



HOD Handbook

MedChi House of Delegates Meeting October 10, 2026

From: Clement Banda, M.D., Speaker of the House
Gurdeep Chhabra, M.D., Vice Speaker of the House

To: MedChi Delegates and Alternate Delegates

Within this handbook, you will find the materials needed for MedChi's Fall House of Delegates meeting on Saturday, October 10, 2026.

The Hotel at Arundel Preserve | 7795 Arundel Mills Boulevard, Hanover, Maryland

[Register for the HOD Meeting here.](#)

To keep informed of all House of Delegates information, visit www.medchi.org/HOD.

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AGENDA

SATURDAY, OCTOBER 10, 2026

- 7:00 am Registration and Breakfast with Exhibitors**
- 7:30 am The Shift to Value-Based Care: Why EQIP Matters**
Olivia Simon, MHCM, EQIP Practice Transformation Specialist, MedChi
Joshua Parks, Senior Manager, InContext
Moderator: Gene Ransom, CEO, MedChi
- 8:15 am Break with Exhibitors**
- 8:30 am The Future of Maryland's AHEAD Model**
William Henderson, Principal Deputy Director, Medical Economics & Data Analytics
Health Services Cost Review Commission
Abid Khan, DrPH, MPP, MHS, Division Director, State & Population Health Group
Center for Medicare & Medicaid Innovation
Farzaneh L. Sabi, M.D., Associate Medical Director
Mid-Atlantic Permanente Medical Group
Moderator: Gene Ransom, CEO, MedChi
- 9:30 am Exhibits & Credentialing**
- 10:00 am House of Delegates Meeting Call to Order**
(times and order of business below are approximate and subject to change)
- 10:00 am Business of the House**
Report of the Credentials Committee – Dan Morhaim, MD, Chair
Report of the Speaker of the House – Clement Banda, MD
Approval of Minutes of April 26, 2026, House of Delegates Meeting
Membership Report
- 10:15 am Presentation of Awards**
- 10:30 am Nominations and Elections**
- 10:45 am Report of the Reference Committee – David Hexter, MD, Chair**
- 12:00 pm Lunch**
- 12:30 pm Report of the Reference Committee Resumes**

Immediately Following Report of the Reference Committee:

Report of the President – Eric Wargotz, M.D.

Report of the Treasurer – Loralie Ma, M.D.

Report of the CEO – Gene Ransom

Inauguration of MedChi's 179th President, James Williams, D.O.

Reports of MedChi Affiliates

Center for a Healthy Maryland

MMPAC

Unity Insurance Agency

3:00 pm Closing Business of the House

Unfinished Business

New Business

Next Meeting – Sunday, April 18, 2027

Adjournment

3:15 pm Board of Trustees Meeting

(time is approximate; board meeting will begin 10 minutes after House adjourns)

MEDCHI HOUSE OF DELEGATES MEETING
April 26, 2026
MINUTES

DELEGATES PRESENT

A list of delegates present is on file in the Executive Office of MedChi.

PANEL PRESENTATION

Prior to Call to Order, there was a legislative panel presentation. Guest speakers included Senator Clarence Lam, M.D., Delegate Terri Hill, M.D., and MedChi CEO, Gene Ransom, CEO. President, Eric Wargotz, M.D., moderated the panel session.

CALL TO ORDER

The 443rd meeting of the MedChi House of Delegates was held virtually via Zoom. MedChi Speaker of the House, Clement Banda, M.D., called the meeting to order at 9:00 am.

REPORT OF THE CREDENTIALS COMMITTEE

Dan Morhaim, M.D., Chair of the Credentials Committee, reported that there was a quorum with greater than fifty delegates present.

APPROVAL OF MINUTES

The minutes of the October 25, 2025, House of Delegates meeting were approved as submitted.

REPORT OF THE REFERENCE COMMITTEE

David Hexter, MD, Chair, presented the Reference Committee Report and the following actions were taken by the House of Delegates:

RECOMMENDED FOR ADOPTION:

(1) BOT Report 1-26 – Follow up to Resolutions from 2025 Spring House of Delegates Meeting

Accepted BOT Report 1-26 as information.

(2) CME Report 1-26 – Update on Looking AHEAD Committee to the MedChi House of Delegates

Accepted CME Report 1-26 as information.

(3) Resolution 6-26 – Support for Pausing Interest Rate Accumulation during Residency Training

Adopted Resolution 6-26 as follows:

RESOLVED, that MedChi, The Maryland State Medical Society, support legislation and advocacy efforts advancing the Resident Education Deferred Interest (REDI) Act to pause the accrual of interest on federal student loans during accredited residency training,

in order to reduce the financial burden on physicians in training, promote recruitment into residency programs, and support workforce stability in underserved specialties and communities.

All testimony on this resolution was supportive. It was noted that the American Medical Association and other groups are actively advocating for federal adoption of the REDI Act.

RECOMMENDED FOR ADOPTION WITH AMENDMENTS

(4) Resolution 2-26 – Reinstitution of AMA Guides Editorial Panel

Adopted Resolution 2-26 as follows:

RESOLVED, that our MARYLAND DELEGATION TO THE American Medical Association ENCOURAGE THE AMA TO re-institute the AMA Guides Editorial Panel to its original configuration and operating status; and be it further

RESOLVED, that our MARYLAND DELEGATION TO THE AMA encourage the AMA TO DIRECT THE AMA Guides Editorial Panel to continue its work on updating the chapters of the AMA Guides to the Evaluation of Permanent Impairment 6th edition 2025 that have yet to be addressed and to continue to bring current evidence-based medicine and practices to the evaluation of permanent impairment.

Reference committee reached consensus that this amendment clarified that the resolution direct action by the Maryland AMA Delegation, rather than directing the AMA itself.

(5) Resolution 4-26 – Restoring Cuts to National Institutes of Health Budget

Adopted Resolution 4-26 with amendments as follows:

RESOLVED, that our MARYLAND DELEGATION TO THE American Medical Association act TO ENCOURAGE THE AMA ~~legislatively~~ to advocate for THE REVERSAL OF THE NIH BUDGET CUTS AND RESTORE FULL FUNDING TO THE NIH ~~these cuts to be reversed with full funding restored.~~

Reference committee reached consensus that this amendment change the directive to be to our Maryland Delegation to the AMA and clarified the directive in a manner consistent with the resolution's intent.

(6) Resolution 5-26 – Addressing IRS Limitations on Direct Primary Care Membership Fees and HSA Eligibility

Adopted Resolution 5-26 with amendments as follows:

RESOLVED, that MedChi, The Maryland State Medical Society, adopt as policy that the

IRS's \$150 monthly cap on Direct Primary Care membership fees for continued HSA contributions is burdensome, arbitrary, and should be revised to reflect regional cost structures and physician practice sustainability; and be it further

RESOLVED, that OUR MARYLAND DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION ~~MedChi~~ request the American Medical Association to advocate for appropriate federal regulatory or statutory revisions to correct these issues; ~~and be it further~~

~~RESOLVED, that MedChi transmit this policy to the AMA House of Delegates for consideration at the earliest appropriate meeting.~~

Reference committee reached consensus that this amendment grant our Maryland Delegation to the AMA discretion to pursue the most effective approach to achieving the resolution's objective, while consolidating the resolved clauses to make the directive more concise.

RECOMMENDED FOR REFERRAL

(7) Resolution 1-26 – Continuous Glucose Monitoring Coverage for Patients with Prediabetes

Reference committee recommended referral to the Board of Trustees due to several complexities that were raised during discussion and the need for further evaluation of clinical evidence, cost implications, and coverage considerations.

RECOMMENDED FOR NOT ADOPTION

(8) Resolution 3-26 – MedChi President and CEO Must Reside in Maryland

Reference committee recommended that Resolution 3-26 not be adopted. The role of CEO does not change frequently, and the position requires the individual to be located in Maryland to effectively fulfill their responsibilities. Furthermore, the Bylaws and Rules state that all active MedChi members must maintain licensure or residence in Maryland and candidates for the Board of Trustees, including President, must have been a member for the previous five years and have attended six HOD meetings or served as a component officer, which further limits the applicability of this resolution. Verification of residency could be problematic, as it is for residency requirements for elected legislators.

Committee Members:

David Hexter, M.D., Chair
Tyler Cymet, D.O.
Joseph Zebley, M.D.
Eva DeVience, M.D.
George Bone, M.D.
H. Russel Wright, M.D.

Amanda Andriessen (Medical Student)

BOT ELECTION

After the Fall 2025 House of Delegates meeting, a potential error was identified. To avoid any ambiguity, the Board of Trustees temporarily appointed Dr. Brent Berger to the Montgomery County trustee seat and Dr. Renee Bovelle to the Prince George's County trustee seat. Both Dr. Berger and Dr. Bovelle were nominated by their respective counties at the Fall 2025 House of Delegates meeting. Following their temporary appointments, Speaker Banda opened the floor for additional nominations. As there were none, The House voted on and elected the aforementioned nominees.

REPORT OF THE PRESIDENT

Eric Wargotz, M.D., gave his President's Report.

TREASURER'S REPORT

Loralie Ma, M.D., presented the financial report.

REPORT OF THE CHIEF EXECUTIVE OFFICER

Gene Ransom presented the operations report and a legislative update.

REPORT OF MEDICAL POLITICAL ACTION COMMITTEES

Stephen Rockower, M.D., presented an update on the Maryland Medical Political Action Committee.

ADJOURNMENT

There being no further business, the meeting was adjourned.

NEXT MEETING

The next meeting of the House of Delegates will be held on Saturday, October 10, 2026.

Respectfully submitted,
Manna Varghese, M.D.
Secretary



MEMBERSHIP REPORT

FIFTY-YEAR MEMBERS

ANNE ARUNDEL COUNTY

Gelsimo A. Cruz, M.D.

BALTIMORE CITY

Bruce W. Berger, M.D.

James D. Levy, M.D.

Carlos N. Patalinghug, M.D.

Stanley B. Silber, M.D.

Alan Z. Steinberg, M.D.

BALTIMORE COUNTY

Leslie Abramowitz, M.D.

Boris Kerzner, M.D.

Cecilia S. Schocket, M.D.

