RESOLUTION

Subject: Sunsetting Policies

Submitted by: Don Stacy, MD

Referred to: Reference Committee

WHEREAS, pursuant to Kentucky Medical Association (KMA) policy, resolved statements and policy statements are subject to review and sunset ten years after adoption unless reaffirmed, amended, or rescinded; and

WHEREAS, the policy statements identified below have been reviewed and determined to remain relevant, appropriate, and consistent with the KMA's current mission and policy objectives; now, therefore, be it

RESOLVED, that KMA reaffirms policy HOD 2015-16 which advocates for further clinical research of cannabis in the treatment of medical conditions.

RESOLUTION

Subject: Sunset Policies

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association House of Delegates (HOD) meets annually to discuss relevant medical issues and formulate policy that is germane; and

WHEREAS, the policies put into place by the HOD are valid for 10 years and then require re-evaluation for relevance into medical practice; and

WHEREAS, there are current topics that need to be reaffirmed as they continue to have relevance to today; now, therefore, be it

RESOLVED, that KMA reaffirms that using its influence to expand mental health and addiction treatment in all forms of drug abuse including evidence-based medical and non-medical addiction treatment modalities (Res 2015-4, 2015 HOD); and be it further

RESOLVED, that KMA reaffirms advocating for physician reimbursement for time spent obtaining pre-certification and pre-authorization for designated services and prescriptions (Res 2015-19, 2015 HOD); and be it further

RESOLVED, that KMA reaffirms advocating for further clinical research of cannabis in the treatment of medical conditions (Res 2015-16, 2015 HOD); and be it further

RESOLVED, that KMA reaffirms advocating for payment mechanisms that allow adequate funding of mental health care in order to assure its continued availability in the primary care physician office (Res 2015-3, 2015 HOD); and be it further

RESOLVED, that KMA reaffirm supporting efforts by state and federal legislators to enact legislation supporting prevention and treatment of diabetes (Res 2015-9, 2015 HOD).

RESOLUTION

Subject: Support Evidence Based Cancer Screening and Early Detection

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, cancer remains a leading cause of morbidity and mortality in the United States, and early detection through appropriate screening is associated with improved survival and reduced disease burden; and

WHEREAS, evidence-based cancer screening enables detection of precancerous lesions and early-stage malignancies, allowing for timely intervention and improved clinical outcomes; and

WHEREAS, the U.S. Preventive Services Task Force (USPSTF) and other national organizations develop cancer screening recommendations based on rigorous review of benefits and harms, supporting evidence-based preventive care; and

WHEREAS, recommended screening for cancers such as breast, cervical, colorectal, and lung cancer has been shown to reduce mortality when appropriately implemented in eligible populations; and

WHEREAS, barriers to cancer screening include lack of access to care, limited health literacy, financial constraints, and gaps in healthcare system delivery; and

WHEREAS, physicians and healthcare systems play a critical role in promoting, recommending, and facilitating appropriate cancer screening in accordance with established guidelines; and

WHEREAS, improving adherence to evidence-based cancer screening has the potential to significantly reduce preventable cancer-related deaths and improve population health outcomes; now, therefore, be it

RESOLVED, that KMA supports the promotion and implementation of evidence-based cancer screening guidelines for breast, lung, colorectal and cervical cancer as developed by the U.S. Preventive Services Task Force and other nationally recognized organizations; and be it further

RESOLVED, that KMA encourages physicians and healthcare professionals to recommend and facilitate appropriate, guideline-concordant cancer screening for eligible patients; and be it further

RESOLVED, that KMA supports public health initiatives aimed at increasing awareness and understanding of the importance of cancer screening and early detection; and be it further

RESOLVED, that KMA advocates for policies that reduce barriers to cancer screening, including improving insurance coverage, affordability, and access to preventive services.

RESOLUTION

Subject: Lipoprotein(a) Screening and Insurance Coverage

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, according to 2022 data from the CDC, heart disease is the leading cause of death in the state of Kentucky, which has the 8th highest heart disease mortality rate in the country[1]; and

WHEREAS, 12.4% of individuals in Kentucky have been diagnosed with coronary heart disease, heart attack, or stroke[2]; and

WHEREAS, Lipoprotein(a) [Lp(a)] is a genetically inherited lipoprotein and an established, independent risk factor for atherosclerotic cardiovascular disease (ASCVD), with a causal and continuous association with cardiovascular events[3]; and

WHEREAS, Lp(a) is similar in structure to low-density lipoprotein (LDL), and most individuals remain asymptomatic until they develop ASCVD, making early detection critical; and

WHEREAS, the American Heart Association's 2022 Scientific Statement recognizes Lp(a) as a genetically determined, causal, and prevalent risk factor for atherosclerotic cardiovascular disease, and recommends that Lp(a) be measured in adults to improve cardiovascular risk stratification and guide clinical management[10]; and

WHEREAS, recent insights from a large national biobank published in Arteriosclerosis, Thrombosis, and Vascular Biology demonstrated a linear relationship between Lp(a) concentrations and ASCVD in middle-aged adults[4]; and

WHEREAS, the landmark 2026 ACC/ AHA/ AACVPR/ ABC/ ACPM/ ADA/ AGS/ APhA/ ASPC/ NLA/ PCNA Guideline on the Management of Dyslipidemia — for the first time in U.S. guideline history — issued a Class I (strongest possible) recommendation for universal Lp(a) measurement at least once in all adults, recognizing Lp(a) as a well-established causal factor of ASCVD independent of LDL-C[5]; and

WHEREAS, Lp(a) screening once in a person's lifetime allows for earlier intervention and more personalized cardiovascular risk management at concentrations ≥50 mg/dL or ≥125 nmol/L, the threshold above which the 2026 guidelines identify substantially elevated cardiovascular risk[5]; and

WHEREAS, despite this Class I guideline recommendation, insurance coverage for Lp(a) testing has not been updated to reflect current evidence: Medicare's coverage policy for cardiovascular biomarkers, governed by LCD L36358, was last updated in January 2026 and continues to rely on a 2009 USPSTF evidence review that predates the large-scale genetic and epidemiological studies establishing Lp(a) as the strongest inherited risk factor for heart disease[6]; and

WHEREAS, Lp(a) screening is not currently required to be covered by insurance companies as part of the Patient Protection and Affordable Care Act of 2010; and

WHEREAS, Kentucky House Bills HB52 and HB180 require coverage for cancer screening and biomarker testing, respectively, but contain no provision requiring coverage of Lp(a) testing as a screening tool[7,8]; and

WHEREAS, a recent cost-effectiveness analysis demonstrated that improved awareness of Lp(a) risk and attendant lifestyle modifications would yield significant cost savings within the current healthcare system[9]; now, therefore, be it

RESOLVED, that KMA supports legislation requiring Lipoprotein(a) [Lp(a)] be a screening test recommended by primary care once in a person's adult life, consistent with the 2026 ACC/AHA/Multisociety Class I guideline recommendation; and be it further

RESOLVED, that insurance coverage for Lp(a) testing be mandatory as a preventive screening tool, and that KMA advocates for updating Medicare's cardiovascular biomarker coverage policy (LCD L36358) to reflect current evidence.

References:

1. Stats of the States — Heart Disease Mortality. Centers for Disease Control and Prevention. February 25, 2022. https://www.cdc.gov/nchs/pressroom/sosmap/heart_disease_mortality/heart_disease.htm
2. Explore Cardiovascular Diseases in Kentucky | AHR. America's Health Rankings. https://www.americashealthrankings.org/explore/measures/CVD/KY
3. Emerging Risk Factors Collaboration, Erqou S, Kaptoge S, et al. Lipoprotein(a) concentration and the risk of coronary heart disease, stroke, and nonvascular mortality. JAMA. 2009;302(4):412–423.
4. Patel AP, Wang M, Pirruccello JP, et al. Lp(a) concentrations and incident atherosclerotic cardiovascular disease. Arteriosclerosis, Thrombosis, and Vascular Biology. 2021;41(1):465–474.
5. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia. J Am Coll Cardiol. Published online March 13, 2026. doi:10.1016/j.jacc.2026.02.001
6. LCD L36358 — MolDX: Biomarkers in Cardiovascular Risk Assessment. Centers for Medicare & Medicaid Services. Last updated January 2026. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=36358
7. H.B. 52, 2024–2025, KY (2025)
8. H.B. 180, 2023–2024, KY (2024)
9. Adams J, Orfanos P, Hu X, et al. Review of current clinical strategies of managing patients with elevated Lp(a): cost-effectiveness of Lp(a) testing and patient awareness. Heart, Lung and Circulation. 2024;33(Suppl 4):S534.
10. Reyes-Soffer G, Ginsberg HN, Berglund L, et al. Lipoprotein(a): a genetically determined, causal, and prevalent risk factor for atherosclerotic cardiovascular disease: a scientific statement from the American Heart Association. Arterioscler Thromb Vasc Biol. 2022;42(1):e48-e60. doi:10.1161/ATV.0000000000000147

RESOLUTION

Subject: Birth Dose of Hepatitis B Vaccine

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, hepatitis B virus (HBV) infection is a significant public health concern associated with chronic liver disease, cirrhosis, and hepatocellular carcinoma; and

WHEREAS, untreated hepatitis B infection can cause issues for adults who are diagnosed with autoimmune conditions later in life; and

WHEREAS, perinatal and early childhood transmission are major contributors to chronic HBV infection, with up to 90% of infants infected at birth developing chronic infection; and

WHEREAS, safe and effective hepatitis B vaccines have been available for decades and have demonstrated high efficacy in preventing HBV infection; and

WHEREAS, administration of the hepatitis B vaccine within 24 hours of birth is a critical intervention to prevent perinatal transmission, including in cases where maternal HBV status is unknown or documentation is incomplete; and

WHEREAS, national and international public health organizations, including the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP pre May 2025), and World Health Organization (WHO), recommend universal hepatitis B vaccination beginning at birth; and

WHEREAS, the hepatitis B birth dose serves as a vital safety net to prevent transmission due to missed maternal screening, false-negative results, or breakdowns in communication of maternal HBV status; and

WHEREAS, timely administration of the birth dose improves completion of the vaccine series and contributes to long-term reductions in HBV infection rates and related morbidity and mortality; now, therefore, be it

RESOLVED, that KMA supports universal administration of the hepatitis B vaccine birth dose for all medically appropriate newborns; and be it further

RESOLVED, that KMA supports educational efforts aimed at increasing awareness among healthcare providers and parents regarding the safety, efficacy, and importance of the hepatitis B birth dose; and be it further

RESOLVED, that KMA opposes policies or practices that discourage or delay the routine administration of the hepatitis B vaccine at birth in the absence of medical contraindications.

