ethnicity, socioeconomic status, and/or personal background, may influence learner assessment, advancement, and professional opportunities across the medical education continuum; Our American Medical Association adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine: **GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE** *Refer to resolution 306 for full language of H-65.951.*
C	307	Support	Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine	Adopted	RESOLVED, that our American Medical Association reaffirm AMA Policy G-615.103, Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy (Reaffirm HOD Policy); and be it further RESOLVED, that our AMA encourage medical education institutions and academic medical centers to recognize physician advocacy activities as a component of faculty appointment, promotion, and tenure criteria (New HOD Policy); and be it further RESOLVED, that our AMA collaborate with relevant organizations representing medical school leadership, to promote best practices for incorporating advocacy efforts into protected non-clinical faculty effort and academic productivity models. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
C	309	Support	Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization	Alternate Resolution 309 adopted in lieu of Original Resolution 309	Adopted language: RESOLVED, That our American Medical Association encourage development and promotion of physician education, continuing medical education (CME), multidisciplinary programming, research, and patient and physician awareness initiatives regarding osteoporosis and bone health optimization as components of musculoskeletal health, frailty prevention, mobility preservation, healthy aging, surgical risk optimization, and improvement of functional outcomes, including evidence-based strategies related to physical activity, nutrition, fall prevention, screening, and individualized clinical decision-making consistent with existing evidence; and be it further RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies.
C	316	Support	Addressing Transitions Within GME Regarding Orientation Standards	Adopted	RESOLVED, that our American Medical Association study mechanisms for training programs to provide residents and fellows with necessary benefits, including but not limited to health insurance, during transitions in undergraduate and graduate medical education (Directive to Take Action); and be it further RESOLVED, that our AMA study the benefits of flexible start dates as it relates to reducing logistical and financial burdens on trainees, including but not limited to the following transitions: (1) from medical school to residency; (2) from a transitional or preliminary year to residency; and (3) from residency into fellowship. (Directive to Take Action)
D	416	Support	Clinical Laboratory Workforce Shortage and Sustainability	Adopted	RESOLVED, that our American Medical Association recognize the unique and critical role of medical laboratory professionals in patient care and public health and the urgent need to address workforce shortages (New HOD Policy); and be it further RESOLVED, that our AMA support advocacy efforts to sustain and strengthen clinical laboratory training and education programs, including assistance for faculty development and infrastructure, to address capacity and recruitment needs (Directive to Take Action); and be it further RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, educational institutions, health care organizations, and professional societies, to promote awareness of clinical laboratory careers, as members of the physician-led health care team, among students and the public. (Directive to Take Action)
D	419	Support	Examining the Impact of Circadian Disruption from Shift Work During Pregnancy	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association study and report back by A-27 on evidence-informed scheduling and workplace accommodation principles to mitigate circadian disruption from shift work for people trying to conceive and pregnant people, including medical trainees, when feasible and consistent with patient care needs, applicable law, and local staffing realities (Directive to take action).

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
D	425	Support	Prioritizing, Measuring, and Preventing Workplace Violence in Health Care	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies. RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy. RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition. RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings. RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce. RESOLVED, that our AMA rescind existing policies D-515.983 (Preventing Violent Acts Against Health Care Providers) and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy) RESOLVED, that our American Medical Association seek legislation, and/or craft model state legislation, calling for civil and/or criminal penalties to be established for any healthcare institution or administrator that tries to discourage, or in any way disincentivize, the reporting of workplace violence (New HOD Policy).
E	CSAPH 07	Support	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	Adopted as amended and remainder of Report filed	ADOPTED LANGUAGE: The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed: 1. That our AMA will: a. Recognize and promote the importance of transparency and explainability so physicians have sufficient information to make sound clinical decisions when using AI clinical decision support tools, which depending on the tool, may include information such as the grading of medical evidence including the data sources. b. Collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems. c. Encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making. d. Monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care. 2. Policy D-480.951, “Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making,” be rescinded as having been accomplished by this report.

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
E	CSAPH 09	Support	In Support of a National Drug Checking Registry	Adopted and remainder of Report filed	The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed: 1. That our AMA: (1) supports drug checking that provides real-world insight into the rapidly shifting drug supply, which helps reduce harm among people who use drugs, better inform clinicians, and enhance public health surveillance efforts; (2) advocates for funding and legal authorization to support drug checking services at the local, county, state, and national level; and (3) will continue to monitor ongoing drug checking efforts. (New HOD Policy) 2. That our AMA reaffirm the following HOD policies: H-95.900, "Supporting Harm Reduction,"; H-95.901, "Drug Policy Reform," and D-95.987, "Prevention of Drug-Related Overdose," (Reaffirm HOD Policy)
E	501	Support	Preregistration in Medical Research	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association amend policy H-460.941 by addition and deletion to read as follows: Our AMA will: (1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform; (2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science; (3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches; (4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed; (5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution; (6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; (7) recognize the importance of preregistration in advancing rigorous and reproducible biomedical research; and (8) study the use of preregistration in medical research, including standardized registries, education on preregistration practice, and alignment with transparency and accountability.