Richard L. Taylor, M.D.

CALVERT COUNTY

Mahin S. Yazdani, M.D.

CARROLL COUNTY

William R. Linthicum, M.D.

KENT COUNTY

Susan K. Ross, M.D.

MONTGOMERY COUNTY

Thomas E. Kasper, M.D.

John R. Melnick, M.D.,F.A.C.P.

PRINCE GEORGE'S COUNTY

V. Prem Chandar, M.D.

Myron I. Murdock, M.D.

Navin C. Shah, M.D.,F.A.C.S.,M.S.

WASHINGTON COUNTY

Vasant Datta, M.D.,C.M.D.

FORTY-YEAR MEMBERS

BALTIMORE CITY

Steven R. Jaskulsky, M.D.

Marc S. Posner, M.D.

BALTIMORE COUNTY

Douglas C. McCorkle, M.D.

HARFORD COUNTY

William P. Cook, M.D.

MONTGOMERY COUNTY

Martin J. Book, D.O.

Lee R. Pennington, M.D.

EMERITUS

ANNE ARUNDEL COUNTY

Nadia Akhmed, M.D.
Jeffrey E. Atkinson, M.D.
Peter R. Graze, M.D.

BALTIMORE CITY

Lisa S. Abrams, M.D.
Patricia M. Disharoon, M.D.
Peter Hinderberger, M.D.
Iredell W. Iglehart, III, M.D.
Richard M. Katz, M.D.
Mitchell Klapper, M.D.
Andrew Malinow, M.D.
Russell W. Moy, M.D.
Susan H. Rubinstein, M.D.
John T. Thompson, M.D.
Edward J. Wolf, M.D.
Neal B. Zimmerman, M.D.

BALTIMORE COUNTY

John B. Chessare, M.D.
John Michael Niehoff, M.D.

CARROLL COUNTY

John C. Baer, M.D.
Myun-Ki Kim, M.D.

FREDERICK COUNTY

James S. Albertoli, M.D.
Robert B. Hodges, M.D.

HARFORD COUNTY

Frank Sparandero, M.D.

HOWARD COUNTY

Julius M. Boateng, M.D.
Lawrence F. Sorkin, M.D.
Barry S. Tatar, M.D.

KENT COUNTY

Frederick T. Lohr, M.D.
Helen A. Noble, M.D., F.A.C.P.
Michael E. Peimer, M.D.
Patrick J. Shanahan, M.D.

MONTGOMERY COUNTY

Jeffrey P. Bernstein, M.D., FAAP
Kenneth W. Eckmann, M.D.
David M. Katz, M.D.
Robert C. Knox, M.D.
Jose A. Quiros, M.D.
Thu N. Tran, M.D.

QUEEN ANNE'S COUNTY

Joseph A. Ciotola, Jr., M.D.

TALBOT COUNTY

David H. Smith, M.D.

WASHINGTON COUNTY

Steven J. Klein, M.D.

WORCESTER COUNTY

Lucy B. Van Voorhees, M.D.

NECROLOGY

(October 16, 2025 – September 30, 2026)

ANNE ARUNDEL COUNTY

Harvey P. Brilliant, M.D. February 18, 2026

BALTIMORE CITY

Carlton C. Greene, M.D. November 26, 2025
Edward S. Klohr, M.D. December 5, 2025
George W. Moran, M.D. January 13, 2026
Marguerite T. Moran, M.D. February 4, 2026
Albert Nahum, M.D. November 12, 2025
Paul E. Roberts, M.D. April 4, 2026

BALTIMORE COUNTY

Marshall A. Levine, M.D. April 6, 2026
Ronald G. Peterson, M.D. November 13, 2025
Leopoldo Salazar, M.D. May 14, 2026
George D. Yannakakis, M.D. January 6, 2026

FREDERICK COUNTY

A. Austin Pearre, M.D. January 20, 2026
George I. Smith, M.D. January 24, 2026

HOWARD COUNTY

Raymond D. Bahr, M.D. January 14, 2026

MONTGOMERY COUNTY

Morton Altschuler, M.D. February 24, 2026
David Corn, M.D. December 10, 2025
Brian P. Driscoll, M.D. September 16, 2026
June R. Pollack, M.D. December 17, 2025

PRINCE GEORGE'S COUNTY

Sombat Grigorian, M.D. May 6, 2026

TALBOT COUNTY

Michael J. Fisher, M.D. August 2, 2026
William H. Wood, M.D.,C.M.D. March 7, 2026

SLATE OF NOMINATIONS

Those elected will assume office at the conclusion of the October 10, 2026, meeting, unless otherwise indicated.
Incumbents are noted with an asterisk (*). Please contact MedChi's Executive Office to request a candidate's curriculum vitae.

PRESIDENT-ELECT

Renee Bovelle, M.D. | Ophthalmology | Prince George's County | Member since 2015 | Currently serves as President of the Prince George's County Medical Society

SPEAKER OF THE HOUSE

Gurdeep Chhabra, M.D. | Oncology | Prince George's County | Member since 2002 | Past President of Prince George's County Medical Society

VICE SPEAKER OF THE HOUSE

Kathryn Kelly, M.D. | Internal Medicine | Montgomery County | Member since 2017 | Currently serves on the Executive Committee of the Montgomery County Medical Society

BALTIMORE COUNTY TRUSTEE

Amit Bharghava, M.D. | Physical and Rehabilitation Medicine | Baltimore County | Member since 2013 | Currently Chair of the Baltimore County Medical Association

MONTGOMERY COUNTY TRUSTEE

Brent Berger, M.D.* | Internal Medicine | Montgomery County | Member since 2015 | Currently serves as Montgomery County Trustee

EASTERN GROUP TRUSTEE

Rene Desmarais, M.D.* | Cardiology | Wicomico County | Member since 2011 | Currently serves as Eastern Group Trustee

TRUSTEE AT LARGE

Dennis Dey, M.D.* | Neurology | Allegany County | Member since 2008 | Currently serves as Trustee at Large and as President of the Allegany County Medical Society

AMA DELEGATE TERM 27-29

There are three open positions. The term begins July 1, 2027.

James York, M.D.* | Orthopedic Surgery | Anne Arundel County | Member since 1982 | Currently serves as AMA Delegate

Renee Bovelle, M.D.* | Ophthalmology | Prince George's County | Member since 2015 | Currently serves as President of the Prince George's County Medical Society

Manna Varghese, M.D.* | Emergency Medicine | Anne Arundel County | Member since 2023 | Currently serves as AMA Delegate

AMA ALTERNATE DELEGATE TERM 27-29

There are three open positions. The term begins July 1, 2027.

Gurdeep Chhabra, M.D.* | Oncology | Prince George's County | Member since 2002 | Currently serves as AMA Alternate Delegate

Robin Motter-Mast, D.O.* | Family Medicine | Baltimore County | Member since 2022 | Currently serves Co-Chair of the MedChi Council on Medical Economics and President of the Baltimore County Medical Association.

Tyler Cymet, D.O. | Internal Medicine | Baltimore City | Member since 1994 | Past President of Baltimore City Medical Society and MedChi

Sheri L. Hamersley, M.D. | Maternal-Fetal Medicine | Montgomery County | Member since 2002 | Currently serves as President-Elect of Montgomery County Medical Society

REPORTS AND RESOLUTIONS

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MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

BOT Report 2-26

INTRODUCED BY: Board of Trustees

SUBJECT: Follow Up to Resolutions from 2026 Spring House of Delegates Meeting

The Board of Trustees presents the following informational report on the follow up actions for resolutions from the 2026 Spring House of Delegates Meeting:

RES.	TITLE		RESOLVES	FOLLOW-UP
1-26	Continuous Glucose Monitoring Coverage for Patients with Prediabetes	Referred	Resolved, that MedChi, The Maryland State Medical Society, advocate for insurance coverage of continuous glucose monitoring for high risk patients (i.e. patients with one of one or more of these risks - obesity, family history, hypertension, dyslipidemia, history of gestational diabetes mellitus (GDM), (or belonging to a high-risk ethnic group); diagnosed with prediabetes, as a preventive measure to reduce disease progression and mitigate the onset of insulin dependence, cardiovascular complications, renal failure, and neuropathy; and be it further Resolved, that MedChi, The Maryland State Medical Society work with the American Medical Association to advance policy supporting insurer coverage of continuous glucose monitoring (CGM) for patients with prediabetes at the national level.	Sent to Medical Economics Committee and is one of many items at a summit later this year
2-26	Reinstitution of AMA Guides Editorial Panel	Adopted with amendments	RESOLVED, that our Maryland Delegation to the American Medical Association encourage the AMA to re-institute the AMA Guides Editorial Panel to its original configuration and operating status; and be it further RESOLVED, that our Maryland Delegation to the AMA encourage the AMA to direct the AMA Guides Editorial	AMA has been working on this issue and is laying the groundwork to improve the guides. The current plan is to let the AMA mobility caucus take the lead on this issue, and the MedChi delegation will support their efforts.

			Panel to continue its work on updating the chapters of the AMA Guides to the Evaluation of Permanent Impairment 6th edition 2025 that have yet to be addressed and to continue to bring current evidence-based medicine and practices to the evaluation of permanent impairment.	
4-26	Restoring Cuts to National Institutes of Health Budget	Adopted with amendments	RESOLVED, that our Maryland Delegation to the American Medical Association act to encourage the AMA to advocate for the reversal of the NIH budget cuts and restore full funding to the NIH.	The Maryland Delegation supported various resolutions and policy related to this issue that passed at the 2026 annual meeting.
5-26	IRS Limitations on Direct Primary Care Membership Fees and HSA Eligibility	Adopted with amendments	RESOLVED, that MedChi, The Maryland State Medical Society, adopt as policy that the IRS's \$150 monthly cap on Direct Primary Care membership fees for continued HSA contributions is burdensome, arbitrary, and should be revised to reflect regional cost structures and physician practice sustainability; and be it further RESOLVED, that our Maryland Delegation to the American Medical Association request the American Medical Association to advocate for appropriate federal regulatory or statutory revisions to correct these issues.	Became MedChi Policy
6-26	Support for Pausing Interest Rate Accumulation during Residency Training	Adopted	RESOLVED, that MedChi, The Maryland State Medical Society, support legislation and advocacy efforts advancing the Resident Education Deferred Interest (REDI) Act to pause the accrual of interest on federal student loans during accredited residency training, in order to reduce the financial burden on physicians in training, promote recruitment into residency programs, and support workforce stability in underserved specialties and communities.	Part of 2027 legislative agenda

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

BOT Report 3-26

INTRODUCED BY: Board of Trustees

SUBJECT: 2027 Budget

1 The Board of Trustees presents the MedChi 2027 Budget for approval by the House of Delegates.

2
3 The budget for 2026 incorporates projected revenues of \$5,259,464 and projected expenses of \$5,259,464
4 leaving a projected budget deficit/surplus of \$(0.00.)