KMA House of Delegates
August 2026

RESOLUTION

Subject: HPV Vaccination until age 45

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, human papillomavirus (HPV) is a common sexually transmitted infection associated with multiple cancers, including cervical, oropharyngeal, anal, penile, vulvar, and vaginal cancers; and

WHEREAS, HPV vaccination is a safe and effective preventive measure that significantly reduces the incidence of HPV-related infections, precancerous lesions, and cancers; and

WHEREAS, the U.S. Food and Drug Administration has approved HPV vaccination for individuals up to age 45; and

WHEREAS, the Advisory Committee on Immunization Practices (ACIP) recommends shared clinical decision-making regarding HPV vaccination for adults aged 27 through 45 who are not adequately vaccinated; and

WHEREAS, many adults aged 27–45 remain unvaccinated and may still be at risk for new HPV infections, particularly with new sexual partners or other risk factors; and

WHEREAS, expanding awareness and support for HPV vaccination in this age group may help reduce the burden of HPV-related cancers and improve public health outcomes; now, therefore, be it

RESOLVED, that KMA supports human papillomavirus (HPV) vaccination for eligible adults up to age 45, consistent with U.S. Food and Drug Administration (FDA) approval and Advisory Committee on Immunization Practices (ACIP) (Pre May 2025) shared clinical decision-making recommendations; and be it further

RESOLVED, that KMA encourages physicians to engage in informed discussions with patients regarding the risks and benefits of HPV vaccination; and be it further

RESOLVED, that KMA supports efforts to improve access to HPV vaccination for adults up to age 45, including insurance coverage and public health initiatives; and be it further

RESOLVED, that KMA promotes education and awareness campaigns to increase understanding of HPV-related cancer prevention across all eligible age groups.

RESOLUTION

Subject: HPV Vaccination and Cervical Cancer

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, screening for cervical cancer has been demonstrated to be effective in detecting cervical precursor lesions and decreasing progression to cancer; and

WHEREAS, pap smear cytology screening should be initiated at 21 years of age; and

WHEREAS, high risk human papilloma virus (HPV) testing should be considered in women aged 30-65 as a part of algorithm or as a FDA approved home collection kit; and

WHEREAS, Kentucky is the only state in the nation with increasing rates of cervical cancer; and

WHEREAS, HPV vaccination has been shown to decrease cervical cancer; now, therefore, be it

RESOLVED, that KMA supports HPV vaccination and cervical cancer screening to prevent cervical cancer.

References:

1. Yang DX, Soulos PR, Davis B, Gross CP, Yu JB. Impact of Widespread Cervical Cancer Screening: Number of Cancers Prevented and Changes in Race-specific Incidence. Am J Clin Oncol. 2018 Mar;41(3):289-294. doi: 10.1097/COC.0000000000000264. PMID: 26808257; PMCID: PMC4958036.
2. Screening for Cervical Cancer. Obstetrics & Gynecology 148(1):p e63-e67, July 2026. | DOI: 10.1097/AOG.0000000000006257
3. https://link.edgepilot.com/x/loTt5qDVB6ijgw0S10XOKLQ?u=https://statecancerprofiles.cancer.gov/incidencerates/index.php?statefips=00%26areatype=state%26age=001%26cancer=057%26stage=999%26race=00%26sex=2%26ruralurban=0%26year=0%26sortVariableName=rate%26sortOrder=desc%26type=incd%26output=0
4. Kamolratanakul S, Pitisuttithum P. Human Papillomavirus Vaccine Efficacy and Effectiveness against Cancer. Vaccines (Basel). 2021 Nov 30;9(12):1413. doi: 10.3390/vaccines9121413. PMID: 34960159; PMCID: PMC8706722.

RESOLUTION

Subject: Supporting Evidence Based Vaccine Policy

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, vaccination is one of the most effective public health interventions, preventing morbidity and mortality from numerous infectious diseases and contributing to community-wide protection; and

WHEREAS, vaccine recommendations in the United States are developed through rigorous, transparent review of scientific evidence, including evaluation of safety, efficacy, effectiveness, and population health impact; and

WHEREAS, the Advisory Committee on Immunization Practices (ACIP) develops national immunization recommendations using standardized, evidence-based methodologies, including systematic review of data and structured frameworks to assess benefits, harms, feasibility, and equity; and

WHEREAS, ACIP has currently become a politically charged committee clouding the recommended immunization schedules by bias; and

WHEREAS, vaccine safety is continuously monitored through robust pre- and post-licensure surveillance systems overseen by the Centers for Disease Control and Prevention and the U.S. Food and Drug Administration; and

WHEREAS, maintaining public trust in vaccines requires adherence to transparent, science-based policymaking and consistent communication grounded in high-quality evidence; and

WHEREAS, state medical societies play a critical role in promoting best practices, guiding clinicians, and advocating for policies that protect public health; now, therefore, be it

RESOLVED, that KMA affirms its support for vaccine policies that are grounded in the best available scientific evidence and nationally recognized guidelines; and be it further

RESOLVED, that physicians and healthcare professionals within the state are encouraged to follow evidence-based immunization schedules in clinical practice and to use these guidelines in patient counseling and shared decision-making; and be it further

RESOLVED, that KMA supports efforts to promote accurate, evidence-based information about vaccines and to address misinformation that may undermine vaccine confidence; and be it further

RESOLVED, that KMA advocates for policies that ensure equitable access to recommended vaccines for all populations within the state; and be it further

RESOLVED, that KMA reaffirms its commitment to evidence-based medicine and public health by supporting vaccination practices that are safe, effective, and grounded in the highest quality scientific standards.

RESOLUTION

Subject: Strengthening Immunization Requirements for School Attendance in Kentucky

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, vaccination is among the most successful public health interventions in history, preventing millions of cases of disease, disability, and death; and

WHEREAS, routine childhood immunization has led to dramatic reductions in vaccine-preventable diseases including measles, mumps, rubella, diphtheria, polio, tetanus, and pertussis; and

WHEREAS, high vaccination coverage creates community protection that helps safeguard infants, immunocompromised individuals, cancer patients, transplant recipients, and others who cannot safely receive certain vaccines; and

WHEREAS, recent measles outbreaks in the United States have demonstrated the ongoing risk posed by declining vaccination rates and clusters of under-vaccinated individuals; and

WHEREAS, scientific evidence overwhelmingly supports the safety and effectiveness of vaccines; and

WHEREAS, school immunization requirements have consistently been associated with higher vaccination rates and reduced transmission of vaccine-preventable diseases; and

WHEREAS, medical exemptions provide appropriate protection for children with legitimate contraindications to vaccination while preserving public health protections for the broader community; and

WHEREAS, physicians have an ethical obligation to advocate for evidence-based measures that prevent disease and protect public health; now, therefore, be it

RESOLVED, that KMA reaffirms its support for evidence-based immunization requirements for attendance in public schools, private schools, and licensed childcare facilities in Kentucky; and be it further

RESOLVED, that KMA advocates for the retention of medically indicated exemptions while opposing the creation or expansion of non-medical exemptions to school immunization requirements; and be it further

RESOLVED, that KMA supports public education initiatives that communicate the safety, effectiveness, and public health benefits of childhood immunization.

2026-10

RESOLUTION

Subject: Study and Recommendations on Screen Time and Digital Learning in K–12 Education

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, excessive recreational and educational screen time among children and adolescents has been associated in the medical literature with increased risks of sleep disturbance, anxiety, depression, reduced physical activity, attention difficulties, and adverse effects on social-emotional development; and

WHEREAS, the rapid expansion of one-to-one device programs and digital instruction in K–12 education has occurred without consistent evidence-based standards regarding appropriate duration, developmental appropriateness, or health impacts; and

WHEREAS, growing research suggests that younger children benefit from direct interpersonal instruction, hands-on learning, physical activity, and reduced reliance on digital devices in educational settings; and

WHEREAS, physicians have an important role in advocating for evidence-based educational and public health policies that promote the physical, cognitive, and emotional well-being of Kentucky's children; now, therefore, be it

RESOLVED, that KMA direct their Public Health Committee to review the current scientific evidence regarding the health effects of screen time and digital learning in K–12 education; and be it further

RESOLVED, that the committee develop evidence-based recommendations regarding age-appropriate use of digital devices in Kentucky schools, including consideration of screen time limits, best practices for digital instruction, and opportunities to increase in-person, hands-on learning; and be it further

RESOLVED, that the KMA reports its findings and recommendations to the House of Delegates and, as appropriate, share them with Kentucky educational leaders, policymakers, school districts, physicians, parents, and the public to promote healthy learning environments.

References:

1. Amez, Simon, and Stijn Baert. "Smartphone Use and Academic Performance: A Literature Review." *International Journal of Educational Research*, vol. 103, 2020, article 101618. https://link.edgepilot.com/x/9tXMe4838QhVNdza4eGqaXk?u=https://doi.org/10.1016/j.ijer.2020.101618.
2. American Academy of Pediatrics. "Media and Young Minds." *Pediatrics*, vol. 138, no. 5, 2016. https://link.edgepilot.com/x/1pivhmyGLjpPGImizt0wrxA?u=https://doi.org/10.1542/peds.2016-2591.
3. Lazonder, Ard W., et al. "Longitudinal Assessment of Digital Literacy in Children: Findings from a Large Dutch Single-School Study." *Computers & Education*, vol. 143, 2020, article 103681. https://link.edgepilot.com/x/qiBjR0JNsQqTv_tGNh9WS7Q?u=https://doi.org/10.1016/j.compedu.2019.103681.
4. Organization for Economic Co-operation and Development. *Country Digital Education Ecosystems and Governance: A Companion to Digital Education Outlook 2023*. OECD Publishing, 2023. https://link.edgepilot.com/x/CjIgGwkNN4pvHUjhvPFWMHI?u=https://doi.org/10.1787/906134d4-en.
5. Zablotsky, Benjamin, et al. *Daily Screen Time Among Teenagers: United States, July 2021–December 2023*. National Center for Health Statistics Data Brief No. 513, Centers for Disease Control and Prevention, Oct. 2024. https://link.edgepilot.com/x/NP5UGtiNkM8w4QhQG372g8g?u=https://www.cdc.gov/nchs/products/databriefs/db513.htm

2026-11

RESOLUTION

Subject: Increasing Awareness of Folic Acid Fortification

Submitted by: Naiya Sims and Emma Higgins (Medical Student Section)

Referred to: Reference Committee

WHEREAS, folic acid consumption is recommended to women of childbearing age to reduce the risk of neural tube defects[1,2]; and

WHEREAS, in 1998, the U.S. Food and Drug Administration (FDA) mandated folic acid fortification of "standard of identity" grain products, such as pasta, flour, and bread[2]; and

WHEREAS, corn masa flour is a staple ingredient in many Hispanic/Latin dishes, such as tortillas and tamales, but it is not considered a "standard of identity" grain product[1]; and

WHEREAS, Hispanic/Latina women are 19% more likely to have a pregnancy affected by a neural tube defect than non-Hispanic women[3,4]; and

WHEREAS, in 2016, the FDA began encouraging, but not mandating, folic acid fortification of corn masa flour[3]; and

WHEREA, in 2024, it is estimated that only 5.8% of products containing corn masa in the United States are fortified with folic acid[4]; and

WHEREAS, the Center for Disease Control and Prevention (CDC) endorses that decreased awareness of the benefits of folic acid among the Hispanic/Latina population may contribute to reduced folate levels compared to non-Hispanic women[5]; and

WHEREAS, the American Medical Association (AMA) supports folic acid fortification of all human-consumed grains and, in 2024, the AMA updated its policy to reflect continued encouragement of programs that educated the public on the importance of folic acid intake through diet, fortification, and supplementation[6,7]; and

WHEREAS, the Kentucky Medical Association (KMA) 2017 Policy Manual recommends folic acid consumption in women of childbearing age, but there is no current policy regarding folic acid fortification of grain products[8]; now, therefore, be it

RESOLVED, that KMA supports folic acid fortification in all grains marked for human consumption; and be it further

RESOLVED, that KMA continues to advocate for educational awareness of the benefits of folic acid consumption in all women of childbearing age.

