Nov 12th, 2024

To:
Theodore Abraham, MD, FASE

Subject: 2024 Interim American Medical Association HOD meeting Summary Report

Dear Dr. Abraham:

This is a brief summary of the 2024 Interim AMA HOD meeting that ran from Nov 8th-12th, 2024 in Orlando, FL. There was great attendance as many of the attendees were there with their families to enjoy all that Disney had to offer. The mood was somewhat somber given the uncertainties that could potentially impact some of the AMA policies given the changing political climate. My co-delegate from ASE, Dr Rahko could not attend this meeting due to a prior commitment.

I would like to give a breakdown of the organization of this meeting. This meeting is organized first into caucuses which are made up by organ system from subspecialty societies (SSS) and the other half of delegates are from state associations. ASE currently has two delegates which allows us considerable latitude in leveraging in the services of AMA on many topics that you are well aware of.

At the assembly, there is first the collection of resolutions that may be sent in by any delegate from either state associations or subspecialty societies for consideration. The reference committees' function much like congressional hearings, where each resolution is presented by its advocate to a committee and anybody that is attending the hearings can stand up and comment upon. Controversial topics take long periods discussion. These resolutions are then worked through by the reference committee and are recommended for adoption or not adoption or are rewritten, revised, or consolidated with multiple resolutions. The reference committees also hear reports from various societies of the AMA, usually on topics that were reports from previous meetings.

The cardiovascular medicine caucus gives us an opportunity to directly meet with delegates from ACC and other subspecialties societies such as SCAI, ASNC, HRS, SCCT and SCMR. There are guests from State Societies who are cardiologists occasionally attend as well. This gives us a good cross section of how other organizations are viewing these issues. There is also a subspecialties service (SSS) caucus which encompasses all subspecialty societies that meets multiple times throughout the meetings. Katherine Stark and I attended these meetings and they give you another cross-sectional flavor as to what other subspecialties societies are interested in and concerned about.

Though there were a limited number of resolutions pertinent to cardiology community broadly and to ASE in particular, there were many interesting and important resolutions which were discussed which impact physician practices.

I will provide a summary of the meeting below:

Friday, 11/08/24:

Dr Bruce Scott, president of AMA spoke that together, we can fight the many issues hysicians are facing-reforming Medicare physician payment, fix prior authorization, fight scope creep, reduce physician burnout and protect patients from inappropriate scope of practice expansions.

Dr Madara spoke about the importance of AMA governance in his penultimate speech. He noted that perhaps the biggest challenge is the growth of the AMA House of Delegates (HOD). In his first address to the HOD, the House had a bit more than 500 delegates. Today, the number stands at more than 700.

Saturday, 11/09/24:

Meeting of reference committees as follows:

- Reference Committee on Amendments to Constitution & Bylaws, which covers the **AMA constitution, bylaws and medical ethics matters**.
- Reference Committee B, which covers **legislation**
- Reference Committee C, which covers **medical education**.
- Reference Committee F, which covers **AMA governance and finance**.
- Reference Committee J, which covers **medical service, practice and insurance**.
- Reference Committee K, which covers **science and public health**.

Sunday, 11/10/24:

There were a lot of AMA sessions throughout the day. There was significant discussion about Medicare payment reform in an open forum. AMA has been sounding the alarm bell for years, warning that high-quality physician care in the Medicare program is jeopardized by a system that has resulted in payment rates that, when adjusted for inflation, have fallen by 29% over the past 20 years. Physicians face another 2.8% cut in pay under the proposed 2025 Medicare physician payment schedule. Now, a bipartisan group in the U.S. House of Representatives has introduced a bill that would provide a 4.7% payment update in 2025. The measure would eliminate the 2.8% Medicare physician payment cut slated for Jan. 1 and provide a positive payment update that is equal to one half of the Medicare Economic Index. We will be watching this closely.

Dr Kim Williams from Cardiology caucus spoke at Lung cancer screening-discussing how incidentally noted CAC when reported could potentially address poor cardiovascular outcomes especially in underserved populations.

Monday, 11/11/24:

Reference Committee on Amendments to Constitution and Bylaws:

Report 2 dealt with name change to Ethics and bylaws which was unanimously accepted.

BOT Report 8 discusses increasing access to medical care for people seeking asylum.

BOT Report 14 discusses privacy protection and prevention of further trauma for victims of distribution of intimate videos and images without consent

CEJA report 1 discussed palliative care. Palliative care is widely acknowledged to be appropriate for patients who are close to death, but also includes persons who have chronic, progressive, and/or eventually fatal illnesses. When caring for patients' physicians should: (a) Integrate palliative care into treatment. (b) Seek and/or provide palliative care, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness. (c)Offer palliative care simultaneously with disease modifying interventions, including attempts for cure or remission.(d) Be aware of, and where needed, engage palliative care expertise in care. Physician as a profession should: e) Advocate that palliative care be accessible for all patients, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.

Resolution 003 recommended that AMA undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges.