5
6 Budget Overview

7
8 1. Overview of Current Financial Status

- 9
 - Net Result: The current budget shows a slight deficit. However, when adjusted for depreciation,

10 the financial result is approximately even.

11
 - Historical Context: Despite the slight deficit, we have experienced large surpluses in previous

12 years. Our goal is to manage our finances to break even while maintaining financial stability.

13 2. Revenue Streams

- 14
 - Events and Publications: Increased revenue slightly – goal to change management structure

15 slightly and improve incentives generating events, publications, and other non-dues activities to

16 positively impact our revenue.

17
 - CTO Funding: There is a slight decrease in CTO funding due to uncertainty and lack of open

18 enrollment. This has affected our budget significantly.

19
 - MNS Revenue: Revenue from MNS (Medical Network Services) has seen an increase,

20 contributing positively to our overall financial health. We have two potential new programs in

21 this space that we hope to increase revenue further.

22
 - EQIP Revenue: Revenue from EQIP (Educational Quality Improvement Program) grew from

23 2022 to 2023, providing a stable revenue source.

24
 - Mid-Atlantic Medical Collections Service: MAMCS has become profitable, adding to our

25 revenue stream.

26 3. Expenses

- 27
 - Labor Costs: The largest expense continues to be labor, including payroll and benefits. There are

28 no major expense increases beyond these areas.

- Other Expenses: Expected increases in contractual services as MedChi will be pursuing a new Database Management system which will encompass the facilitation of organization wide efficiency.

4. Membership Dues

- Dues Increase: There will be no increase in membership dues for the upcoming period. This decision reflects our commitment to keeping membership affordable while managing our budget effectively.

5. Future Outlook

- Financial Management: We will continue to focus on managing our finances towards a balanced budget. Given the recent surpluses, we are in a strong position to absorb the slight deficit and plan for future stability.
- Continued Investment: We will maintain our investment in staff and revenue-generating activities to support long-term growth and sustainability.

We believe that this budget has incorporated all the factors necessary for a reasonable and fair budget.

Supporting documentation will be provided during the House of Delegates on Saturday, October 24, 2026 upon request.

There are no dues increases. The current dues are as follows:

Medical Student	Free
Resident and Fellow	Free
First year Active	\$300
Second year Active	\$400
Full Active	\$500
Affiliate (out of state)	\$205
Associate (part-time)	\$300
Administrative Affiliate (practice manager)	\$75

Recommendations:

1. That the House of Delegates approve the 2027 Budget, and
2. That the remainder of the report be filed.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

CC Report 1-26

INTRODUCED BY: Communications Council

SUBJECT: Overview of Activities for 2026

The primary purpose of the Council on Communications is to increase MedChi's visibility in the media and coordinate improved communications across MedChi and its component medical societies. The council consists of co-chairs Bruce Smoller M.D., and Stephen Rockower M.D., along with Padmini Ranasinghe, M.D., Alexander Tarasco, M.D., Bernita Taylor, M.D. and James Bryant, CEO of Montgomery County Medical Society.

The Council on Communications focused on ongoing improvements to MedChi's communications and social media efforts. During council meetings, members reviewed newsletter performance, social media strategies, upcoming publications, and organizational goals, with an emphasis on engagement, content planning, and system updates.

Under council leadership:

- MedChi News was moved to a Tuesday publication schedule to encourage increased reader engagement;
- MedChi's social media presence was expanded to include TikTok and broader use of YouTube.
- Editorial changes are being made to Maryland Medicine as a cost-cutting measure.

During the remainder of the year, the Council looks forward to updating the MedChi website in conjunction with the onboarding of MedChi's new association management system.

The Council on Communications is actively looking to expand its volunteer membership. Any MedChi member with an interest in communications is encouraged to participate.

Respectfully submitted,
Stephen Rockower, MD
Bruce Smoller, MD

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

CL Report 1-26

INTRODUCED BY: Council on Legislation

SUBJECT: Review of 2026 Legislative Agenda

Every year, the Legislative Council reviews the prior year's legislative agenda and decides which issues remain priorities for the following year.

Note: *Italics/underline* indicate results of the 2026 General Assembly Session and recommended actions.

RECOMMENDATIONS:

1. **Support reforms to hold health insurers accountable for unfair policies and practices, such as automatic payment reductions (e.g., downcoding) and unnecessary credentialing delays, that disadvantage physician practices and restrict patients' access to timely, high-quality care.**

ACCOMPLISHED: MedChi successfully had two bills introduced in the 2026 Session. The first bill, *Senate Bill 808/House Bill 1093: Health Insurance – Provider Panels – Requirements*, resulted from a resolution adopted at the Fall 2025 MedChi House of Delegates from the Montgomery County Medical Society. Among other provisions, the bill shortened the timeframe from 120 days to 60 days for insurers to approve or deny a physician's credentialing application to join a carrier's network. The bill applied to carriers in the Medicaid program and in the fully insured marketplace. This bill aligns Maryland with most other states and will help physicians access networks more quickly and receive payments more promptly. The Firm defeated several amendments that would have granted managed care organizations additional time to process and would have circumvented the bill's intent.

The second bill, *Senate Bill 797/House Bill 1153: Maryland Medical Assistance Program and Health Insurance – Claims for Reimbursement – Downcoding*, resulted from CIGNA's summer 2025 announcement that it would begin automatically downcoding certain E&M codes. The Firm drafted a bill and requested legislative sponsorship to address downcoding. Ultimately, the bill's objectives were achieved through an MIA-issued order fining CIGNA for its policy and issuing a subsequent bulletin. This order eliminated the need for legislation. However, the legislation highlighted the ongoing difficulty physicians face with prompt payment from insurers. The Firm continued these efforts even after the Session ended by: 1) initiating comment letters on various health insurance issues, including the implementation of real-time benefits, 2) the inclusion of denied claims in the Maryland Medical Care Database, and 3) opposition to UnitedHealthcare's mid-year rate increase in the small-group market.

The Firm also worked with the MIA on MedChi's support for *House Bill 277/Senate Bill 139: Insurance – Third Party Administrators – Enforcement*, which closes significant enforcement gaps that exist within the regulatory framework for third-party administrators (TPAs) under current law by authorizing the Insurance Commissioner to impose a civil penalty of up to \$10,000 for each violation of

the entire Insurance Article by a TPA, instead of only for a violation of the provisions of law that directly govern TPAs.

CONTINUE ongoing advocacy efforts to reduce burdens and simplify administrative processes.

2. Safeguard Maryland's investment in Medicaid and access to care for every Marylander by restoring Medicaid Evaluation & Management (E&M) payment rates to 100% of Medicare E&M payment rates.

ACCOMPLISHED: The Fiscal Year 2027 Budget (which runs from July 1, 2026 through June 30, 2027) successfully level-funded Medicaid E&M codes for physician payments. Prior to the start of the 2026 Session, MedChi coordinated with the Component Societies, specialty societies, and other health care practitioner organizations and sent a joint letter to the Governor requesting that E&M codes be maintained. Given that the State was once again facing a \$1.4 billion deficit and a continued structural deficit projected to balloon to \$4 billion by 2031, the level-funding of payments is a definitive win. This is especially true when other constituencies received rate reductions, such as developmental disabilities at \$123 million.

CONTINUE: The Fiscal Year 2028 budget is already projected to have a \$3.5 billion deficit, setting up a very difficult year to contend for limited funds. Still, MedChi will continue to advocate for fair and adequate payment rates, with the goal to return to 100% of Medicare.

3. Fight legislation that would weaken Maryland's current medical liability environment, including bills that repeal or increase non-economic damages caps, or bills that lower the standard for awarding punitive damages.

ACCOMPLISHED: MedChi successfully opposed bills that would have weakened Maryland's medical malpractice environment. Our efforts have resulted in the continued failure of these bills and helped preserve a more balanced legal climate in the State. *House Bill 906/Senate Bill 871: Civil Actions – Punitive Damage Awards – Surcharge* would have lowered the standard for an award of punitive damages from the current one of “actual malice” to, among things, a “pattern of repeated misconduct” or “acts or omissions that create a high degree of harm to others.” *House Bill 316: Confidentiality of Medical Records – Definition of Medical Record* would have expanded the definition of medical record to include any information recorded by a health care provider through written, electronic, or other means, including audio or video. While not directly inclusive of medical malpractice, MedChi opposed *House Bill 476/Senate Bill 474: Civil Actions – Noneconomic Damages – Personal Injury and Wrongful Death*, would have removed the cap on noneconomic damages for personal injury and wrongful death, due to concerns that it would eventually extend to medical malpractice. The House Judiciary Committee did not move the bill forward, but it has referred it to an interim study (which MedChi is participating in), a sign that it will most likely return next session.

CONTINUE: MedChi will continue its efforts to preserve a more balanced legal climate and fight legislation that would repeal the non-economic damage cap and/or other bills that would disadvantage the medical community.

4. Oppose measures to expand the scope of practice of non-physician health care practitioners beyond their education and training, especially when it comes to prescribing medication.