References:

1. *Fortifying corn masa flour products with folic acid*. U.S. Food and Drug Administration. (2024, June). https://www.fda.gov/food/food-additives-petitions/fortifying-corn-masa-flour-products-folic-acid
2. Crider, K., Bailey, L., & Berry, R. (2011). *Folic Acid Food Fortification—Its History, Effect, Concerns, and Future Directions*. PubMed Central. https://pmc.ncbi.nlm.nih.gov/articles/PMC3257747/
3. *Folic Acid: Sources and Recommended Intake*. Centers for Disease Control and Prevention. (2026, June). https://www.cdc.gov/folic-acid/about/intake-and-sources.html
4. *Corn Masa Fortification*. Food Fortification Initiative. (2025). https://ffinetwork.org/corn-masa-fortification/
5. *Improving Folic Acid Intake*. Centers for Disease Control and Prevention. (2025, May). https://www.cdc.gov/folic-acid/health-equity/index.html
6. *Folic Acid Fortification of Grain Products H-150.918*. AMA Policy Finder. (2023). https://policysearch.ama-assn.org/policyfinder/detail/folic%20acid?uri=%2FAMADoc%2FHOD. xml-H-150.918.xml
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8. *KMA Policy Manual*. Kentucky Medical Association. (2017). https://kyma.org/shared/content/uploads/2017/10/2017-18-KMA-POLICY-MANUAL-WEB.pdf

2026-12

RESOLUTION

Subject: Improve Access to Grocery Stores and Healthy Foods

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, access to affordable, nutritious food is a fundamental determinant of health and is essential for the prevention and management of chronic diseases; and

WHEREAS, “food deserts” are defined as geographic areas with limited access to affordable and nutritious foods, including fresh fruits, vegetables, and whole grains, often due to a lack of nearby grocery stores; and

WHEREAS, food deserts disproportionately affect low-income, rural, and historically marginalized communities, contributing to health disparities and inequities in diet-related conditions such as obesity, diabetes, and cardiovascular disease; and

WHEREAS, limited access to grocery stores and healthy food options is associated with poorer diet quality and increased risk of chronic disease; and

WHEREAS, improving access to grocery stores, farmers’ markets, and other healthy food sources has been associated with improved dietary behaviors and community health outcomes; and

WHEREAS, barriers to healthy food access include transportation limitations, economic constraints, neighborhood infrastructure, and historical patterns of disinvestment; and

WHEREAS, evidence-based policy approaches—including financial incentives for grocery store development, support for local food systems, and integration of food access into healthcare initiatives—can improve availability and affordability of healthy foods in underserved areas; and

WHEREAS, state medical societies play a critical role in addressing social determinants of health and advocating for policies that improve population health and reduce disparities; now, therefore, be it

RESOLVED, that KMA supports policies and initiatives aimed at increasing access to affordable, nutritious foods in underserved and food desert communities; and be it further

RESOLVED, that KMA supports policy measures that incentivize grocery retailers to locate in underserved communities, including grants, tax incentives, and public-private partnerships; and be it further

RESOLVED, that KMA encourages integration of “food as medicine” initiatives, including produce prescription programs and medically tailored nutrition support, into healthcare systems to address food insecurity for patient & community health.

KMA House of Delegates
August 2026

2026-13

RESOLUTION

Subject: Educating the Public on Nicotine Products and Associated Health Risks

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, nicotine-containing products, including combustible cigarettes, e-cigarettes, vaping devices, nicotine pouches, and other emerging delivery systems, are widely used and increasingly marketed to youth and young adults; and

WHEREAS, nicotine is a highly addictive substance with well-documented adverse effects on cardiovascular, pulmonary, and neurological health, including impacts on brain development in adolescents and young adults; and

WHEREAS, the proliferation of flavored nicotine products and targeted marketing strategies has contributed to increased initiation and sustained use among youth populations; and

WHEREAS, there exists widespread public misunderstanding regarding the relative risks of various nicotine products, including the misconception that certain products are harmless or significantly safer without sufficient evidence, especially nicotine pouches; and

WHEREAS, physicians and public health organizations play a critical role in providing accurate, evidence-based information to patients and the broader community; now, therefore, be it

RESOLVED, that KMA develop and promote educational initiatives aimed at increasing public awareness of the health risks associated with all forms of nicotine use; and be it further

RESOLVED, that KMA supports reducing youth access to nicotine products including nicotine pouches; and be it further

RESOLVED, that KMA supports limiting advertising practices that appeal to minors when it comes to nicotine pouches and products.

2026-14

RESOLUTION

Subject: Expanding Access to Continuous Glucose Monitoring (CGM) For Patients with Type 2 Diabetes in Kentucky

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, diabetes is a public health crisis in Kentucky, affecting approximately 486,000 adults (14.5%), well above the national average of 12%, making Kentucky the 7th-highest state for Type 2 diabetes prevalence, with more than 26,000 new diagnoses annually at rates that have more than doubled since 2000[1]; and

WHEREAS, the annual economic burden of diabetes in Kentucky exceeds $5.1 billion, with the state experiencing the largest percentage increase in diabetes-related medical and Medicaid costs in the nation from 2013–2021[1]; and

WHEREAS, continuous glucose monitoring (CGM) provides real-time glucose trends and detects postprandial hyperglycemia and glycemic variability not captured by HbA1c or fingerstick testing, enabling earlier and more personalized lifestyle and therapeutic intervention[2,6]; and

WHEREAS, a 2024 systematic review and meta-analysis of randomized controlled trials demonstrated that CGM-based interventions significantly reduced HbA1c and increased time in range, with consistent benefit in non-insulin-treated Type 2 diabetes[2]; and

WHEREAS, CGM has been shown to be a powerful motivator for sustained behavior change, with high patient acceptability in individuals with early Type 2 diabetes mellitus, particularly when combined with lifestyle or digital health coaching[3]; and

WHEREAS, older adults aged 65 years and older with Type 2 diabetes mellitus face heightened risk from unrecognized hypo and hyperglycemia, and CGM use in this population has been shown to reduce hypoglycemia, hospitalizations, morbidity, and mortality, while improving quality of life[4]; and

WHEREAS, current Medicare and commercial payer policies restrict CGM coverage primarily to insulin use or documented hypoglycemia, thereby excluding many adults with non-insulin-treated Type 2 diabetes despite growing evidence of benefit[5]; and

WHEREAS, expanding CGM access aligns with value-based care, current diabetes care guidelines, and Kentucky public health priorities, and represents a cost-effective strategy to prevent disease progression and reduce downstream complications[1,2]; and

WHEREAS, CGM ($1,000-$3,000 annually) costs a fraction of the downstream expense of uncontrolled diabetes and its complications, saving an estimated $100,000-$200,000 or more in lifetime direct medical expenditures and CGM-driven reductions in hospitalizations for hypoglycemia complications[1,4,5,7]; and

WHEREAS, from 2013 to 2021 Kentucky saw the largest percentage increase of any state in both diabetes medical costs (79%), and Medicaid diabetes costs (483%)[4,5]; and

WHEREAS, one of the most prominent changes in the ADA 2026 Standards concerns diabetes technology, wherein CGM is now recommended at the time of diagnosis and thereafter representing a broader approach that encourages early use of technology to support glucose awareness and improve outcomes; now, therefore, be it

RESOLVED, that KMA advocate before the Centers for Medicare & Medicaid Services, the Kentucky Department of Medicare and Medicaid and all commercial insurers operating in Kentucky for expansion of continuous glucose monitoring coverage to include all adults with Type 2 diabetes mellitus regardless of insulin use; and be it further

RESOLVED, that KMA advocates for removal of insulin-use requirements as eligibility criteria for continuous glucose monitoring coverage in favor of evidence-based clinical criteria, and that this policy position be transmitted to relevant state and national stakeholders, including the American Medical Association.

References:

1. Kentucky Cabinet for Health and Family Services, Department for Medicaid Services, Department for Public Health, Office of Health Data and Analytics, and Personnel Cabinet, Department of Employee Insurance. *2019 Kentucky Diabetes Report*. Frankfort, KY; 2019.
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RESOLUTION

Subject: Improving Access to Chronic Disease Care to Reduce Preventable Complications and Hospitalizations

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, uninterrupted access to medically necessary medications, supplies, therapies, and other healthcare services is essential to maintaining disease control and functional health for individuals living with chronic medical conditions; and

WHEREAS, interruptions in access to medically necessary therapies may result in disease exacerbations, avoidable emergency department visits, hospitalizations, prolonged inpatient stays, and increased healthcare expenditures; and

WHEREAS, challenges obtaining appropriate medications, home health services, and durable medical equipment may delay discharge from inpatient settings, especially for medically complex patients who may necessitate use of intensive care unit resources in settings without a step-down unit; and

WHEREAS, quantity limits on disposable medical supplies may not adequately account for wear and tear, displacement, site hygiene, and other urgent events; and

WHEREAS, the Kentucky Preferred Drug List is subject to periodic modification by the Pharmacy and Therapeutics Committee to promote cost-effective care, which may unintentionally disrupt continuity of treatment for patients with chronic medical conditions who are clinically stable on established therapies when “non-medical switching” is required due to the modifications, potentially resulting in adverse health outcomes and increased healthcare utilization; and

WHEREAS, excessive or repetitive prior authorization requirements may delay medically necessary care, increase administrative burden on patients and healthcare professionals, and contribute to adverse patient outcomes, with more than one-quarter of physicians in the 2025 American Medical Association Prior Authorization Physician Survey reporting that a prior authorization requirement resulted in a serious adverse event for a patient under their care; and

WHEREAS, Kentucky has enacted prior authorization reforms that provide exemptions based on provider performance metrics, but patients receiving medically necessary therapies from providers who do not qualify for such exemptions may continue to experience authorization-related delays; and

WHEREAS, multiple states have enacted legislation limiting or prohibiting prior authorization requirements for specific categories of medications and treatments, demonstrating legislative recognition

that certain therapies warrant expedited access due to their importance in preventing morbidity and improving continuity of care; and

WHEREAS, multiple states have enacted or considered legislation designed to limit non-medical switching and mid-year formulary changes for clinically stable patients, recognizing that treatment changes driven by coverage or cost considerations rather than clinical need may disrupt continuity of care and adversely affect health outcomes; and

WHEREAS, states possess authority to define coverage requirements within public healthcare programs, and coverage policies adopted by public programs may influence broader healthcare delivery and insurance practices; and

WHEREAS, current KMA policy supports changes to the prior authorization process to "alleviate the burdens patients face in obtaining coverage for prescription drugs," "reduce delays in patient care," and to "reduce the administrative burden of prior authorization," but does not specifically promote exemptions from prior authorizations beyond medications for "treatment of an opioid use disorder"; and

WHEREAS, current KMA policy does not address the harms of non-medical switching due to modifications of the Kentucky Preferred Drug List; now, therefore, be it

RESOLVED, that KMA take further steps to support timely access to medically necessary durable medical equipment, medical supplies, outpatient therapies, home health services, and nursing services that facilitate hospital discharge and prevent avoidable complications and hospitalizations; and be it further

RESOLVED, that KMA support targeted exemptions from prior authorization requirements for selected therapies, supplies, and services when delays in access are likely to increase patient harm, healthcare utilization, or overall healthcare expenditures; and be it further

RESOLVED, that KMA support policies that protect clinically stable patients from non-medical switching and other coverage-related treatment interruptions not based on medical necessity; and be it further

RESOLVED, that KMA advocate for insurance coverage policies that support effective chronic disease management and reduce preventable healthcare spending; and be it further

RESOLVED, that KMA offer insight from its members to assist policymakers in recognizing the medications, supplies, and services for which such policy development would offer the most benefit.