Resolution 10 asked AMA develop and distribute comprehensive materials to enable medical staffs to become effective agents for collective negotiation with hospitals and health systems and that AMA allocate appropriate resources and support to assist medical staffs in understanding their rights, the negotiation process, and strategies for successful collective action and help with policies at the state and federal levels.

Resolution 007 asks that AMA encourage all Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for interpreter services to ensure Reference Committee C&B appropriate enrollment and ongoing participation of medical and clinical research 2 participants with Limited English Proficiency and Deaf or Hard of Hearing people (New 3 HOD Policy); and that AMA advocate for the Department of Health and Human Services 6 and Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent of Subjects Who Do Not Speak English (1995)" and support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations.

 # Reference Committee C:

Report 1 discussed education regarding medication reconciliation. It (a) recognizes that medication reconciliation is a multidisciplinary process and (b) supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care.

Resolution 302 directs AMA to strengthen parental leave policies for medical trainees and recent graduates, and recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their

attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave., and with eligibility beginning at the start of employment without a waiting period.

Resolution 304 is long overdue and deals with payment and benefit parity for resident and fellow section. AMA is to partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

Resolution 306 is of some interest to us at ASE as we offer CME activities. Resolution 306 directs AMA work with relevant stakeholders to minimize the financial and time burden of reporting continuing medical education, including but not limited to participation in a common reporting standard; and that AMA advocate for medical specialty and state medical boards to continue to allow manual entry of continuing medical education until all boards and continuing medical education providers participate in a common reporting standard; and that AMA work with relevant stakeholders to examine the feasibility of a single common continuing medical education requirement for maintaining state licensure; any continuing medical education that requires answering questions to be categorized as "Self-Assessment continuing medical education."

 # Reference Committee F:

Resolution 608 asks that AMA modify its Constitution and Bylaws to allow the Resident and Fellow Section (RFS) to directly elect the resident/fellow member of our AMA Board of Trustees as well as modify its Bylaws to allow the RFS to directly elect the resident/fellow member to AMA Council on Constitution and Bylaws (CCB), AMA Council on Medical Education (CME), AMA Council on Medical Service (CMS), and AMA Council on Science and Public Health (CSAPH).

Speakers report 1 is a report from Election task force and is quite lengthy and laid out all their recommendations regarding fair election process. This generated a lot of testimony which was mixed.

BOT report 16 generated a lot of testimony. This dealt with financial burden placed on representatives and engagement by the organizations who send representatives to the AMA HOD meetings to participate in the policy-making process. AMA understands that it is essential to the strength of organized medicine to have these voices heard. BOT is committed to supporting attendance at AMA HOD meetings, providing immediate financial relief on a short-term emergency basis, and developing a plan for long-term sustainable participation. In addition, Resolution 609 requests AMA BOT restore the length of the regular Meetings (Annual and Interim) of the HOD to the length that occurred in 2024, and shall do so at the Annual Meeting of the House of Delegates in 2025 continuing that any proposed changes to the structure or format of the Regular Meetings of the House of Delegates, including but not limited to duration, composition, or apportionment, be brought before the House for open discussion and approval by vote prior to implementation.

Resolution 605 is also of interest to us at ASE. The recommendation is that AMA establish a process by which medical students, residents and fellow who are delegates or alternate delegates to the HOD sponsored by Federation organizations shall receive either reimbursement or prepayment by AMA of

expenses associated with their attendance at business at the Annual and/or Interim meetings. This was set at $1000 in 2024 per designated delegate and alternate delegate that attends the Annual and/or Interim meetings. Also, there was a lot of testimony that meeting stipend be given to the delegate or alternate delegate themselves, rather than to the state or subspecialty society that they represent. In addition, it was felt that it is important to restore the length of the regular meetings (Annual and Interim) of the HOD to the length that occurred in 2024, and shall do so at the annual meeting of the HOD in 2025 and continuing.

 # Reference Committee J:

CMS report 3 discusses time-limited patient care. The CMS recommends that the following recommendations be adopted. They recommend that AMA support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free from undue influence from outside entities such as, but not limited to, payers, administrators, and health care systems, AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. In addition, AMA has been directed to reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits and reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership.

Resolution 808 advocates that Medicare, Medicaid, and all other insurers provide covered alternatives to the patient and the patient's prescribing physician at the time that coverage for a medication is denied.

Resolution 812 actively advocates for all health plans with therapy caps or thresholds to include an exception process. This process should, at a minimum, follow the Medicare standard for therapy cap exceptions, ensuring that patients can access the necessary services to restore functional abilities and enhance quality of life.

Resolution 825 deals with transparency of facility fees for hospital outpatient department visits. This resolution advocates for legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at hospital outpatient department designated clinics. In addition AMA was asked to advocate the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service.