ACCOMPLISHED: MedChi worked to defeat or neutralize several scope of practice bills this Session. The most prominent bills included: *House Bill 377/Senate Bill 326: Physician Assistants and*

Midwives – Parity With Other Health Care Practitioners, which passed the General Assembly, but only with MedChi’s amendments to remove the authority being sought for a physician assistant to be able to approve an involuntary admittance to a health care facility. *House Bill 520/Senate Bill 470: State Board of Physicians – Naturopathic Doctors – Scope of Practice, Renewals, and Professional Liability Insurance (failed)*, which, among other provisions, would have allowed naturopathic doctors to prescribe medications, excluding controlled dangerous substances. *House Bill 1150/Senate Bill 506: Health Occupations – Pharmacists – Minor Conditions and HIV Prevention and Treatment (Rapid Testing and Preventive Care Act)* would have allowed pharmacists to diagnose “minor conditions” and then prescribe medications to treat the condition. *House Bill 1021/Senate Bill 568: Health Occupations – Licensed Psychologists – Prescriptive Authority*, which would have allowed psychologists to obtain certification from the State Board of Examiners of Psychologists to prescribe medications.

CONTINUE: MedChi will continue advocacy efforts as scope of practice issues arise.

5. Protect the interests of physicians and patients in the new Maryland AHEAD Model, including ensuring greater and more equitable primary care participation and increasing access to the Episode Quality Improvement Program for all specialties.

ACCOMPLISHED: MedChi successfully had amendments favorable to physicians included in *Senate Bill 515: Health Services Cost Review Commission – Health Facilities – Jurisdiction and Rate Setting*, which passed the Senate, but unfavorable amendments added in the House Health Committee resulted in the bill ultimately not advancing. As passed in the Senate, the bill would have required the Health Services Cost Review Commission (HSCRC) to consider physician costs when setting hospital rates and would have required a study to further examine costs and the need to ensure rate setting aligned with the goals of the AHEAD Model. At MedChi’s request, the Senate removed the provision that would have given the HSCRC authority to set physician rates.

CONTINUE: MedChi will continue to work with and advocate for physicians in implementing the AHEAD Model, specifically EQIP and MDPCP.

6. Ensure that regulatory and disciplinary actions of the Board of Physicians are fair and just.

ACCOMPLISHED: While no specific legislation was introduced this Session regarding the regulatory or disciplinary actions involving the Board of Physicians, legislation introduced by the Maryland Health Care Commission would have established a review and approval process for a physician practice involved in a “material change transaction,” such as a sale. While not against the intent of *House Bill 944/Senate Bill 494: Maryland Health Care Commission – Certificates of Need and Material Change Transactions*, MedChi worked with other stakeholders to require that a workgroup be formed to discuss issues before the passage of legislation. The workgroup is currently meeting with MedChi representation.

CONTINUE: MedChi will continue advocacy efforts and work with the Board of Physicians when issues arise.

7. Promote public health and safety initiatives that address health equity and social determinants of health.

ACCOMPLISHED: MedChi successfully supported *House Bill 637/Senate Bill 385: Public Health – Recommendations for Immunizations, Screenings, and Preventive Services – Pharmacist*

Administration and Required Health Insurance Coverage (The Vax Act), granting the Maryland Secretary of Health the authority to issue, publish, and distribute specified recommendations for immunizations, screenings, and preventative services. The bill effectively decouples the State from the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices' recommendations. The Firm worked to ensure that MedChi was prominently featured on the Governor's legislative panel and to secure its strong support for the legislation. MedChi also strongly supported *House Bill 1109/Senate Bill 790 – Public Health Reform Act*, a follow-up implementation measure for the Maryland Commission on Public Health (COPH).

CONTINUE: MedChi will continue its advocacy efforts to promote meaningful public health initiatives.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

LC Report 1-26

INTRODUCED BY: Looking AHEAD Committee

SUBJECT: Overview of Activities for 2026

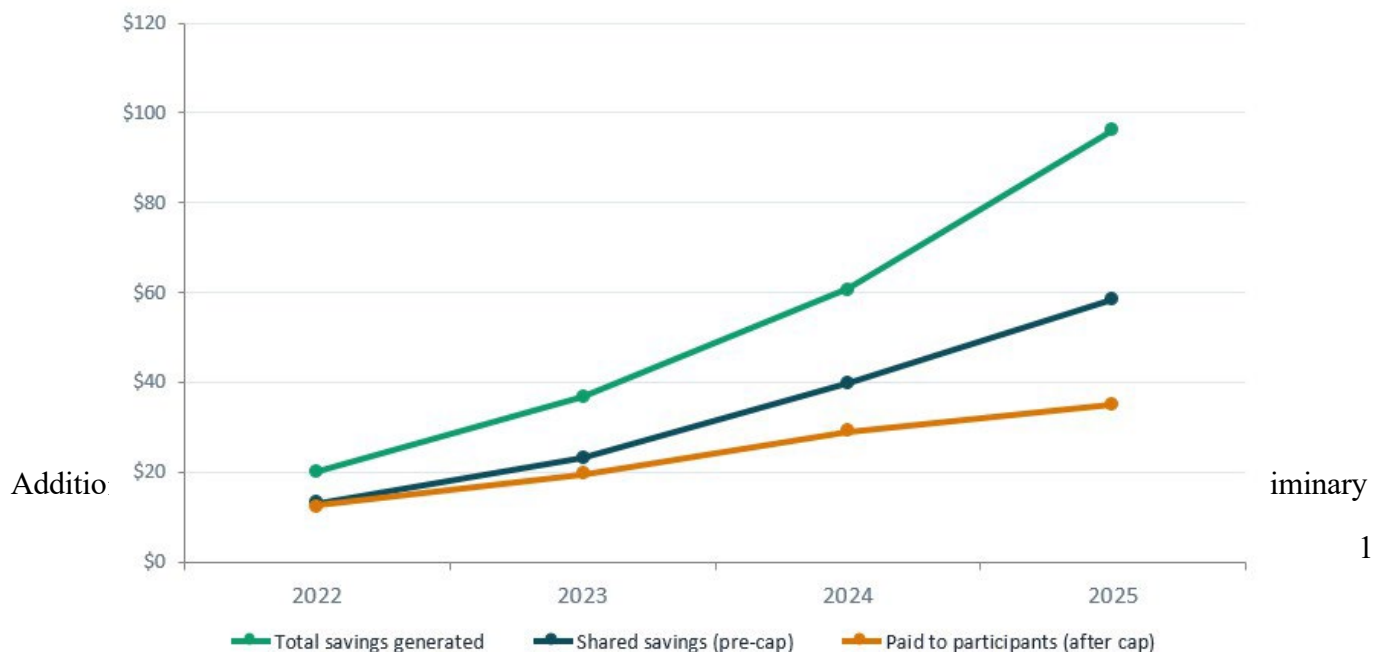
The Looking AHEAD Committee continues to focus on ensuring that Maryland's transition to the federal AHEAD Model preserves meaningful physician participation, strengthens primary care, and builds upon the value-based care programs that have worked well under Maryland's Total Cost of Care Model. Maryland formally transitioned to AHEAD on January 1, 2026, and implementation decisions being made now will shape physician participation in the Maryland health care system for years to come.

Episode Quality Improvement Program (EQIP)

The continued growth and preservation of the Episode Quality Improvement Program (EQIP) remains one of MedChi's most significant accomplishments in Maryland's transition to AHEAD. MedChi strongly advocated for the continuation of EQIP because it provides specialists and other practitioners with a physician-led pathway into value-based care without requiring them to become part of a hospital system or traditional ACO.

Performance Year 4 (Calendar Year 2025) was a breakout year for the program, generating \$96.3M in savings — up 58% year over year. Of that, \$35.8M will be distributed to participants after quality and CAP adjustments. The scale of the gain is striking: PY4 alone accounted for 44% of all shared savings in program history, nearly matching the \$75.9M earned across the first three years combined. Participation in the upside also broadened, with 75% of entities receiving shared savings in PY4.

EQIP Year Over Year Results



MedChi Entity enrollment includes 13 EQIP entities, 101 practices, and 259 practitioners. Practitioner participation increased approximately 76 percent, with significant new participation in primary care, pain management, ophthalmology, and physical therapy. These numbers remain preliminary pending CMS eligibility review.

MedChi is also providing substantial practice transformation support. Through the EQIP Practice Transformation Grant (PTG) Program, 92 practices are currently working with MedChi to receive practice transformation services to strengthen their EQIP performance. Participating practices are receiving assistance with data analysis and performance monitoring through Terrapin Analytics, EHR optimization through CRISP, care management and remote patient monitoring resources, and additional practice transformation educational resources on implementing value-based care.

This work is important beyond the immediate success of EQIP. It demonstrates that independent and community physicians can successfully participate in value-based care when they have appropriate data, infrastructure, technical assistance and payment incentives. As AHEAD evolves, the Looking AHEAD Committee will continue advocating for EQIP to remain a central component of Maryland's physician alignment strategy.

Primary Care: Preserving MDPCP and Building the Medicaid Program

Protecting the Maryland Primary Care Program has been another major priority of the Looking AHEAD Committee and of MedChi. During development of AHEAD, there was substantial uncertainty regarding the future of MDPCP. MedChi consistently advocated that Maryland should not abandon a successful physician-centered primary care infrastructure simply because the federal payment model was changing.

The House of Delegates previously made preservation of MDPCP for both Medicare and Medicaid a MedChi organizational priority. MedChi worked with state officials, federal officials, primary care organizations and physician practices to make the case for maintaining MDPCP and providing a pathway for additional practices to participate.

That advocacy has produced meaningful results. MDPCP continues under AHEAD, now operating as MDPCP-AHEAD, and approximately 460 Maryland practices are participating in 2026. Maryland has also established PC AHEAD as an additional entry-level Medicare pathway for practices that are newer to value-based payment arrangements.

At the same time, the Looking AHEAD Committee has been deeply engaged in the development of the Medicaid Advanced Primary Care Program. The Medicaid program is particularly important because participation in the Medicaid pathway is now a prerequisite for participation in either MDPCP-AHEAD or PC AHEAD. The first full performance year of the Medicaid Advanced Primary Care Program began January 1, 2026.

MedChi has worked to educate practices, conduct town halls, assist physicians through the application process and identify practical barriers to participation. Our advocacy remains focused on ensuring that Medicaid participation provides sufficient resources to practices, that administrative requirements are manageable, and that care-management and transformation funding reaches the physicians actually

responsible for delivering care. MedChi will continue working with the Maryland Department of Health, CMS, CRISP and other partners to improve the program as implementation proceeds.