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1. https://www.ama-assn.org/practice-management/prior-authorization/ama-prior-authorization-physician-survey
2. https://apps.legislature.ky.gov/recorddocuments/bill/26RS/hb176/bill.pdf
3. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00191?journalCode=hlthaff
4. https://www.chfs.ky.gov/agencies/dms/dpo/ppb/Documents/SinglePDLFAQsforProviders.pdf
5. https://pmc.ncbi.nlm.nih.gov/articles/PMC12721913/
6. https://pmc.ncbi.nlm.nih.gov/articles/PMC10398101/
7. https://pubmed.ncbi.nlm.nih.gov/31081414/
8. https://csro.info/advocacy/our-issues/non-medical-switching
9. https://www.cga.ct.gov/2017/rpt/2017-R-0203.htm
10. https://kyma.org/wp-content/uploads/2024/09/2024-2025-KMA-POLICY-MANUAL-1.pdf
11. 7 states (Massachusetts, Maryland, New Jersey, West Virginia, Illinois, Vermont, and Kentucky) already have a complete ban on PAs on Medications for Opioid Use Disorder.
12. Supplies examples: for the management of ventilators, respiratory care, ostomy care, parenteral and/or enteral feeding and supplementation, wound care, medication management, central line care, mobility aids, urological supplies, etc.

2026-16

RESOLUTION

Subject: Support Initiatives of the KY Office of Dementia Services

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, Alzheimer's disease and related dementias represent a growing public health challenge, with increasing prevalence, significant morbidity and mortality, and substantial impact on patients, caregivers, and healthcare systems; and

WHEREAS, individuals living with dementia and their caregivers require coordinated, comprehensive, and accessible services across the continuum of care; and

WHEREAS, the Kentucky Office of Dementia Services (ODS), within the Department for Aging and Independent Living, provides statewide leadership in improving quality of life for individuals living with dementia and their caregivers through education, community engagement, and system coordination; and

WHEREAS, the ODS advances key initiatives including promoting brain health and risk reduction, enhancing early detection and diagnosis, supporting caregivers, strengthening a dementia-capable workforce, and coordinating implementation of the Kentucky Dementia State Plan; and

WHEREAS, programs such as Dementia Friendly Communities and Dementia Friends Kentucky aim to increase public awareness, reduce stigma, and foster supportive environments for individuals living with dementia; and

WHEREAS, physicians and healthcare organizations play a critical role in recognizing cognitive impairment, guiding care planning, educating patients and families, and connecting individuals to community resources; now, therefore, be it

RESOLVED, that KMA supports the mission and initiatives of the Kentucky Office of Dementia Services (ODS); and be it further

RESOLVED, that KMA encourages physicians and healthcare systems to engage with and utilize ODS resources to support patients living with dementia and their caregivers; and be it further

RESOLVED, that KMA supports efforts to enhance early detection of cognitive impairment and improve access to dementia-related care and services across the state; and be it further

RESOLVED, that KMA supports public health initiatives that promote brain health, reduce dementia risk, and improve awareness and education about dementia.

2026-17

RESOLUTION

Subject: Eliminate Taxation on Menstrual Products

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, menstrual products, including sanitary pads, tampons, and other hygiene supplies, are essential items necessary for basic health, hygiene, and dignity; and

WHEREAS, menstruation is a normal physiologic process experienced by a substantial portion of the population over decades of life, requiring consistent access to menstrual hygiene products; and

WHEREAS, sales taxes on menstrual products increase financial barriers to access, disproportionately affecting low-income individuals and contributing to “period poverty,” which has been associated with missed school, missed work, and adverse health outcomes; and

WHEREAS, major medical and public health organizations, including the American Medical Association, have recognized menstrual products as essential health items and have called for the elimination of sales taxes on these products; and

WHEREAS, numerous jurisdictions domestically and internationally have taken steps to remove taxes on menstrual products as part of broader efforts to promote menstrual equity and public health; and

WHEREAS, improving access to affordable menstrual products supports health, educational attainment, workforce participation, and overall well-being; now, therefore, be it

RESOLVED, that KMA supports the elimination of state and local sales taxes on menstrual products; and be it further

RESOLVED, that KMA recognizes menstrual products as essential health and hygiene items rather than luxury goods; and be it further

RESOLVED, that KMA advocates for policies that reduce financial barriers to menstrual product access.

2026-18

RESOLUTION

Subject: Barriers Preventing Physicians from Running for Public Office

Submitted by: Michael Kuduk, MD (KMA Past President)

Referred to: Reference Committee

WHEREAS, currently there are 20 physicians serving in Congress as compared to 132 lawyers (Congress.gov); and

WHEREAS, currently there are 86 physicians serving in state legislatures as compared to over 1,000 lawyers (American Bar Association); and

WHEREAS, physician involvement in legislatures is perhaps the most effective method in which physicians can directly advocate for their patients and for public health; and

WHEREAS, significant barriers exist to physician participation in legislatures, such as loss of income, lack of support from employers, inadequate practice coverage, and loss of clinical time; now, therefore, be it

RESOLVED, that KMA shall direct its delegation to our American Medical Association to file a resolution requesting that our AMA study the barriers confronting and preventing physicians from running for public office, especially state and federal legislatures, with a report back to the AMA House of Delegates at the following annual meeting to inform further development of policy.

2026-19

RESOLUTION

Subject: Mandatory Transparency and Data Disclosure in Algorithmic Claims Adjudication

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky's House Bill 176 (2026) protects patients and physicians by granting "Gold-Carding" prior authorization exemptions to physicians who maintain a ninety-three percent (93%) clinical approval rate; and

WHEREAS, health plans increasingly use automated algorithms, artificial intelligence (AI), and algorithmically-assisted systems, including nominal "human-in-the-loop" sign-offs, to batch-deny claims and prior authorization requests; and

WHEREAS, these "black box" systems hide the logic behind their decisions, preventing treating physicians from verifying if a denial is based on peer-reviewed medicine or corporate cost-containment; and

WHEREAS, automated and algorithmically-driven denials artificially suppress a physician's approval rate, blocking them from the Gold-Carding protections established by HB 176; and

WHEREAS, the Kentucky Department of Insurance currently lacks the statutory authority to inspect the proprietary code, logic, and clinical guidelines used by these automated systems; and

WHEREAS, patient safety and the physician-patient relationship demand that any system used to deny medical care be fully transparent, auditable, and referenceable; now, therefore, be it

RESOLVED, that KMA advocates for legislation and rules mandating that any health plan using automated, AI-driven, or algorithmically-assisted review systems (including systems where software recommendations guide a human reviewer) provide full transparency by:

1. Registering all clinical criteria, underlying logic, and policies with the Kentucky Department of Insurance prior to deployment;

2. Providing the physician and patient with an immediate, plain-language explanation of the specific clinical reasons and data that triggered the denial, explicitly stating to the patient that this is an administrative decision by the health plan and does not reflect a lack of clinical merit or documentation by the physician; and

3. Disclosing the scientific source literature, data, and last modification date for the system's clinical pathways; and be it further

RESOLVED, that KMA advocates for laws declaring that any algorithmic denial failing to meet these transparency rules is legally void, resulting in immediate administrative approval and mandatory payment of the claim; and be it further

RESOLVED, that KMA advocates that any denial resulting from a non-compliant algorithmic review must be counted as a clinical approval in the ninety-three percent (93%) Gold-Carding calculation under HB 176, preventing insurers from using illegal tools to block physician exemptions.

2026-20

RESOLUTION

Subject: Prohibiting Automated Adverse Benefit Determinations without Clinical Peer Review

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, commercial insurers are increasingly utilizing automated processing tools, including proprietary algorithms and artificial intelligence (AI), to systematically downcode or deny medical claims without clinical validation; and

WHEREAS, the Kentucky General Assembly successfully enacted historic prior authorization reform through House Bill 176 during the 2026 Regular Session, establishing a critical pathway for "Gold-Carding" exemptions based on a 93% clinical approval threshold; and

WHEREAS, the unchecked deployment of automated algorithms and artificial intelligence by insurance metrics can result in batch-denials of complex medical services, medical necessity determinations, and covered treatments arbitrarily reclassified as uncovered services without individual clinical variance review; and

WHEREAS, such automated adverse benefit determinations can artificially suppress a physician's approval rating, thereby subverting the legislative intent of HB 176 and blocking access to statutory exemptions; and

WHEREAS, the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015) establishes that the regulation of the "business of insurance" is reserved to the States, protecting Kentucky’s authority to define and enforce fair claims practices within its borders; and

WHEREAS, The United States Presidential Executive Order of December 11, 2025, seeks to promote national AI uniformity but does not supersede the State’s specific regulatory authority to protect policyholders and providers from bad faith insurance practices; and

WHEREAS, the requirement for clinical oversight in adverse benefit determinations is a matter of insurance contract enforcement and professional accountability, rather than the regulation of technology itself; and

WHEREAS, the American Medical Association (AMA) Policy H-480.939 entitled titled "Augmented Intelligence in Health Care," mandates that payor utilization of algorithmic systems to make claims determinations or set coverage limitations must be fully disclosed to the impacted parties and remain subordinate to physician control; and

WHEREAS, model state frameworks, such as the 2026 Illinois Transparency in Downcoding Act, have successfully established that downcoding decisions cannot be made solely by automated tools and must be verified by a licensed peer of the same or similar specialty; now, therefore, be it

RESOLVED, that KMA petition the Kentucky Department of Insurance to classify an "Automated Adverse Benefit Determination without Contemporaneous Human Review" as a per se violation of the Kentucky Unfair Claims Settlement Practices Act (KRS 304.12-230); and be it further

RESOLVED, that KMA seek legislative or regulatory requirements ensuring that any entity adjusting or downcoding a medical claim must maintain a verifiable audit trail proving that a Kentucky-licensed physician reviewed the relevant medical record and clinical documentation prior to the alteration of payment, thereby ensuring compliance with state clinical standards regardless of the technology employed; and be it further

RESOLVED, that KMA advocate for legislation and state regulatory rules in line with AMA policy that explicitly prohibit any health benefit plan from issuing an adverse benefit determination using automated, algorithmic, or artificial intelligence systems without providing the treating physician the opportunity for a documented, timely peer-to-peer clinical review with a clinical peer holding a valid, unrestricted license in the Commonwealth of Kentucky within the same or similar specialty.