E	502	Support	Support for Rapid Methadone Inpatient Stabilization and Linkage to Care	Adopted as amended	ADOPTED LANGUAGE: SUPPORT FOR RAPID INPATIENT STABILIZATION AND LINKAGE TO CARE FOR PREGNANT PATIENTS WITH OPIOID USE DISORDER RESOLVED, that our American Medical Association will advocate for removal of barriers to the development and implementation of pregnancy-specific treatment pathways for pregnant patients with Opioid Use Disorder, including: a. Encouraging treatment tailored for pregnancy and the individual patient (i.e. choice of medication, dosage, and frequency of dosing) informed by clinical evaluation, history, available resources, and patient and physician preference; b. Advocating for medication take home flexibilities for pregnant patients; c. Ensuring that institutions have care pathways in place to dispense adequate medication for 72 hours to allow time to link to ongoing treatment; d. Encouraging the development of hospital-based medication initiation protocols that allow for faster dose titrations due to medical monitoring; e. Advocating for coverage for tailored treatment of opioid use disorder in pregnant patients; and f. Ensuring linkage to prenatal care as well as addiction treatment (level of care based upon patient need) prior to discharge.

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
E	503	Support	Expansion of Psychedelic Assisted Therapy (PAT)	Reaffirmed in lieu of	Existing Policy H-120.917 and Policy H-100.943 reaffirmed in lieu of Resolution 503
E	505	Support	Avoiding misuse of artificial intelligence (AI) in clinical practice	Adopted as amended	ADOPTED LANGUAGE RESOLVED, that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document; and be it further RESOLVED, that Policy H-480.931 and Policy H-480.940 be reaffirmed.
E	512	Support	Medical Cannabis Use in Older Adults	Adopted as amended	ADOPTED LANGUAGE: CANNABIS USE IN OLDER ADULTS RESOLVED, that our American Medical Association support the development and publication of educational resources on cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks; and be it further RESOLVED, that our AMA encourage expanded research into the therapeutic uses of cannabis in older adults—such as for managing agitation in individuals with cognitive impairment—as well as its possible adverse effects.
E	515	Support	Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure	Adopted as amended	ADOPTED LANGUAGE RESOLVED, that our American Medical Association advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians and the insured patient with the specific clinical logic, evidence-based sources, and version history of any augmented intelligence (AI) or algorithmic tools used in the issuance of an adverse determination; and be it further RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited with re-audits triggered by material changes to the AI model, its training data, or applicable clinical guidelines, and with periodic comprehensive audits at minimum annually regardless of such changes, to ensure it reflects current evidence-based clinical guidelines and recognized standards of care.
F	604	Support	Annual Scorecard to Evaluate the AMA's Impact	Adopted as amended	RESOLVED, that our American Medical Association shall implement a comprehensive scorecard to measure its effectiveness in key areas including, but not limited to, the following specific metrics: 1. Medicare Impact: percent change in the Medicare Physician Fee Schedule; 2. Advocacy Impact: number of federal policies successfully influenced or implemented; 3. House of Delegates Impact: number of AMA policies translated into legislation or federal policy; 4. Financial Impact: percentage of revenue dedicated to advocacy; and, 5. Physician Engagement: total number of its member physicians directly engaged in advocacy efforts through contact with lawmakers (Directive to Take Action); and be it further RESOLVED, that our AMA shall review metric definitions and targets and provide a report by the 2027 AMA Annual Meeting. Any future updates to metrics or targets shall be recommended via a report to the AMA House of Delegates so that the AMA HOD can approve final metrics and targets for the subsequent year before or during the AMA Interim Meeting immediately preceding the year the metrics and targets are to take effect (Directive to Take Action); and be it further RESOLVED, that our AMA shall publish the AMA's scorecard performance for the prior year by the end of the first month of the following year, starting in January 2028. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
G	BOT 20	Support	Mitigating the Impact of Excessive Prior Authorization Processes	Adopted as amended and remainder of Report filed	ADOPTED LANGUAGE: The Board of Trustees recommends the following and the remainder of the report be filed: 1. That the referred resolve clause of Resolution 704-A-25 not be adopted. 2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians including, if feasible, a potential class action lawsuit. 3. That existing AMA policies H-320.939, "Prior Authorization and Utilization Management Reform", D-320.974, "Insurer Accountability When Prior Authorization Harms Patients", and H-320.950, "Eliminating Precertification" be reaffirmed.