BOT report 13 is of great interest to us at ASE. BOT report 13 deals with AMA/specialty society RVS update. It asks that AMA collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee's study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology. It also directed AMA support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS), reaffirm Policy D-400.983, which supports the RUC and its ability to implement methodological improvements, reaffirm Policy H-400.959, which supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies, reaffirm

Policy H-400.969, which calls on the Centers for Medicare & Medicaid Services to adopt the recommendations of the RUC for work relative values for new and revised Current Procedural Terminology (CPT®) codes, and strongly supports the use of the RUC process as the principal method of refining and maintaining the Medicare RBRVS.

BOT report 15 directed AMA to research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment.

Resolution 811 had mixed testimony. It advised that AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to estimate differences in physician practice expenses across practice geography (e.g., urban vs. rural, or region and advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. We will need to watch Medicare Geographic Practice Cost Index (GPCI) adjustments established for every Medicare payment locality.

Resolution 820 is regarding home sleep apnea testing. AMA has been asked to extend efforts to expand access to and insurance coverage of physician ordered home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions.

Resolution 814 initiates prior authorization legislation aimed at Medicare Advantage plans, state Medicaid programs as well as commercial payers, via model legislation, that allows for fair reimbursement for physician's time and that of their office staff when dealing with prior authorization. Resolution 801 asks AMA immediately collaborate with payers to seek adequate reimbursement for professional time spent answering questions on the patient portal not related to a recent visit and, that AMA continue to advocate for physicians to receive adequate compensation or seek relief from overreaching administrative tasks that take physicians' time away from direct patient care during our present climate of ever-increasing unpaid and unfunded mandates on their time.

Resolution 802 deals with physician burnout with inbox management resources, advocate for increasing the relative value unit for inbox management recognizing that it is asynchronous care that provides value and reduces overall health care costs as well as advocate for electronic health record tools that calculate physician time spent in the inbox.

 # Reference Committee B:

BOT report 2 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. Also, it asks that AMA pursue 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 physician supervision of the ED.

BOT report 1 deals with development, deployment and use in health care. This is of interest to us at ASE. I have attached this lengthy resolution as attachment #1.

BOT report 3 deals with Stark Law self-referral ban. This was referred. It recommended that AMA 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) 18 19 2. Also directed that AMA support 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.

Resolution 227 deals with Medicare payment parity for telemedicine services. It directs that AMA advocate for Medicare to reimburse providers for telemedicine-provided services at an equal rate as if the services were provided in-person.is to do with elimination of 14 day
Resolution 225 elimination of Medicare 14 day rule and urges AMA to actively lobby the federal government to readdress and change laboratory date of service rules under Medicare, e.g. the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that complex laboratory services performed on pathologic specimens collected from an inpatient hospital procedure be paid separately from inpatient bundled payments, consistent with Outpatient rules.

 # Reference Committee K:

CSAPH report 4 discusses reducing sodium intake to improve public health. This report calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals, school meals, meals in health care facilities, and other meals provided by daily meal providers, advocate for federal, state, and local efforts to reduce sodium levels in products from food manufacturers and restaurants without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients. This is to also to assist in achieving the Healthy People 2030 goal for sodium consumption, by will working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, Academy of Nutrition and Dietetics, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake and other dietary approaches to reduce hypertension.

Resolution 904 deals with regulation of ionized radiation exposure for healthcare workers. This resolution encourages public and private healthcare institutions to ensure more comprehensive coverage of different body types by providing PPE that more completely protects employees of all genders and pregnancy statuses, such as lead and lead-free aprons with capped sleeves, axillary supplements, and maternity aprons.

In summary, there was a huge volume of resolutions presented but the vast majority of them did not have direct impact on ASE and the vast majority did not have direct impact on cardiovascular disease or medical imaging. However, certain resolutions that are of potential interest to ASE have been highlighted and need to be watched closely as to the impact it has on the ASE members. We will be

following these resolutions intently at the annual AMA 2025 meeting, and will provide updates accordingly.

Again, it was our pleasure to serve ASE by attending the interim AMA 2024 meeting. Not only do we have the ability to interact on issues directly but also it is also vital to maintain our delegate status so that the society can maintain all the advantages particularly at the RUC committee where we can have direct access and not have to go through other associations such as ACC. I also want to particularly acknowledge the outstanding support of Katherine Stark and her tireless efforts to maintain the advocacy committee and maintain our presence at AMA. Katherine has made multiple important contacts with ACC personnel and other subspecialty societies that are invaluable to ASE. She is knowledgeable about policy, and is well respected.

Please feel free to contact us if you have questions or need additional information. Katherine Stark has all of the details if you so desire to explore any of these substantial reports or resolutions.

Sincerely,

Kamu Maganti, MD, FASE

cc:
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Attachment 1

BOT report 1

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. 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. Reference Committee B (I-24) Page 11 of 60 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 patientfacing 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. Reference Committee B (I-24) Page 12 of 60 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 Reference Committee B (I-24) Page 13 of 60 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. Reference Committee B (I-24) Page 14 of 60 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. Reference Committee B (I-24) Page 15 of 60 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 Reference Committee B (I-24) Page 16 of 60 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.