References:

1. https://policysearch.ama-assn.org/policyfinder/detail/H-480.939?uri=%2FAMADoc%2FHOD.xml-H-480.939.xml
2. https://legiscan.com/IL/text/SB3114/id/3354237

RESOLUTION

Subject: Protecting Physicians from Proprietary Clinical Artificial Intelligence Liability

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky General Assembly successfully enacted historic prior authorization reform through House Bill 176 during the 2026 Regular Session, establishing a critical statutory pathway for "Gold-Carding" exemptions based on a ninety-three percent (93%) clinical approval threshold over a rolling twelve-month evaluation period; and

WHEREAS, health benefit plans, managed care organizations, and proprietary software vendors are increasingly deploying clinical artificial intelligence (AI), machine-learning protocols, and predictive algorithms to dictate determinations of medical necessity, step-therapy, and prior authorization approvals; and

WHEREAS, conditioning vital administrative benefits, such as a physician's statutory HB 176 "Gold-Card" exemption status, upon strict adherence to an insurer's algorithmic metrics creates immense systemic coercion to conform to automated, cost-centric clinical pathways over individualized patient care; and

WHEREAS, under current medical professional liability and tort doctrines, the treating clinician remains the sole target of litigation if an algorithmic recommendation or insurance pathway is followed and results in an adverse patient outcome, while corporate payers shield themselves from accountability using contractual "hold harmless" and indemnification clauses; and

WHEREAS, high-quality, safe medical care requires that a physician's independent clinical judgment remain paramount, meaning physicians shall not be required to follow, nor be limited by, any automated or algorithmic clinical pathways when determining the best course of treatment for an individual patient; and

WHEREAS, the McCarran-Ferguson Act confirms the statutory authority of the Commonwealth of Kentucky to regulate the business of insurance, which inherently encompasses the power to establish consumer and provider protections against predatory, insurance-mandated liability shifts; now, therefore, be it

RESOLVED, that KMA advocate for legislation stating that if a commercial health benefit plan or third-party utilization review entity uses artificial intelligence (AI) or automated algorithms to dictate medical necessity or condition administrative benefits (including Gold-Carding status), the insurer and its software vendors shall share equal legal and medical malpractice liability for any resulting patient harm;

and be it further

RESOLVED, that KMA seek legislation to prohibit insurance contracts from forcing physicians to sign fine-print "hold harmless" clauses that shift 100% of the legal blame onto the clinician when following an insurer's mandatory algorithmic pathway; and be it further

RESOLVED, that KMA adopt a policy stating that when a commercial payor or third-party review company uses automated algorithms to steer, restrict, or override a licensed physician’s individualized medical judgment, that entity is actively making a clinical determination and must be held to the same medical standard of care and professional liability as a licensed physician.

RESOLUTION

Subject: Augmented Intelligence (AI) in Medical Practice

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, Augmented intelligence (AI) algorithms analyze medical data, predict outcomes, and suggest treatment plans at unprecedented speed; and

WHEREAS, AI models trained on historically biased data sets, risk perpetuating health disparities in underserved populations; and

WHEREAS, The American Medical Association (AMA) and the Kentucky Medical Association (KMA) explicitly prefer the term "augmented intelligence" to affirm that technology must enhance, not replace, human clinical judgment; now, therefore, be it

RESOLVED, that KMA advocates to parties implementing augmented intelligence (AI) tools for rigorous, continuous clinical validation of all clinically applied AI tools prior to and during deployment in patient care; and be it further

RESOLVED, that the treating physician retains ultimate authority over all AI-generated recommendations, consistent with the following AMA policies H-480.940, H-480.939, Resolution 007.A-23 and the 2019 AMA Principles for AI Development and Deployment:

- AMA Policy H-480.940 - “Augmented Intelligence in Health Care": Establishes that AI must be designed to enhance physician decision-making and that the term "augmented intelligence" is preferred to emphasize human-centered design.
- AMA Resolution 007.A-23 - "Regulation of Augmented Intelligence in Health Care": Calls for regulatory oversight, transparency, and accountability in the development and deployment of AI tools in medicine.
- AMA Policy H-480.939 - "Augmented Intelligence in Medical Education": Supports the integration of AI literacy into medical training while preserving the centrality of physician judgment.
- AMA Principles for Augmented Intelligence Development and Deployment (2019) - A foundational framework outlining that AI in health care should (1) be designed to enhance clinical decision-making, (2) be transparent and explainable, (3) protect patient privacy, (4) mitigate bias, and (5) safeguard the physician's role in clinical care.

2026-23

RESOLUTION

Subject: Exemption Threshold for Prior Authorization of Medications

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the passage of House Bill 176 provides for a 93% exemption threshold for providers who achieve an approval rate of 93% for a specific medical service or procedure during a 12-month evaluation period, are automatically exempt from prior authorization of that service for the following year; and

WHEREAS, House Bill 176 explicitly excludes prescription drugs; and

WHEREAS, the 2025-26 KMA Policy Manual on page 9 states that KMA continues to seek changes to the prior authorization process and to alleviate the burdens patients face in obtaining coverage for prescription drugs; now, therefore, be it

RESOLVED, that KMA supports Legislation that mandates prescription drugs be part of an exemption threshold similar to that instated with House Bill 176.

2026-24

RESOLUTION

Subject: Ensuring Minimum Clinical Training Hours for Autonomous Prescribing and Practice

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Commonwealth of Kentucky currently grants autonomous prescribing authority to Advanced Practice Registered Nurses (APRNs) after a four-year "passive timer" (KRS 314.042), which fails to account for actual clinical hours, case complexity, or standardized competency; and

WHEREAS, the original legislative intent of the four-year collaborative period was publicly defended as "somewhat mimicking the concept of a medical residency period," yet the current statutory language permits part-time employment and unverified hours to satisfy the requirement; and

WHEREAS, there is a profound training disparity between physicians, who complete between 12,000 and 16,000 hours of residency and fellowship, and non-physician practitioners who may complete as few as 500 clinical hours before entry into practice; and

WHEREAS, peer states including Florida, Arkansas, and Delaware have already transitioned from passive timers to mandatory clinical hour requirements ranging from 3,000 to over 6,000 hours, establishing a national regulatory trend toward competency-based independence; now, therefore, be it

RESOLVED, that KMA advocates for legislation to amend KRS 314.042 to require that an advanced practice registered nurse (APRN) must complete a minimum of four (4) calendar years and a minimum of 5,000 verified clinical hours of physician-collaborated practice before becoming eligible to prescribe without a collaborative agreement, establishing these dual requirements as the mandatory minimum floor for autonomous prescriptive authority; and be it further

RESOLVED, that KMA advocates that any legislation establishing these clinical hour requirements must include explicit statutory protections for participating physicians, ensuring that a collaborative agreement does not create a principal-agent relationship, and that a physician’s legal liability is strictly limited to administrative compliance with hour verification rather than vicarious liability or negligent supervision claims stemming from the independent prescribing decisions of the non-physician practitioner; and be it further

RESOLVED, that KMA advocates for legislative and regulatory measures that require enhanced transparency, geographic tracking, and mandatory auditing of prescribing patterns, particularly concerning Schedule II controlled substances, utilizing the Kentucky All Schedule Prescription Electronic

Reporting (KASPER) system to objectively assess prescriber safety and patterns before and after any transition to independent prescriptive authority.

2026-25

RESOLUTION

Subject: Collaborative Drug Therapy Management

Submitted by: Michael Kuduk, MD (KMA Past President)

Referred to: Reference Committee

WHEREAS, physicians possess expertise in generating differential diagnoses, creating effective diagnostic and therapeutic plans, and utilization of deductive medical reasoning; and

WHEREAS, pharmacists possess expertise in pharmacology, pharmacokinetics, drug-drug interactions, and the ability to monitor ongoing therapy; and

WHEREAS, evidence shows that well designed collaborative drug therapy management programs utilize both physicians' and pharmacists' expertise to improve patient care (CDC August 2005); and

WHEREAS, evidence shows that physician-led team based care results in improved patient care outcomes and improved provider well-being (ACP Position Paper, 2025); now, therefore, be it

RESOLVED, that KMA support legislation which establishes and maintains physician-led collaborative drug therapy management programs, which allow monitoring, modifying and discontinuing of a patient's drug therapy by an authorized pharmacist under the supervision of a physician in accordance with a collaborative practice agreement and which do not have a diagnostic component; and be it further

RESOLVED, that KMA oppose legislation which establishes and maintains collaborative drug therapy management programs which are not physician led, possess a diagnostic component, or which create a separate provider-physician relationship.