G	CMS 09	Support	Nonprofit Status	Adopted as amended and remainder of Report filed	ADOPTED LANGUAGE: The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows: NONPROFIT HOSPITAL POLICIES, H-155.954 1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. 2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. 3. Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. 4. Our AMA advocates for a standardized definition of what is considered a "community benefit" that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status. 5. Our AMA advocates for the development of transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios. 6. Our AMA advocates for transparency and consistency regarding governmental oversight of nonprofit hospitals, enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status. 7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)
G	701	Support	The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models	Adopted as amended	NEW TITLE: PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS RESOLVED, that our American Medical Association advocate to exempt practices from mandatory participation in value-based programs (VBP), including associated reporting requirements and penalties, when such practices meet one or more criteria indicating limited capacity to participate. This includes but is not limited to small practice size, lower Medicare fee-for-service revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless the physician or practice voluntarily elects to participate. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
G	702	Support	Physicians Who Do Not Practice in Hospital Setting	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association amend D-230.981 as follows: 1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital. 2. Our AMA will collaborate with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices. 3. Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation. (Modify Current HOD Policy)
G	704	Support	Advocating Against Automatic Refill Requests	Adopted	RESOLVED, that our American Medical Association communicate effectively with large pharmacy chains and conglomerates for the purpose of explaining the unnecessary administrative burden of automatic, non-patient-initiated refill requests and petitioning them to require all medication refill requests use a patient directed “opt-in” approach (Directive to Take Action); and be it further RESOLVED, that our AMA petition the Centers for Medicare and Medicaid Services to restrict participating pharmacies from sending medication refill requests to physicians unless the patient “opts-in” to using the refill request. (Directive to Take Action)
G	707	Support	Malpractice Insurance for Employed Physicians	Referred	RESOLVED, that our American Medical Association support a requirement for employers to purchase only occurrence malpractice insurance policies for their employed physicians, fellows and residents. (New HOD Policy)
G	708	Support	Oppose Imposition of Fees on Physicians for Electronic Payment Transfers	Adopted	RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid Services (CMS) to issue a legally-binding rules compliant with the Administrative Procedure Act with a notice and comment period preventing the use of virtual credit cards or imposition of electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
G	709	Support	Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Accountability Act (HIPAA), and allow for accountability should the decision be called into question (Directive to Take Action); and be it further RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction and therefore, accountable to appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions (Directive to Take Action); and be it further RESOLVED that our American Medical Association amend their Policy H-285.939 as follows: MANAGED CARE MEDICAL DIRECTOR LIABILITY, H-285.939 Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. 1. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions. 2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations. 3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability. (Modify Current HOD Policy)
G	711	Support	Oppose Denials Based on Origin of Referral	Adopted	RESOLVED, that our American Medical Association advocate against prior authorization denials based solely upon the referring physician or appropriately licensed clinician. (Directive to Take Action)
G	712	Support	Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions	Adopted	RESOLVED, that our American Medical Association advocate that health systems, hospitals, other physician employers, and third-party payors recognize that the profession of medicine is not a commoditized entity, is fundamentally anchored in the patient-physician relationship, and should not be reduced solely to productivity measures (Directive to Take Action); and be it further RESOLVED that our AMA encourage employers of physicians to utilize productivity benchmarks, performance expectations, and compensation structures that recognize and integrate the full scope of physician work, including clinical, administrative, educational, and operational responsibilities that may not be fully captured by traditional productivity metrics (New HOD Policy); and be it further RESOLVED, that our AMA advocate for regulatory, employer, and practice models that provide both employed and independent physicians with appropriate time, resources, compensation, support, and recognition for non-billable work that is essential to patient care, physician well-being, and health system function. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
G	713	Support	Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies	Adopted as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated (Directive to Take Action); and be it further RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care (Directive to Take Action); and be it further RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non38 opioid pain care (New HOD Policy); and be it further RESOLVED, that our AMA encourage further research on the impact of insurance41 related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies (New HOD Policy); and be it further RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status. (Directive to Take Action)
G	714	Support	Physician Case Log Portability	Adoped as amended	ADOPTED LANGUAGE: RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, that ensures timely access to these files but takes into consideration operational realities, verification processes, and patient privacy safeguards (Directive to Take Action); and be it further RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)
G	715	Support	Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA	Adopted	RESOLVED, that our American Medical Association will advocate that a vendor or clearinghouse that offers a multi-payer platform may not create separate payer-specific enrollment mechanisms into standard adopted HIPAA transactions (Directive to Take Action); and be it further RESOLVED, that our AMA will advocate that a health plan may not use a vendor for electronic transactions that unnecessarily create duplicate administrative work for physician practices by creating a separate mechanism of enrollment in the same standard transaction for different health plans. (Directive to Take Action)

Cmte	Item	ASRA Pain Medicine Action	Title	HOD Action	Resolved/Recommendation
G	717	Oppose	Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse	Referred with report back at A-27	RESOLVED, that our American Medical Association advocate for implementation of the standard national health plan identifier (HPID) that all transactions must be communicated directly with the health plan (Directive to Take Action); and be it further RESOLVED, that our AMA advocates for the implementation of a national centralized electronic healthcare transaction clearinghouse that would allow physician practices, other providers, health plans, clearinghouses, health IT vendors, state and federal regulators, digital health products, and consumer apps to maintain only one standard direct connection through which all electronic transactions can flow seamlessly, securely, and at low cost to any other participant guided by a transaction ID and a standard identifier such as a health plan identifier (HPID) and/or national provider identifier (NPI). (Directive to Take Action)