The larger objective is to create a sustainable primary care infrastructure that works across Medicare and Medicaid, provides opportunities for new practices to enter value-based care, and protects the physician-led care transformation infrastructure Maryland has spent years building.

ACCESS and Broader AHEAD Advocacy

The Looking AHEAD Committee is also closely following the new federal ACCESS Model, Advancing Chronic Care with Effective, Scalable Solutions. ACCESS began nationally in July 2026 and creates a new Medicare payment pathway for technology-supported management of chronic conditions including hypertension, diabetes, chronic musculoskeletal pain and depression. The model allows participating organizations to provide services such as remote monitoring, coaching and other technology-supported interventions, with payment increasingly tied to patient outcomes.

ACCESS presents both an opportunity and an important advocacy challenge for physicians. Technology-supported care can improve access and give physicians new tools to manage chronic disease, particularly in rural and underserved communities. At the same time, these new arrangements must complement rather than fragment the physician-patient relationship.

MedChi's work is therefore focused on ensuring that referring and primary care physicians remain central to patient care, that information generated through ACCESS is returned to the patient's existing physician and incorporated into the clinical record, that physicians are appropriately compensated for coordination and co-management, and that ACCESS does not duplicate or undermine Maryland's existing MDPCP, EQIP, ACO and other value-based care arrangements. CMS has specifically created a co-management payment for referring clinicians and has stated that ACCESS is intended to complement existing ACO and shared-savings arrangements, making implementation and coordination especially important.

More broadly, MedChi continues to advocate aggressively as AHEAD moves from concept to implementation. Our priorities remain ensuring adequate investment in primary care, maintaining meaningful pathways for independent physicians to participate in value-based care, protecting physician autonomy, reducing unnecessary administrative burden, ensuring appropriate risk adjustment and preserving direct physician access to the resources generated by health care transformation. These have been consistent MedChi priorities throughout development of the AHEAD Model.

Significant changes remain ahead as CMS is developing new hospital global budget methodologies, Primary Care AHEAD continues to evolve, and the Geo AHEAD accountable care structure is scheduled to begin in 2028. The Looking AHEAD Committee will continue to engage with CMS, the Maryland Department of Health, HSCRC, CRISP, Maryland's congressional delegation and other stakeholders to ensure that the physician voice remains central as those decisions are made.

The transition to AHEAD represents one of the most significant changes to Maryland health care financing in decades. MedChi's objective remains straightforward: preserve what is working, improve what is not, and ensure that physicians and their patients benefit from Maryland's next generation of

health care transformation.

No action is requested. This report is submitted for information and discussion.

Respectfully submitted,

Benjamin Lowentritt, MD

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 09-26

INTRODUCED BY: Wicomico County Medical Society

SUBJECT: Cancer Genetic Screening

1 Whereas genetic testing and screening for heritable cancers is underutilized for all cancer types, and

2
3 Whereas the Affordable Care Act only mandates BRCA genetic testing, and

4
5 Whereas insurance coverage for recommended testing is not universal, and

6
7 Whereas many genetic tests are now available, and

8
9 Whereas disparities for testing and screening exist, and

10
11 Whereas early detection of cancer is a mainstay of appropriate medical care, and

12
13 Whereas the Maryland Health Care Commission (MHCC) has evaluated the elimination of cost-
14 sharing for cancer genetic testing in 2024 as required by law for the legislative establishment of new
15 insurance mandates, and 16

17 Whereas the MHCC found that this would have an insignificant impact on insurance premiums, (1)

18
19 Be it resolved that MedChi advocate for Maryland legislation that mandates insurance coverage
20 without copays for hereditary cancer risk assessment and screening as recommended by The National
21 Comprehensive Cancer Network and/or like organizations. This legislation would apply to Medicaid
22 and all healthcare insurance entities licensed in the State of Maryland . 23

24

25 Fiscal Note: Included in the advocacy budget.

26
27 Reference:

28 (1)https://mhcc.maryland.gov/sites/default/files/reports/cancer_genetic_testing_evaluation.pdf

MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 10-26

INTRODUCED BY: MedChi Medical Student Section;
Tiffany Kamberi; University of Maryland School of Medicine

SUBJECT: Transparency and Education Regarding Artificial Intelligence in
Clinical Practice

Whereas, Artificial intelligence (AI) is increasingly incorporated into clinical practice, creating a need for medical students to understand its practical applications, limitations, and responsible use in patient care^{1,2}; and

Whereas, Meaningful transparency in clinical education requires that trainees understand which AI tools are used in their training environments, the purposes these tools serve, their known limitations, and the responsibilities of trainees and supervising physicians²; and,

Whereas, AI education should address applications across medical specialties, the training needed to use these tools appropriately, recognition of potential errors and bias, protection of patient information, and preservation of independent clinical judgment; and,

Whereas, A survey of U.S. medical students identified limited awareness of available AI educational resources and gaps in familiarity with clinically relevant AI applications³; and,

Whereas, Research involving early-career physicians has identified a need to connect AI ethics education more closely with clinical workflows⁴; and

Whereas, In 2025, the American Medical Association adopted policy supporting expanded AI education and literacy among medical schools, including curricular toolkits and faculty development resources⁵; and

Whereas, Maryland enacted Senate Bill 597 in 2026 establishing the Maryland Artificial Intelligence Partnership within the University System of Maryland, providing a potential opportunity for collaboration on AI education and policy⁶; and

Whereas, General AI educational resources should be supplemented by institution-specific instruction so that medical students and residents can understand the tools used at their clinical training sites, their approved uses, and the applicable supervision and safety reporting procedures; and

Whereas, Preparing trainees to evaluate AI-generated outputs, recognize when those outputs are inappropriate for an individual patient, and seek guidance from supervising physicians is essential to the responsible integration of AI into clinical training; therefore be it

RESOLVED, That MedChi support the integration of practical, longitudinal education on the clinical use of artificial intelligence into medical education in Maryland; and be it further

RESOLVED, That MedChi encourage medical schools, teaching hospitals, and residency programs to provide trainees with accessible information about institutionally approved AI tools used in their clinical learning environments, including their intended uses, known limitations, required human oversight, and procedures for reporting errors or safety concerns; and be it further

RESOLVED, That MedChi seek collaboration with Maryland medical schools, teaching hospitals, and relevant state agencies to identify and disseminate accessible educational resources, drawing on existing AMA materials and incorporating clinical, technical, ethical, and legal expertise; and be it further

RESOLVED, That MedChi encourages participating institutions to review these educational resources at least annually and following significant changes in applicable requirements or institutional AI use, and to include medical students and residents in evaluating their relevance and effectiveness.

Fiscal Note: Included in the advocacy budget.

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MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 11-26

INTRODUCED BY: Medical Student Section;
 Tiffany Kamberi; University of Maryland School of Medicine

SUBJECT: Preserving Medicaid Coverage and Access Through State Investment

1 Whereas, Nearly one in four Marylanders relies on Medicaid for health insurance coverage, and
2 approximately half of those covered are children, underscoring the program's essential role in serving
3 eligible children, older adults, individuals with disabilities, pregnant women, and low-income adults
4 and families¹; and
5

6 Whereas, Medicaid is a major source of health coverage for racial and ethnic minority populations
7 and has helped narrow racial and ethnic disparities in insurance coverage, underscoring the
8 importance of preserving Medicaid funding to protect these gains²; and
9

10 Whereas, The Maryland Department of Health reported in May 2025 that federal funding accounted
11 for nearly 60% of Maryland's \$14.6 billion Medicaid budget, underscoring the State's reliance on
12 federal support and the need for state investment to mitigate the effects of federal funding reductions
13 on patient access to care³; and
14

15 Whereas, H.R. 1, enacted on July 4, 2025, changes Medicaid eligibility and enrollment requirements
16 and restricts avenues states use to finance their Medicaid programs, creating challenges for
17 maintaining coverage and access to care^{4,5}; and
18

19 Whereas, Maryland's Department of Legislative Services has projected that Medicaid changes under
20 H.R. 1 will result in coverage losses and increased administrative costs, demonstrating the need for a
21 coordinated state response⁶; and
22

23 Whereas, Changes to Medicaid eligibility and renewal requirements increase the importance of
24 adequately resourced eligibility processing, renewal assistance, and beneficiary outreach to help
25 eligible Marylanders maintain coverage and continuity of care; and
26

27 Whereas, Low reimbursement rates and administrative burden are recognized barriers to physician
28 participation in Medicaid, with implications for beneficiaries' access to care⁷; and
29

30 Whereas, MedChi has opposed Medicaid payment cuts, warning that these cuts, combined with
31 federal funding reductions under H.R. 1, could jeopardize physician participation and the adequacy
32 of provider networks serving Maryland Medicaid beneficiaries⁸; and
33

34 Whereas, The American Medical Association opposed Medicaid funding reductions in H.R. 1,
35 warning that these reductions would shift costs to states, physicians, and hospitals and threaten
36 patient access to care⁹; and
37

Whereas, Revenue from Maryland’s premium tax on health maintenance organizations and managed care organizations has historically supported Medicaid funding, including increased provider reimbursement¹⁰; and

Whereas, Reductions in existing Medicaid financing sources without adequate replacement funding could place additional pressure on physician reimbursement, provider participation, and access to care for Medicaid beneficiaries; and

Whereas, Additional state investment can help mitigate reductions in federal Medicaid support, sustain adequate physician reimbursement, and preserve access to covered health care services; and

Whereas, Stable and predictable Medicaid financing is necessary to sustain provider participation, support safety-net services, and protect continuity of care for Maryland patients; therefore be it

RESOLVED, That MedChi support additional state investment to help offset reductions in federal Medicaid funding resulting from H.R. 1 and preserve coverage and access to timely, high-quality care for Maryland Medicaid beneficiaries; and be it further

RESOLVED, That MedChi advocate for adequate Medicaid funding and physician reimbursement to sustain provider participation and oppose additional state reductions that would undermine patient access to covered services; and be it further

RESOLVED, That MedChi support preservation of existing Medicaid financing sources and development of sustainable replacement funding when those sources are reduced or discontinued, consistent with applicable federal requirements.

Fiscal Note: Included in the advocacy budget.