RESOLUTION

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

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

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

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

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

WHEREAS, the Kentucky General Assembly recognized the unique risks posed by pain management facilities when it enacted KRS 218A.175 (HB 1, 2012), which provides that only a physician with a full and active license to practice medicine in Kentucky may hold an ownership or investment interest in a pain management facility formed after April 24, 2012, and further requires that a physician owner or physician designee be physically present and practicing medicine in the facility for at least fifty percent (50%) of the time that patients are present, holding board certification in pain management, interventional pain, or hospice and palliative medicine; and

WHEREAS, under KRS 218A.175, a certified registered nurse anesthetist or nurse practitioner may work within a pain management facility but may not hold an ownership interest in, nor serve as the physician owner or required medical director of, such a facility, a statutory safeguard that is being circumvented in practice through nonphysician-operated "pain institutes" that either evade licensure as pain management facilities or operate in violation of these ownership and on-site supervision requirements; and

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

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

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

WHEREAS, patients are frequently unable to determine, from clinic names, advertising, or signage alone, whether the professional diagnosing their pain condition, recommending a procedure, performing an invasive intervention, or managing their follow-up care is a physician, and deserve clear and enforceable transparency in this regard; and

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

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

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

RESOLVED, that KMA affirm that the independent diagnosis, longitudinal management, procedural selection, and performance of chronic interventional pain procedures constitute the practice of medicine and must be directed and performed by physicians with appropriate specialty training and credentials; and be it further

RESOLVED, that KMA explicitly oppose the independent, unsupervised establishment and operation of pain clinics, pain institutes, or similar practices by certified registered nurse anesthetists or other nonphysician clinicians, and oppose any expansion of scope of practice permitting independent performance of complex interventional pain procedures absent active, onsite physician supervision; and be it further

RESOLVED, that KMA call upon the Kentucky Board of Medical Licensure, Kentucky Board of Nursing, and relevant state regulatory bodies to investigate and take appropriate enforcement action against nonphysician-operated pain practices that are functioning outside the bounds of their licensure and without required physician supervision; and be it further

RESOLVED, that KMA call upon the Cabinet for Health and Family Services, the Kentucky Board of Medical Licensure, and the Office of Inspector General to rigorously enforce the physician-ownership, on-site presence, and board-certified medical director requirements of KRS 218A.175 and its implementing regulations, and to investigate facilities operating as, or advertising, chronic pain management services that are not owned, directed, and staffed in compliance with that statute; and be it further

RESOLVED, that KMA advocate for statutory and regulatory clarification distinguishing chronic interventional pain medicine from perioperative anesthesia-related pain care, and ensuring that credentialing, privileging, licensure enforcement, and reimbursement structures reflect the education, training, competency, and patient-safety standards required for this specialty; and be it further

RESOLVED, that KMA require and support enforceable transparency in advertising, clinic naming, informed consent, and all patient-facing communications, such that no clinic, institute, or practice may imply, through name or marketing, physician-level care unless a physician is directly and actively involved in diagnosis, procedural performance, and management of the patient; and be it further

RESOLVED, that KMA advocate for the reduction of unnecessary prior authorization and administrative barriers that delay patient access to physician-led, evidence-based interventional pain care, while opposing any regulatory relief or streamlining that would facilitate unsupervised nonphysician procedural practice; and be it further

RESOLVED, that KMA collaborate with the American Society of Anesthesiologists, the American Society of Regional Anesthesia and Pain Medicine, other appropriate specialty societies, and state regulatory stakeholders to develop model legislation, credentialing standards, and enforcement mechanisms that preserve physician-led interventional pain care, protect patient safety, and ensure that scope of practice remains grounded in education, training, demonstrated competency, and documented clinical outcomes; and be it further

RESOLVED, that KMA direct its staff and legislative counsel to monitor and report annually to the House of Delegates on the prevalence of nonphysician-operated interventional pain practices in Kentucky and on the status of related legislative, regulatory, and enforcement efforts.

2026-27

RESOLUTION

Subject: Codifying Specialty Guardrails, Surgical Definitions, and Physician-Led Team Accountability

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, a 2022 National Bureau of Economic Research (NBER) study and the Hattiesburg Clinic study found that independent non-physician care resulted in significantly higher costs per member per month, increased emergency department utilization, and a 20% higher rate of 30-day preventable hospitalizations compared to physician-led care; and

WHEREAS, current "specialty switching" loopholes allow non-physician practitioners to move from primary care to high-risk specialties without residency-equivalent training, posing an immediate threat to patient safety; and

WHEREAS, patient safety requires a clear statutory distinction between a "Physician-Led Team" where the physician retains ultimate responsibility for diagnosis, and autonomous invasive practice; now, therefore, be it

RESOLVED, that KMA advocates for a statutory definition of surgery and establish that "surgery and invasive medical procedures" are the practice of medicine and should only be performed by physicians, healthcare practitioners acting strictly within their legally established, independent surgical scopes of practice, or appropriately supervised practitioners acting within physician-delegated authority and within the scope of their education, training, and demonstrated competency; and be it further

RESOLVED, that KMA actively partners with and calls upon state and national specialty societies to formally draft and codify specialty-specific guardrails and supplemental training pathways defining the minimum clinical competency required for any practitioner to perform complex or invasive diagnostic or surgical acts; and be it further

RESOLVED, that KMA advocates for specialty guardrails that mandate direct, on-site physician supervision for high-risk surgical acts, including but not limited to the surgical use of lasers, or any procedure involving the excision or thermal ablation of human tissue, while ensuring that the required level of physician supervision for invasive diagnostic, minor interventional, or delegated emergent procedures, including minor incisions, aspirations, and punctures, be determined by the recognized physician specialty societies representing the supervising physician's field of practice based on documented training and demonstrated competency; and be it further

RESOLVED, that KMA advocates for a non-delegable responsibility standard, ensuring that any physician supervising a non-physician practitioner or overseeing specialty guardrails maintains ultimate clinical and legal liability for the medical acts performed within that physician-led team; and be it further

RESOLVED, that KMA advocates that privileges to perform invasive or specialty procedures be based upon documented education, physician-defined standardized training, demonstrated competency, and ongoing quality assessment rather than professional title alone.

2026-28

RESOLUTION

Subject: Establishing a Uniform Standard of Care and Regulatory Oversight for Medical Acts

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, many non-physician groups seek to expand their scopes into medical and surgical practice without completing medical school or standardized residency training; and

WHEREAS, states such as Delaware have successfully codified standard of care parity (18 Del. C. § 6801), mandating that the legal standard of skill and care required of every health-care provider must be measured by the degree of skill and care ordinarily employed in the corresponding field of medicine, regardless of the practitioner's underlying licensure title; and

WHEREAS, unsupervised, independent practice models managed by non-physicians have been shown to increase overall healthcare costs and specialty utilization, while physician-led care consistently lowers diagnostic error and ensures optimal patient safety; now, therefore, be it

RESOLVED, that KMA seeks to amend KRS 311.550 to establish that the legal definition of the "Practice of Medicine" is determined by the nature of the medical or surgical act performed rather than the licensure title of the practitioner; and be it further

RESOLVED, that KMA advocates for statutory amendments to KRS 311.550 ensuring that, notwithstanding any other provision of law or any exclusionary provisions contained in subsection (11) of the statute, any practitioner not licensed to practice medicine or osteopathy who performs an autonomous diagnostic, prescriptive, or surgical act shall be held to the same medical standard of care and degree of skill ordinarily employed by a physician licensed under KRS Chapter 311 to practice medicine or osteopathy (MD or DO); and be it further

RESOLVED, that such statutory amendments shall explicitly clarify that holding a non-physician practitioner to the medical standard of care does not expand their authorized scope of practice, grant autonomous authority to practice medicine, or alter the legal definition of the unauthorized practice of medicine.

Appendix:

Sample wording for statute amendment:

KRS 311.550 is amended to read as follows:
(10) The "practice of medicine or osteopathy" means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities; **provided, however, that notwithstanding any other provision of law or any exclusionary provisions contained in subsection (11) of this section, the "practice of medicine" shall be determined by the nature of the medical or surgical act performed rather than the license held by the practitioner. Any practitioner not licensed under this chapter to practice medicine or osteopathy who performs an autonomous diagnostic, prescriptive, or surgical act shall be held to the same medical standard of care and degree of skill ordinarily employed by a physician licensed under this chapter to practice medicine or osteopathy.**

Reference:

Delaware Code Title 18, Chapter 68, Section 6801(6) under the definition of "Medical negligence".

The statutory language reads as follows:
"'Medical negligence' means any tort or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health-care provider to a patient. The standard of skill and care required of every health-care provider in rendering professional services or health care to a patient shall be that degree of skill and care ordinarily employed in the same or similar field of medicine as defendant, and the use of reasonable care and diligence."

2026-29

RESOLUTION

Subject: Strengthening Patient Transparency through the "Truth in Healthcare Professional Services Act"

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, patients deserve clear and transparent information regarding the education, training, and professional licensure of their healthcare providers to make informed decisions about their care; and

WHEREAS, there is an increasing number of healthcare practitioners who hold doctoral-level degrees but are not licensed as physicians (MD or DO), leading to significant public confusion when the title “Doctor” is used in a clinical or marketing setting; and

WHEREAS, current Kentucky Revised Statute (KRS) 311.375 focuses primarily on the relative font size of titles but does not mandate the disclosure of specific license types in all forms of patient interaction and digital advertising; and

WHEREAS, the American Medical Association (AMA) has developed model legislation for the "Truth in Healthcare Professional Services Act" to ensure that all healthcare professionals accurately and clearly disclose their training and qualifications; and

WHEREAS, national data shows that 88 percent of patients believe healthcare providers should be required to display their level of training and legal licensure clearly; now, therefore, be it

RESOLVED, that KMA advocate for legislation to amend and strengthen KRS 311.375 to include the core tenets of the "Truth in Healthcare Professional Services Act"; and be it further

RESOLVED, that such legislation should require all healthcare professionals to wear a name tag during all patient encounters that clearly identifies the professional license they hold; and be it further

RESOLVED, that KMA seek to require that all healthcare advertisements, including websites and social media profiles, clearly state the practitioner’s specific license type and prohibit the use of deceptive or misleading language that implies a scope of practice or level of training not supported by the practitioner’s license; and be it further

RESOLVED, that KMA collaborate with the Kentucky General Assembly to ensure that any individual using the title “Doctor” or “Dr.” in a clinical setting must immediately follow that title with their specific license or degree in a manner that is clearly audible or legible to the patient.

2026-30

RESOLUTION

Subject: Detrimental Impact of Restrictive Covenants on Health Care in Kentucky

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, Kentucky has a shortage of Health Care Providers; and

WHEREAS, KMA current policy states that if progress is not made on the use of restrictive contract terms by employers, KMA will pursue alternative means that may include legislative or regulatory action, or advocacy through the AMA (Res 2016-12, 2016 HOD); and

WHEREAS, KMA Policy is stated to work with the Kentucky Hospital Association, the individual hospitals and health care systems to eliminate restrictive covenants from their employed physician contracts; and

WHEREAS, KMA policy states that if KMA's efforts to eliminate restrictive covenants with employed physicians contracted by hospital and health care systems are unsuccessful, the KMA states will then pursue legislative action (Res 2016-5, 2016 HOD); and

WHEREAS, restrictive covenants disrupt continuity of care by forcing a patient's provider to practice in a different region once they absolve their contract with a group; and

WHEREAS, restrictive covenants hinder recruitment and retention of knowledgeable and renown physicians; and

WHEREAS, restrictive covenants potentially limit patient access to care; now, therefore, be it

RESOLVED, that KMA supports legislation that eliminates all restrictive covenants in all physician contracts and not limited to employed physicians, so as to better serve the health care needs of the Commonwealth of Kentucky.

2026-31

RESOLUTION

Subject: Preserving Clinical Autonomy in Corporate & Private Equity-Owned Practices

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the "Corporate Practice of Medicine" (CPOM) doctrine in Kentucky, established by legal precedent such as *Kendall v. Beiling* (1943), is intended to prevent commercial influence from superseding the physician's primary duty of loyalty to the patient[1]; and

WHEREAS, legal analysis published in the *Stanford Law Review* (2024) details how Private Equity (PE) firms circumvent these doctrines by acquiring practices through "Management Services Organizations" (MSOs), a structure that allows non-physician investors to control practice finances and operations via a "Friendly PC" model while evading regulatory oversight[2]; and

WHEREAS, a 2022 study published in *JAMA Health Forum* (Singh et al.) analyzing nearly 1 million patients found that PE acquisition of physician practices was associated with a 20.2% increase in costs charged to insurance and a 37.9% increase in new patient visits, indicating pressure to maximize volume and revenue over value-based care[3]; and

WHEREAS, further research in *JAMA Health Forum* (Bruch et al., 2023) indicates that PE-acquired practices are statistically more likely to alter workforce composition by replacing physicians with Advanced Practice Providers (APPs) to reduce labor costs, thereby effectively allowing financial entities to dictate clinical staffing ratios[4]; and

WHEREAS, a systematic review in the *British Medical Journal* (2023) concluded that private equity ownership is "most consistently associated with increases in costs to patients and payers" with "mixed to harmful" impacts on healthcare quality[5]; and

WHEREAS, Kentucky patients have a right to know if their physician's medical decisions are being influenced by a third-party investor whose primary fiduciary duty is to shareholders rather than patients; now, therefore, be it

RESOLVED, that KMA advocate for state legislation that modernizes and reinforces the Corporate Practice of Medicine doctrine by explicitly defining "Clinical Interference" to include any non-physician, unlicensed corporate entity exercising control over staffing ratios, clinical appointment duration, physician referral patterns, or the selection of medical devices, biologics, and pharmaceuticals; and be it further

RESOLVED, that KMA support legislation requiring "Truth in Ownership" transparency, mandating that any medical practice operating in the Commonwealth backed by a majority non-physician corporate equity or venture capital structure must clearly disclose its upstream ownership and management entity on its public website and in patient registration materials.

References:

1. *Kendall v. Beiling*, 295 Ky. 782, 175 S.W.2d 489 (1943).
2. Gupta A, Knight V, Zhu JM. Private Equity and the Corporatization of Health Care. *Stanford Law Review*. 2024;76.
3. Singh Y, Song Z, Polsky D, et al. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum*. 2022;3(9):e222886.
4. Bruch JD, Foot C, Singh Y, et al. Workforce Composition in Private Equity–Acquired vs Non–Private Equity–Acquired Physician Practices. *JAMA Health Forum*. 2023;4(10):e233420.
5. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ*. 2023;382:e075244.

RESOLUTION

Subject: Securing Physician Autonomy and Professional Protections in Corporate Healthcare Employment

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, as the healthcare delivery model in Kentucky shifts rapidly from independent practices to consolidated corporate, institutional, and hospital systems, the administrative policies imposed by non-clinical managers increasingly challenge the clinical autonomy of physicians; and

WHEREAS, employed physicians are routinely mandated by institutional employers to enter into collaboration or supervisory agreements with Advanced Practice Providers (APPs), including Nurse Practitioners (NPs) and Physician Assistants (PAs), without the physician possessing any direct authority over the hiring, credentialing, or clinical volume management of those providers; and

WHEREAS, under current state tort doctrines, the supervising physician remains personally exposed to immense vicarious malpractice and professional liability for the clinical acts or omissions of mandated APPs, creating an unfair risk shift from the employer to the individual clinician's license; and

WHEREAS, pioneering state legislation, modeled after Oregon's framework [1] to curb corporate medicine, establishes explicit boundaries prohibiting unlicensed entities from manipulating clinical schedules, altering required staffing levels, or enforcing predatory restrictive covenants to silence clinicians; and

WHEREAS, safeguarding the physician's legal and ethical duty to care requires that physicians face zero adverse administrative or financial consequences for prioritizing evidence-based specialty standards over corporate volume metrics; now, therefore, be it

RESOLVED, that KMA advocate for state legislation explicitly prohibiting any corporate, institutional, or hospital employer from imposing negative administrative consequences, including retaliatory compensation adjustments, scheduling manipulation, or negative performance evaluations, against an employed physician for exercising independent clinical judgment or adhering to specialty standard-of-care guidelines; and be it further

RESOLVED, that KMA seek legislation providing that when a physician shall not be held liable solely by virtue of a required supervisory or collaborative agreement for independent clinical decisions made by another licensed practitioner absent negligence in supervision, delegation, or other conduct creating independent physician liability; and be it further

RESOLVED, that KMA seek legislative and regulatory frameworks based on established state peer models to ensure that no corporate entity or healthcare system can exercise backdoor control over clinical staffing ratios, patient appointment durations, or diagnostic coding metrics; and be it further

RESOLVED, that KMA support legislation declaring that all non-competition, non-disclosure, and non-disparagement clauses within corporate physician employment contracts are completely void and unenforceable if utilized to penalize or retaliate against a physician for reporting or resisting administrative interference in patient care.

References

1. https://olis.oregonlegislature.gov/liz/2025r1/Measures/Overview/SB951

2026-33

RESOLUTION

Subject: Awareness of the Potential Detriments of Private Equity Funds in Health Care

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, private equity funds (PEFs) are typically non-physician partnerships with a physician in a leadership role that acquire companies by leveraging assets of the purchase rather than investing PEF money, and restructure said companies with a goal of financial gain in a short timeframe (3-7 years)[1]; and

WHEREAS, PEFs acquire a variety of heath care facilities including urgent treatment, nursing homes, and hospitals[1]; and

WHEREAS, PEFs have increased expansion in a variety of physician specialties including but not limited to emergency medicine (25-40% of all practices), anesthesia (18.8%), dermatology (10%), and oncology (10%)[1]; and

WHEREAS, PEFs increase profit by decreasing staff (nurses and others), cutting physician salaries, and replacing physicians with non-physicians[2]; and

WHEREAS, PEFs are associated with increased hospital-acquired adverse events such as falls and central line infections[3]; and

WHEREA, PEFs are associated with increased hospitalization rates and higher mortality in nursing homes[4]; and

WHEREAS, PEFs have been shown to increase cost to patients/payers[5]; now, therefore, be it

RESOLVED, that KMA supports awareness of the potential detriments of private equity funds (PEFs) in health care; and be it further

RESOLVED, that KMA advocates for facility and practice transparency regarding ownership and physician contracts; and be it further

RESOLVED, that KMA promotes physician autonomy; and be it further

RESOLVED, that KMA fosters awareness of corporate strategies to circumvent Kentucky's Corporate Practice of Medicine Law (KRS 274.015).

References:

1. Unruh L, Rice T. Private equity expansion and impacts in united states healthcare. Health Policy. 2025 May;155:105266. doi: 10.1016/j.healthpol.2025.105266. Epub 2025 Mar 3. PMID: 40036910.
2. Bernard, R. Physicians taking back medicine: The rising toll of private equity in health care. Medical Economics Journal. Jan-Feb.2026;103(1):27.
3. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. JAMA. 2023 Dec 26;330(24):2365-2375. doi: 10.1001/jama.2023.23147. PMID: 38147093; PMCID: PMC10751598.
4. Orewa GN, Karabukayeva A, Pradhan R, Jimoh I, Weech-Maldonado R. The effects of private equity ownership in U.S. nursing homes quality and financial performance: A systematic review. Health Policy. 2025 Nov;161:105388. doi: 10.1016/j.healthpol.2025.105388. Epub 2025 Jul 18. PMID: 40729865.
5. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ. 2023 Jul 19;382:e075244. doi: 10.1136/bmj-2023-075244. PMID: 37468157; PMCID: PMC10354830.

2026-34

RESOLUTION

Subject: Medicaid As Employer Welfare

Submitted by: Michael Kuduk, MD (KMA Past President)

Referred to: Reference Committee

WHEREAS, H.R. 1 (2025) requires able-bodied Medicaid recipients to work a minimum of 80 hours per month with either employment, community services or educational activities; and

WHEREAS, in 2023 64% of Medicaid receiving adults not on SSI or Medicare were working either full time or part time (Kaiser Family Foundation); and

WHEREAS, due to Medicaid income eligibility requirements, the vast number of working Medicaid recipients were working in low wage jobs; and

WHEREAS, these jobs were across a variety of sectors, both public and private (GAO report 21-45, 2020); and

WHEREAS, many employers offer their employees health insurance, but the cost of that insurance is prohibitively expensive for a low wage worker; and

WHEREAS, for this reason employers across multiple sectors end up not paying for insurance for low wage earners and gain economic benefit from not doing so; now, therefore, be it

RESOLVED, that KMA shall direct its delegation to our American Medical Association to file a resolution requesting that our AMA study the economic benefits employers enjoy from having the Medicaid program serve as health insurance for some of their employees, the number of Medicaid insureds who already fulfill the H.R. 1 work requirements, and the economic importance of Medicaid to those employees, with a report back to the AMA House of Delegates at the following annual meeting to inform further development of public policy.

RESOLUTION

Subject: Opposing Medicaid Reimbursement Cuts and Safeguarding Independent Physician Practices

Submitted by: Thomas Higgins, MD

Referred to: Reference Committee

WHEREAS, Department for Medicaid Services relies on a robust network of participating physicians to provide high-quality, equitable, and timely healthcare to over one million vulnerable citizens across the Commonwealth of Kentucky; and

WHEREAS, independent physicians and physician-owned private practices serve as vital, cost-effective infrastructure anchors in their local communities, keeping patients out of high-cost institutional settings and emergency departments; and

WHEREAS, independent practices operate on fixed, narrow operating margins and must absorb exponential increases in overhead costs, including clinical staffing retention, medical supplies, mandatory electronic health record systems, and regulatory compliance infrastructure, without the ability to shift costs or rely on hospital-tier facility fees; and

WHEREAS, a four percent (4%) reduction in Medicaid reimbursement rates represents a direct financial penalty on physicians that will disproportionately jeopardize the economic viability of independent medical practices; and

WHEREAS, peer-reviewed economic data confirms that flattening or cutting Medicaid physician fee schedules forces private practices to consolidate into large hospital systems, limit their panel of Medicaid patients, or close their doors entirely, directly triggering severe care deficits and driving up overall state healthcare expenditures through increased low-value utilization; and

WHEREAS, Kentucky is already facing a critical physician workforce shortage, and further compounding the financial strain of Medicaid participation will severely undermine physician recruitment, retention, and access to specialized care across the Commonwealth; now, therefore, be it

RESOLVED, that KMA aggressively oppose any reduction or cut to Medicaid reimbursement rates for physician services, designating the preservation of existing funding lines as a non-negotiable legislative and administrative priority; and be it further

RESOLVED, that KMA advocate for targeted state legislation and regulatory protections that insulate independent, physician-owned practices from flat-rate budget cuts, explicitly recognizing private practices as distinct from heavily subsidized, consolidated institutional health systems; and be it further

RESOLVED, that KMA seek statutory reforms to establish a mandatory minimum floor for Medicaid provider reimbursements, requiring that physician fee schedules be permanently indexed to the Consumer Price Index for Medical Care (CPI-M) to ensure long-term, predictable financial sustainability for practices caring for Kentucky's Medicaid population.