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MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 12-26

INTRODUCED BY: MedChi Medical Student Section;

Tiffany Kamberi; University of Maryland School of Medicine

SUBJECT: Protecting and Funding Maryland's AHEAD Medicaid Advanced Primary
Care Program

Whereas, Approximately 1.5 million Marylanders receive health coverage through Medicaid, underscoring the importance of maintaining accessible, comprehensive care for Medicaid beneficiaries¹; and

Whereas, Research indicates that Medicaid connects low-income adults with a usual source of care and access to primary care and preventive services²; and

Whereas, A greater supply of primary care physicians is associated with longer life expectancy and lower mortality, supporting policies and programs that sustain the primary care workforce and improve access to care³; and

Whereas, The 2026 Primary Care Scorecard reported that primary care accounted for only 4.5% of total U.S. health care spending in 2023, highlighting the limited share of spending devoted to these services⁴; and

Whereas, States that allocate a greater share of health care spending to primary care have demonstrated lower rates of hospital and emergency department visits⁵; and

Whereas, The federal Centers for Medicare & Medicaid Services (CMS), through the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, supports increased investment in primary care to improve health outcomes and control health care spending⁶; and

Whereas, Maryland participates in the AHEAD Model, and sustained investment in primary care aligns with the State's existing goals of improving health care quality, coordinating patient care, and promoting long-term affordability⁷; and

Whereas, Maryland's Medicaid Advanced Primary Care Program, also known as the Medicaid Path, is a component of the State's AHEAD framework that supports access to comprehensive, coordinated primary care for Medicaid beneficiaries⁸; and

Whereas, The Maryland Health Care Commission has recommended increased investment and alignment across payers to support advanced primary care, reinforcing the importance of sustained support for Maryland's Medicaid Advanced Primary Care Program⁹; and

Whereas, The program's care delivery requirements include enhanced access to care, follow-up after hospital and emergency department visits, specialist referral coordination, behavioral health screening, and connections to community resources⁸; and

Whereas, Fulfilling these requirements requires investment in clinical staff, care management, information systems, and practice support that extends beyond the resources needed for individual patient visits; and

Whereas, Stable and predictable program funding enables participating physicians and other practitioners to retain staff, develop care coordination services, and maintain the resources necessary to participate successfully in value-based care; and

Whereas, Reductions in program funding or support could undermine practice sustainability, limit participation, and disrupt access to comprehensive care for Medicaid beneficiaries; therefore be it

RESOLVED, That MedChi support sustained funding and continued implementation of Maryland's Medicaid Advanced Primary Care Program under the AHEAD Model to preserve and strengthen access to comprehensive, coordinated care for Medicaid beneficiaries; and be it further

RESOLVED, That MedChi opposes funding reductions or program changes that would undermine patient access or participating practices' ability to meet program requirements and deliver advanced primary care.

Fiscal Note: Included in the advocacy budget.

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MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 13-26

INTRODUCED BY: MedChi Medical Student Section;
Umailla Naeem; University of Maryland School of Medicine
SUBJECT: Supporting Folic Acid Fortification of Corn Masa Flour to Address
Health Equity and Prevent Neural Tube Defects

1 Whereas, neural tube defects (NTDs)—including spina bifida (1,294 cases annually), anencephaly
2 (776 cases), and encephalocele (407 cases)—are among the most common birth defects in the
3 United States, affecting approximately 2,500 pregnancies annually, with a combined prevalence of
4 approximately 6.7 per 10,000 live births;¹ and,
5

6 Whereas, folic acid fortification of enriched grain products, mandated federally in 1998, resulted in
7 a 35% reduction in NTDs nationally and has been proven to be one of the most cost-effective
8 public health interventions, saving an estimated \$603 million annually in direct and indirect costs;^{2,3}
9 and,
10

11 Whereas, Hispanic and Latino populations in the United States experience neural tube defects at
12 disproportionately high rates—with Hispanic women having the highest NTD prevalence (4.17 per
13 10,000 live births) compared to non-Hispanic white women (3.22 per 10,000 live births),
14 representing a significant and persistent health disparity;⁴ and,
15

16 Whereas, the 1998 federal fortification mandate included wheat, rice, corn grits, and pasta, but
17 explicitly excluded corn masa flour—a dietary staple consumed at substantially higher rates by
18 Hispanic and Latino communities—thereby creating a 27-year structural gap in fortification policy
19 that has disproportionately affected this population;⁵ and,
20

21 Whereas, the FDA approved voluntary fortification of corn masa flour in 2016 at levels of 0.7
22 mg/lb, but voluntary uptake has failed: national surveys have found that most corn masa flour and
23 corn tortilla products remain unfortified, demonstrating that market-based approaches are

insufficient to address this health disparity;^{6,7} and,

Whereas, folic acid supplementation is most effective during the periconception period, yet approximately 50% of pregnancies are unintended, and lower-income women experience higher rates of unintended pregnancy, making mandatory food fortification—rather than individual supplementation—a necessary structural intervention to reach the populations at highest risk;⁸ and,

Whereas, immigrant women from Latin America and Mexico, where corn masa flour is mandatorily fortified, often assume that U.S. corn products meet the same standards, leading to inadequate folic acid intake among recent immigrants and their children;⁹ and,

Whereas, multiple states have successfully passed corn masa fortification legislation: California (AB 1830, effective January 1, 2026), Alabama (HB 384, effective June 1, 2026), Delaware (HB 337, passed both chambers), and New Jersey (S-4193/A-5119, sent to governor), all requiring 0.7 mg/lb fortification with implementation timelines of 12-24 months;^{10,11,12,13} and,

Whereas, major corn masa manufacturers, including those producing Mission Foods and Azteca brands, have demonstrated that fortification is technically feasible and poses minimal industry burden;¹⁴ and,

Whereas, the lifetime cost of spina bifida care exceeds \$791,900 per individual in direct and indirect medical expenses, while the cost of food fortification is negligible, making this intervention extraordinarily cost-effective from both health equity and economic perspectives;¹⁵ and,

Whereas, Maryland's 12.1% Hispanic/Latino population includes concentrated communities in Prince George's County (21.2%) and Montgomery County (20.5%), representing a significant portion of the state's Latino population, and Maryland is home to the Kennedy Krieger Institute's Philip A. Keelty Center for Spina Bifida and Related Conditions—a leader in spina bifida treatment and prevention—creating Maryland as an ideal location for leadership on this issue;¹⁶ and,

Whereas, the FDA has not updated federal fortification mandates since 1998 despite scientific evidence supporting corn masa inclusion, suggesting that state-level policy innovation and

55 leadership will be necessary to influence federal rulemaking;¹⁷ and,

56
57 Whereas, mandating corn masa fortification with mandatory bilingual labeling (English and
58 Spanish), community-centered education, and health equity-focused evaluation ensures that the
59 intervention reaches the populations at highest risk and creates accountability for whether health
60 disparities actually close; and, 61

62 Whereas, physicians have a professional obligation to advocate for structural and policy
63 interventions that address health disparities, and organized medicine's support for evidence-based
64 health equity policy strengthens legislators' commitment to passing such legislation;¹⁸ and,

65
66 Whereas, this issue aligns with the American Medical Association's stated priorities on health
67 equity, health policy, and maternal-infant health, and state-level action positions national organized
68 medicine to advocate for federal policy change;¹⁸ therefore, be it

69
70 RESOLVED, That MedChi endorses and actively supports state legislation mandating folic acid
71 fortification of corn masa flour at 0.7 mg/lb and wet masa at 0.4 mg/lb and authorizes its

72 representatives to testify in favor of this legislation before the Maryland House and Senate; and, 73

74 RESOLVED, That MedChi advocates for bilingual labeling (English and Spanish) on all fortified
75 corn masa products, community-centered education campaigns regarding folic acid and neural tube
76 defect prevention, and health equity-focused evaluation metrics (including disaggregated data by
77 race/ethnicity, nativity, language, and income) to ensure that fortification policies are implemented
78 with accountability for closing health disparities; and, be it 79

80 RESOLVED, That our Maryland Delegation to the American Medical Association (AMA) act to
81 encourage the AMA to endorse mandatory folic acid fortification of corn masa flour and other
82 corn-based products at the federal level; to communicate with the FDA and U.S. Department of
83 Health and Human Services the medical establishment's position that federal fortification mandates
84 should be updated to include corn masa flour; and to recognize state-level corn masa fortification
85 legislation as a model for how to embed health equity requirements—bilingual labeling, community

86 partnership, and equity-focused evaluation—into food policy; and, be it further 87
88 RESOLVED, That MedChi transmit this resolution to the American Medical Association House of
89 Delegates for consideration at the earliest appropriate meeting; and, be it 90
91 RESOLVED, That MedChi encourages the Maryland Department of Health to coordinate with the
92 FDA regarding Maryland's fortification legislation, share implementation data and health outcomes
93 with federal regulators, and position Maryland as a contributor to the evidence base for federal
94 policy change; and, be it 95
96 RESOLVED, That a copy of this resolution be sent to: the Maryland Department of Health; the
97 FDA Center for Food Safety and Applied Nutrition; the American Medical Association; the
98 American Academy of Pediatrics; March of Dimes; Senator Clarence Lam; Delegate Jennifer
99 White Holland; Delegate Terri L. Hill; and the Kennedy Krieger Institute.