RESOLUTION

Subject: Achieving Equitable, Affordable, Efficient Healthcare

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, 55-87%[1] of Kentucky patients forgo medical care or medications secondary to cost; and

WHEREAS, the current US healthcare financing system creates inherent vulnerabilities in continuity of coverage and access to care as evidenced by the estimated loss of coverage to 200,000-350,000 Kentuckians as a result of U.S. H.R.1 2025. new regulations[2,3], the expiration of enhanced Marketplace subsidies, and rising premium costs[4,5]; and

WHEREAS, absence of care adversely affects healthcare outcomes; and

WHEREAS, the US has the highest per capita healthcare costs[6], the lowest life expectancy[7], the greatest burden of chronic disease[7], and the highest maternal and infant mortality rates of peer high-income nations[7]; and

WHEREAS, healthcare costs and time off work due to illness are estimated to be responsible for 2/3 of US bankruptcies[8]; and

WHEREAS, these problems do not exist in countries which provide universal coverage to their inhabitants; and

WHEREAS, a progressive tax-based system of health insurance financing is more equitable than the current system, would be easier to navigate for patients, and less cumbersome for providers, would ensure that everyone has healthcare coverage, would lower costs and save lives[9]; and

WHEREAS, 6 state medical societies (Washington, Vermont, Hawaii, New Hampshire, Maine, and Massachusetts) have already passed resolutions endorsing universal coverage and/or a single payer system; and

WHEREAS, private carriers are motivated to deny claims, found to be nearly 20% in 2024 for in-network services and as many as 37% for out-of-network services for those insured on the Marketplace[10], of which fewer than 1% were appealed, in order to satisfy the financial returns demanded by shareholders; and

WHEREAS, current KMA policy only expresses support for “universal access,” which already exists and does not address the barriers of obtaining affordable or equitable care; now, therefore, be it

RESOLVED, that KMA endorses the adoption of a system of universal healthcare coverage with comprehensive benefits in the US, and the elimination of financial barriers to care; and be it further

RESOLVED, that this does not preclude the availability of private payment or the purchase of private insurance for non-covered services for those who can afford and wish to obtain them.

References:

1. https://www.asclepiusinitiative.org/_files/ugd/cfb40c_105e50841e714c1396b58585cb050143.pdf
2. https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-and-enrollment-loss-across-the-states/
3. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf
4. https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/
5. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/
6. https://data-explorer.oecd.org/vis?lc=en&fs[0]=Topic%2C1%7CHealth%23HEA%23%7CHealth%20expenditure%20and%20financing%23HEA_EXP%23&fs[1]=Measure%2C0%7CExpenditure%23EXP_HEALTH%23&pg=0&fc=Measure&snb=1&vw=br&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_SHA%40DF_SHA&df[ag]=OECD.ELS.HD&df[vs]=1.0&dq=.A.EXP_HEALTH.USD_PPP_PS%2BPT_B1GQ._T.._T.._T...&pd=2023%2C&to[TIME_PERIOD]=false
7. https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022
8. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304901?role=tab
9. https://pmc.ncbi.nlm.nih.gov/articles/PMC8572548/
10. https://www.kff.org/patient-consumer-protections/claims-denials-and-appeals-in-aca-marketplace-plans-in-2024/

RESOLUTION

Subject: Protection of Kentucky Patients from Federal Care Deregulation (Reaffirmation and Amendment of Existing Policy)

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the 2024-2025 KMA Policy Manual establishes that evidence-based medical practice standards should be founded on the best available evidence, including peer-reviewed scientific literature (Res 2022-15); and

WHEREAS, the "One Big Beautiful Bill Act" (OBBBA), enacted in July 2025, and subsequent actions by the Department of Health and Human Services (HHS) have systematically rescinded evidence-based clinical safety standards to reduce federal expenditures; and

WHEREAS, independent analysis by the University of Pennsylvania's Leonard Davis Institute of Health Economics and the Yale School of Public Health, cited by the Senate Finance Committee in June 2025, projects that these specific deregulatory actions will result in approximately 51,000 additional preventable deaths annually across the United States; and

WHEREAS, HHS has further rescinded the "Richardson Waiver" (90 Fed. Reg. 11,029), thereby eliminating the requirement for public notice-and-comment rulemaking, which directly contradicts KMA's policy supporting physician input in medical review and regulatory changes; and

WHEREAS, Kentucky physicians face ethical and legal jeopardy if forced to lower their clinical practice to match relaxed federal rules, potentially increasing exposure to medical malpractice liability under state law; now, therefore, be it

RESOLVED, that KMA amend its policy on Evidence-Based Care (Res 2022-15) to read: "KMA affirms that the doctor-patient relationship is the bedrock on which safe and ethical medical care is provided... KMA encourages the passage and implementation of laws, regulations, health codes, medical practice standards and institutional/corporate rules that are evidence-based <u>as established by recognized medical specialty societies at the national, state, and local levels</u> with significant efficacy and value... <u>regardless of any rescission or weakening of parallel federal clinical or safety regulations</u>. KMA opposes criminal <u>or civil</u> sanctions against physicians... who deliver care that is evidence-based..."; and be it further

RESOLVED, that KMA adopt as policy that it will advocate for state legislation ensuring that Kentucky physicians and healthcare facilities shall not be penalized under state licensure or liability laws for adhering to these higher, evidence-based specialty standards, notwithstanding any lower federal minimum safety or clinical standards; and be it further

RESOLVED, that KMA adopt as policy that it will petition the Kentucky Department of Insurance to adopt regulations prohibiting private payers from denying coverage for services based on the removal or rescission of a federal mandate, provided those services remain recommended by the relevant medical specialty society.

References

One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (enacted July 4, 2025).

Kentucky Medical Association. 2024-2025 KMA Policy Manual. Available at: https://kyma.org/wp-content/uploads/2024/09/2024-2025-KMA-POLICY-MANUAL-1.pdf.

U.S. Senate Committee on Finance. 51,000 Americans Will Die Every Year as a Direct Result of Republican Health Plan: New Analysis. Washington, DC: U.S. Senate; June 3, 2025. [Available at Finance.senate.gov].

Werner RM, Coe NB, Roberts ET. Projected Mortality Impacts of the Budget Reconciliation Bill. Philadelphia, PA: Leonard Davis Institute of Health Economics, University of Pennsylvania & Yale School of Public Health; June 2025.

Rescission of the Richardson Waiver and Re-alignment of Rule-making Procedures, 90 Fed. Reg. 11,029 (March 3, 2025) (to be codified at 45 C.F.R. Subtitle A).

Appendix

Current KMA Policy Language	**Proposed Amended Language (Resolution)**
"Evidence-Based Care: KMA affirms that the doctor-patient relationship is the bedrock on which safe and ethical medical care is provided, with decision-making between a physician and a patient private and specific to the patient's conditions. KMA encourages the passage and implementation of laws, regulations, health codes, medical practice standards and institutional/corporate rules that are evidence-based with significant efficacy and value, as demonstrated by best available evidence, including peer-reviewed scientific literature. KMA oppose criminal sanctions against physicians and other medical providers who deliver, and patients who receive, care that is evidence-based, and has significant efficacy and value, as demonstrated by the best available evidence, including peer-reviewed scientific literature. (Res 2022-15, 2022 HOD)"	"Evidence-Based Care: KMA affirms that the doctor-patient relationship is the bedrock on which safe and ethical medical care is provided, with decision-making between a physician and a patient private and specific to the patient's conditions. KMA encourages the passage and implementation of laws, regulations, health codes, medical practice standards and institutional/corporate rules that are evidence-based as established by recognized medical specialty societies utilizing transparent, peer-reviewed scientific methodologies with significant efficacy and value, as demonstrated by best available evidence, including peer-reviewed scientific literature, regardless of any rescission or weakening of parallel federal clinical or safety regulations. Kentucky physicians shall not be required to follow, nor be limited by, these reduced federal parameters when determining necessary patient care. KMA oppose criminal or civil sanctions against physicians and other medical providers who deliver, and patients who receive, care that is evidence-based, and has significant efficacy and value, as demonstrated by the best available evidence, including peer-reviewed scientific literature."

2026-38

RESOLUTION

Subject: Encourage Health Systems and Private Practices to Include 988 on Automated Voice Messaging

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, the 988 Suicide & Crisis Lifeline provides individuals experiencing mental health crises, suicidal thoughts, or substance use crises with immediate access to trained crisis counselors; and

WHEREAS, physician practices and health systems frequently serve patients who may be experiencing behavioral health emergencies or emotional distress; and

WHEREAS, automated telephone messaging may serve as an opportunity to direct individuals in crisis to appropriate emergency and behavioral health resources outside normal office hours; now, therefore, be it

RESOLVED, that KMA encourages health systems and private practices to include 988 on their automated voice messaging line.

2026-39

RESOLUTION

Subject: Promote Existing 988 Educational Resources for Physician Practices

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, awareness of the 988 Suicide & Crisis Lifeline remains an important component of connecting individuals to timely behavioral health services; and

WHEREAS, numerous state agencies, federal agencies, and private organizations have developed educational materials that physician practices may use to inform patients about the 988 Suicide & Crisis Lifeline; and

WHEREAS, increasing awareness of existing behavioral health resources may improve access to crisis intervention services for Kentuckians; now, therefore, be it

RESOLVED, that KMA promotes existing state, federal, and private resources for physician practices that educate and inform patients on the 988 suicide & crisis lifeline.

2026-40

RESOLUTION

Subject: Partner with Non-Profit Organizations to Improve Physician Education on Mental Health Awareness and Suicide Prevention

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, physicians are often among the first healthcare professionals to identify signs of mental health conditions, suicidal ideation, and emotional distress in patients, making education on recognition, intervention, and referral an important component of clinical practice; and

WHEREAS, evidence-based educational programs, including Question, Persuade, Refer (QPR) suicide prevention training and continuing medical education focused on mental health awareness, can equip physicians with practical skills to recognize warning signs, engage in supportive conversations, and connect individuals with appropriate resources; and

WHEREAS, nonprofit organizations, including the Pete Foundation, have developed expertise and educational resources that can expand access to high-quality mental health awareness and suicide prevention training for physicians across the Commonwealth; now, therefore, be it

RESOLVED, that KMA partner with non-profit organizations on improving physician education around mental health awareness and suicide prevention.

2026-41

RESOLUTION

Subject: Support Legislation Prohibiting Ownership of Machine Gun Conversion Devices

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

WHEREAS, machine gun conversion devices are federally illegal devices designed to convert semiautomatic firearms into weapons capable of firing multiple rounds with a single pull of the trigger; and

WHEREAS, federal law generally prohibits the possession and transfer of machine guns and classifies machine gun conversion devices as machine guns under federal law; and

WHEREAS, state laws addressing the possession of machine gun conversion devices vary, and aligning state law with existing federal law may improve consistency in enforcement; now, therefore, be it

RESOLVED, that KMA supports legislation that would align state and federal law to prohibit ownership of machine gun conversion devices.