101 Fiscal Note: Included in the advocacy budget.

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MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 14-26

INTRODUCED BY: MedChi Medical Student Section;
Umailla Naeem; University of Maryland School of Medicine

SUBJECT: Federal and Maryland Policy Response to Medical Student Debt
Crisis from Federal Borrowing Caps and Elimination of Grad PLUS
Loans

Whereas, effective July 1, 2026, federal legislation (One Big Beautiful Bill Act / H.R. 1) placed new annual and aggregate caps on federal graduate student loan borrowing, limiting medical students to \$50,000 per year and \$200,000 total professional degree borrowing, while simultaneously eliminating the Federal Grad PLUS loan program that previously allowed students to borrow up to their school's full cost of attendance;^{1,2} and,

Whereas, the average cost of medical school is \$297,745 at public institutions and \$408,150 at private institutions, creating funding gaps of \$97,745 to \$208,150 for students who now cannot access Grad PLUS loans and are capped at \$200,000 in federal borrowing;^{3,4} and,

Whereas, according to the Association of American Medical Colleges (AAMC), 70% of medical school graduates carry student loan debt, with median debt of \$215,000 for the class of 2025, already exceeding the new \$200,000 federal cap before accounting for undergraduate borrowing;^{5,6} and,

Whereas, over 84% of medical student borrowers carry balances of at least \$100,000, and 56% owe \$200,000 or more, with many first-generation, lower-income, and students from underrepresented backgrounds carrying higher debt burdens;^{4,7} and,

Whereas, these new federal borrowing caps will disproportionately burden students without family financial support, including first-generation, lower-income, and students from underrepresented racial and ethnic backgrounds, potentially widening educational access disparities and reducing diversity in the physician workforce;^{2,7} and,

Whereas, students unable to cover educational costs through federal loans may be forced to defer enrollment, seek private loans with stringent credit requirements and less flexible repayment terms, or abandon medical school entirely, thereby reducing the pipeline of future physicians at a time when the United States faces a projected shortage of 13,500 to 86,000 physicians by 2036;^{8,9} and,

Whereas, higher medical school debt may deter physicians from practicing in primary care, rural areas, or other specialty and practice settings serving underserved populations, as debt burden can force physicians to prioritize higher-paying specialties over patient need or personal preference;¹⁰ and,

Whereas, the American Medical Association (AMA) has actively opposed these federal borrowing caps and advocated for expansion of service-based loan forgiveness programs and federal loan products, recognizing the threat to physician workforce development and diversity;^{10, 11, 12} and,

Whereas, Maryland's existing Loan Assistance Repayment Program (LARP) provides loan repayment assistance to primary care physicians and physician assistants serving in underserved areas of the state, but funding levels and specialty eligibility remain limited;¹³ and,

Whereas, Maryland's 13.8% Hispanic/Latino population and 31.1% Black population, with concentrations in Prince George's County (24.9% and 60.7%) and Baltimore City (8.2% and 59.2%), are underrepresented in the physician workforce and would benefit from targeted financial support to ensure equitable access to medical education;¹⁴ and,

Whereas, medical student financial stress and debt burden are recognized contributors to physician burnout, mental health concerns, and career dissatisfaction, affecting not only students' well-being but also long-term physician retention and patient care quality; therefore be it¹⁵

RESOLVED, That MedChi support the American Medical Association's advocacy efforts to reverse, raise, or eliminate federal borrowing caps for graduate professional students, and to restore or create federal loan products and repayment programs that allow medical students to access affordable financing to cover the full cost of medical education;^{11,12} and be it further

RESOLVED, That MedChi advocate for Maryland state-level solutions to address the medical student debt crisis, specifically including: (1) expansion of the Maryland Loan Assistance Repayment Program (LARP) to increase annual assistance amounts, extend eligibility to additional specialties and practice settings beyond primary care (including emergency medicine, psychiatry, pediatrics, and other critical shortage specialties), and increase accessibility for recent graduates and physicians serving in rural and underserved areas;¹³ (2) exploration of new state loan forgiveness programs for physicians committing to practice for defined periods in Health Professional Shortage Areas (HPSAs), rural communities, or safety-net settings;¹⁶ (3) support for institutional scholarship expansion at Maryland medical schools to offset rising tuition costs, particularly for low-income and underrepresented students;⁷ and (4) state coordination with federal loan servicers to provide accurate financial counseling to Maryland medical students; and be it further

RESOLVED, That MedChi encourage Maryland medical schools to enhance financial literacy and financial planning education for medical students, including education on loan repayment strategies, public service loan forgiveness, income-driven repayment plans, and available state and institutional financial assistance programs; and be it further

RESOLVED, That MedChi request that the Maryland Department of Health assess and report on the impact of federal borrowing caps on medical school enrollment, demographics of enrolled students, career specialty choice, and projected effects on the Maryland physician workforce pipeline; and be it further

RESOLVED, That MedChi request that its Maryland delegation to the American Medical Association continue to advocate at AMA meetings for federal policy changes to address medical

student debt, and amplify AMA messaging to state and federal lawmakers regarding the threat of current borrowing caps to physician workforce development and healthcare access.¹²

Fiscal Note: Included in the advocacy budget.

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MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 15-26

INTRODUCED BY: MedChi AMA Delegation

SUBJECT: Clarification of AMA Delegation Term Limit Exception

1 Whereas, MedChi Bylaw 12.20 provides that delegates and alternate delegates to the American
2 Medical Association serve two-year terms and generally may serve no more than six consecutive
3 terms as either a delegate or alternate delegate; and
4

5 Whereas, Bylaw 12.20 expressly provides an exception to that limitation when an individual holds,
6 or is a declared or nominated candidate for, an additional elected or appointed position with the
7 American Medical Association whose responsibilities extend beyond the end of that individual's term
8 as a delegate or alternate delegate;¹ and
9

10 Whereas, the purpose of this existing exception is to permit continued service on the MedChi AMA
11 Delegation when necessary to support a Maryland physician serving in or seeking an additional
12 American Medical Association leadership or appointed position; and
13

14 Whereas, clarification is appropriate regarding whether time served on the MedChi AMA Delegation
15 while an individual qualifies for this existing exception should be included in calculating the six-
16 consecutive-term limitation; and
17

18 Whereas, such clarification can provide for consistent application of the existing Bylaw without
19 changing the language of Bylaw 12.20 or creating a new exception; therefore be it
20

21 RESOLVED, that the MedChi House of Delegates clarify that, for purposes of applying Bylaw
22 12.20, time served as a delegate or alternate delegate while an individual qualifies for the existing
23 exception for an additional elected or appointed American Medical Association position, or as a
24 declared or nominated candidate for such a position as provided in Bylaw 12.20, shall not be counted
25 toward the six consecutive-term limitation, and the running of that term-limit period shall be tolled
26 during such qualifying service.
27

28
29 Fiscal Note: No financial implications.

References:

MedChi, The Maryland State Medical Society. Bylaws of the Medical and Chirurgical Faculty of Maryland, Article 12.20, Term, revised October 26, 2024.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY |
HOUSE OF DELEGATES

Resolution 16-26

INTRODUCED BY: Queen Anne’s County Medical Society

SUBJECT: Protecting Maryland’s Medical Liability Reforms

1 WHEREAS, maintaining a stable medical liability environment is critical to preserving patient access
2 to physicians, particularly in rural communities and in specialties already experiencing workforce
3 shortages, and MedChi has warned that significant increases in liability exposure can increase
4 professional liability premiums, encourage physicians to limit services, retire, or leave practice, and
5 further reduce access to care; and 6

7 WHEREAS, in response to a medical liability crisis, Maryland enacted significant medical liability
8 reforms in 2004, including limits on noneconomic damages in medical malpractice actions, and
9 Maryland’s medical malpractice noneconomic damages cap is \$920,000 for causes of action arising
10 in 2026, with an automatic annual increase of \$15,000; and 11

12 WHEREAS, during the 2026 Maryland General Assembly session, House Bill 476 and Senate Bill
13 474 proposed eliminating Maryland’s longstanding limits on noneconomic damages in personal
14 injury and wrongful death actions outside of medical malpractice, and although the legislation did not
15 directly repeal the medical malpractice cap, MedChi has warned that eliminating other noneconomic
16 damage limitations would establish a precedent that could be used to challenge the medical

17 malpractice cap in future sessions; House Bill 476 was ultimately referred to interim study; and 18

19 WHEREAS, House Bill 906 and Senate Bill 871 proposed another significant change to Maryland
20 tort law by allowing punitive damages in negligence actions based on gross negligence, rather than
21 Maryland’s longstanding requirement of actual malice, substantially lowering the threshold for such
22 extraordinary damages and potentially increasing liability exposure for physicians and other
23 defendants; and
24

25 WHEREAS, Maryland’s contributory negligence doctrine is also under renewed legislative
26 examination, with House Bill 466 proposing comparative negligence for certain claims and being
27 referred to interim study in 2026; Maryland law currently provides that a plaintiff’s contributory
28 negligence can completely bar recovery, while a comparative-negligence system generally allows
29 recovery reduced according to the plaintiff’s share of fault, a change that could have significant
30 implications in medical liability cases in which patient conduct or noncompliance contributes to an
31 injury; and
32

33 WHEREAS, developments in neighboring Virginia demonstrate that longstanding medical liability
34 protections cannot be taken for granted, as Virginia Senate Bill 536 was amended during the 2026
35 legislative session to propose increasing that state’s medical malpractice cap from \$2.75 million to \$6

36 million, prompting significant concern from the physician community about the potential effects on
37 physician practices and access to care; and 38
39 WHEREAS, although Virginia ultimately did not enact the proposed \$6 million cap, the final
40 legislation instead established extensive medical malpractice insurance, claims, verdict, and cost
41 reporting requirements specifically intended to inform future evaluation of Virginia's medical
42 malpractice damages-cap framework, demonstrating that the debate over substantial changes to
43 medical liability protections will continue; and therefore be it 44
45 RESOLVED, That the Queen Anne's County Medical Society urges MedChi, The Maryland State
46 Medical Society, to keep the preservation and protection of Maryland's existing medical liability and
47 tort reforms a top legislative priority, including vigorously opposing efforts to repeal, substantially
48 increase, or undermine the cap on noneconomic damages in medical malpractice cases; weaken
49 Maryland's contributory negligence standard in a manner that increases medical liability exposure;
50 lower the standard for punitive damages; or otherwise enact changes that would destabilize
51 Maryland's medical liability environment, increase the cost of practicing medicine, or threaten
52 patient access to physicians. 53

54
55

Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 17-26

INTRODUCED BY: MedChi Medical Student Section
Authored by: Komal Gandhi of University of Maryland, School of
Medicine

SUBJECT: Protecting Menstrual Health Through Regulation and Transparency of
Endocrine-Disrupting Chemicals in Menstrual Products

Whereas, women may use 10,000 or more menstrual products throughout their lifetime;¹ and

Whereas, menstrual products have been found to contain measurable amounts of endocrine-
disrupting chemicals (EDCs) including phthalates, phenols and parabens;^{2,3} and

Whereas, vulvar and vaginal tissue are highly absorptive, raising concern for increased local
exposure to EDCs during repeated and prolonged use of menstrual products;² and

Whereas, exposure to EDCs, including potential exposure via menstrual products, has been
associated with gynecologic and endocrine conditions, such as endometriosis, uterine fibroids,
adenomyosis, and polycystic ovarian syndrome;²⁻⁵ and

Whereas, women of color or from lower socioeconomic backgrounds face higher cumulative
exposure to EDCs through menstrual and personal care products;⁵ and

Whereas, significant racial and ethnic disparities exist in the prevalence, diagnosis, and surgical
treatment of common gynecologic conditions;^{5,6} and

Whereas, Maryland has demonstrated a commitment to regulating EDCs in personal care products
through recent legislation (HB0643);⁷ and

Whereas, multiple states, including Vermont, Colorado, Maine, California, Minnesota, and New
York, have enacted policies banning the intentional addition of EDCs in cosmetic and menstrual
products and/or addressing ingredient transparency;⁸⁻¹³ therefore be it

RESOLVED, that MedChi, the Maryland State Medical Society, supports state-level policies that
extend EDC regulation to ban the intentional use of EDCs in menstrual products and require
chemical ingredient disclosure; and be it further

RESOLVED, that MedChi, the Maryland State Medical Society, supports increased research and
surveillance on the health effects of chronic exposure to endocrine-disrupting chemicals through
menstrual products.

Fiscal Note:

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MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 18-26

INTRODUCED BY: MedChi Medical Student Section
 Authored by: Komal Gandhi of
 University of Maryland, School of Medicine

SUBJECT: Promoting Standardized Accessibility of Patient Medical
 Documentation Across Healthcare Settings

Whereas, 1 in 4 Americans have a disability;¹ and

Whereas, patients with disabilities have 3 times as many doctors visits per year and two times as many hospitalizations compared to patients without disabilities;² and

Whereas, access to personal health information is essential for patient autonomy, informed decision-making, and participation in healthcare; and

Whereas, federal disability rights laws, including the Americans with Disabilities Act (Title II Regulations Sections 35.108(d)(1)(vii) and 36.105(d)(1)(vii)), Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act, and certain state Medicaid and public program regulations require healthcare entities to ensure effective communication and provide reasonable accommodations for patients with disabilities;³⁻⁴ and

Whereas, Maryland requires Medicaid managed care organizations to provide enrollee materials in accessible formats that accommodates individuals with disabilities (10.67.05.01B(1));⁵ and

Whereas, accommodations, such as American Sign Language (ASL) and other interpreters; nonvisual access to print, including large print, Braille, electronic format, and easy read formats for written materials; alternatives to telephone contact, and captioning on videos, are not universal in healthcare settings;⁶ and

Whereas, patients with visual and other disabilities may encounter barriers when medical documentation is not available in accessible formats, which negatively affects patient outcomes and trust in healthcare providers; and

Whereas, Washington recently adopted regulations requiring pharmacies and dispensing facilities to provide accessible prescription information for patients who are blind, visually impaired, or otherwise print-disabled (WAC 246-945-027);⁷ and

Whereas, the American Medical Association has adopted policies supporting improved care for patients with disabilities and promoting patient autonomy and access to care (H-90.968, H-90.967); therefore, be it

RESOLVED, that MedChi, the Maryland State Medical Society, supports the development of state-level standards ensuring accessible formats for patient-facing medical documentation across healthcare settings; and be it further

RESOLVED, that these standards will be developed in collaboration with community-based organizations that have lived experience and expertise in their area of disability, like the National Federation of the Blind.

Fiscal Note: Included in the advocacy budget.

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MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 19-26

Introduced by: MedChi Medical Student Section;
 Amanda Andriessen, Johns Hopkins University School of Medicine

Subject: Maintaining Access and Coverage for Maryland Medicaid
 Beneficiaries by Removing Medicaid Managed Care Organizations

1 Whereas, the Maryland Medicaid program provides health coverage to more than 1.3 million people,
2 including one in two children, and is the primary payer for long-term care services;¹ and
3

4 Whereas, Maryland Medicaid is administered through a fee-for-service (FFS) program and through
5 nine private managed care organizations (MCOs), with 85% of enrollees covered by MCOs;¹ and
6

7 Whereas, the 2025 Budget Reconciliation Act reduces Medicaid funding by \$1 trillion over the next
8 decade and requires implementation of work requirements and six-month enrollment periods for
9 certain populations;² and
10

11 Whereas, these recent federal changes will result in 130,000 Marylanders losing coverage, reduce
12 federal funds for Maryland Medicaid by \$2.7 billion annually, and cost \$8-10 million more a year to
13 administer;³ and
14

15 Whereas, physicians and health systems participating in Medicaid managed care programs frequently
16 report significant administrative burdens associated with plan participation, including prior
17 authorization requirements,⁴ credentialing processes, network contracting, and claims administration,
18 which has led to decreased participation by providers; and
19

20 Whereas, State oversight of Medicaid MCOs is not as routine or robust, leading to patients facing
21 delays and denials of necessary care;⁵ and
22

23 Whereas, Connecticut terminated its contracts with MCOs and implemented a state-administered
24 FFS and care coordination program with support from administrative service organizations (ASO),
25 which saw a 33% increase in physician participation in the first year, decreased ER visits,⁶ improved
26 early-cancer detection rate,⁷ and saved the stated \$4 billion in taxpayer money since then;⁸ and
27

28 Whereas, research estimates Maryland would save \$521 million a year by eliminating contracts with
29 MCOs and switching to a managed fee-for-service model of state-run Medicaid;⁹ and
30

31 Whereas, the American Medical Association passed Resolution 116, A-26, to study the implications
32 of MCO Medicaid models in comparison to state-administered Medicaid programs with respect to
33 cost, administrative burden, physician reimbursements, and access to care¹⁰; and
34

35 Whereas, the Maryland House of Delegates passed HB1112 to study the impact of removing MCOs
36 and alternative options for Medicaid administration during the 2026 legislative session;¹¹ Therefore,

be it:

RESOLVED, that MedChi encourages state legislative efforts to study the fiscal implications of removing managed care organizations from the Medicaid program and alternate options for administering the Medicaid program, such as with administrative service organizations or enhanced primary care case management; and be it further

RESOLVED, that MedChi encourages state legislative efforts and Maryland Medicaid Administration policies that remove contracts with managed care organizations from the Medicaid program and support a state-administered Medicaid program.

Fiscal Note: Included in the advocacy budget.

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MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 20-26

INTRODUCED BY: MedChi Medical Student Section;

Hope Zamora, Kyle Patel, and Amanda Andriessen, Johns Hopkins
University School of Medicine

SUBJECT: Recognizing and Addressing Moral Injury in Maryland's Healthcare
System

Whereas, the construct of moral injury originated in military psychiatry to describe the psychological wounds sustained when individuals perpetrate, witness, or fail to prevent acts that transgress their deeply held moral beliefs, Dean and colleagues (2018) adapted this framework to healthcare, arguing that physicians experience moral injury when systemic constraints force them to consistently provide care they know to be inadequate, inequitable, or harmful¹⁻²; and

Whereas, burnout, which is manifested as emotional exhaustion and diminished personal accomplishment attributed to demand-resource mismatches, is conceptually distinct from moral injury, which results from the guilt, shame, and erosion of professional identity that physicians face when systemic failures prevent them from delivering care aligned with their ethical and medical obligations²⁻⁴; and

Whereas, a 2025 national survey of 1,207 practicing physicians found that 47% often or always felt unable to provide optimal care, often due to inadequate time, 44% reported being unable to deliver medically necessary treatment because of insurance barriers, and 68% reported moderate or severe distress due to being unable to provide optimal care⁵; and

Whereas, research has identified that systemic contributors to moral injury include prior authorization requirements, coverage denials, productivity quotas, excessive documentation, and the financialization of healthcare, which obstruct timely, evidence- based, patient-centered care⁵; and

Whereas, the 2025 American Medical Association Prior Authorization Physician Survey found that 95% of physicians report that prior authorization is associated with care delays, 92% report negative

24 impacts on clinical outcomes, and 26% report that prior authorization has led to a serious adverse event
25 for a patient in their care⁶; and 26

27 Whereas, prior interventions for the related but distinct construct of physician burnout (such as
28 resilience training, mindfulness, and wellness initiatives) have failed to significantly resolve physician
29 moral distress, requiring solutions that address the systemic conditions generating moral conflicts⁷⁻⁸;
30 and
31

32 Whereas, moral injury contributes to physician workforce instability and shortages by impacting
33 clinicians and medical trainees at all levels, with moral distress cited as the reason for which 25% of
34 surveyed physicians are currently considering leaving a position due to moral distress, 27% of surveyed
35 physicians have already left one position within healthcare, and 25% of surveyed medical students are
36 considering quitting their studies^{5,9-11}; and 37

38 Whereas, moral injury sustained by healthcare workers has profound societal impacts including
39 reduced quality, access to, and affordability of care, thereby threatening patient outcomes and driving
40 up healthcare costs¹²⁻¹³; and 41

42 Whereas, the AMA and MedChi have established policies to promote physician wellness and restrict
43 prior authorization utilization, improve reimbursements for administrative tasks, and reduce corporate
44 influence over healthcare delivery, in recognition of the burden that these barriers impose on
45 physicians¹⁴⁻¹⁹; therefore be it:
46

47 RESOLVED, that MedChi recognize moral injury as a significant threat to the well-being and retention
48 of medical students, residents, and practicing physicians, impacting their ability to deliver evidence-
49 based, equitable, and patient-centered care due to institutional, financial, or administrative barriers;
50 and be it further 51

52 RESOLVED, that MedChi encourage state and American Medical Association (AMA) policies and
53 systemic reforms designed to address the root causes of moral injury in healthcare, including but not
54 limited to decreasing administrative burdens, limiting excessive prior authorization requirements,
55 minimizing the influence of financial incentives on clinical decision-making, and preventing further

financialization of healthcare. As the scope of this resolution extends beyond the state of Maryland, MedChi requests that the American Medical Association support this resolution.

Fiscal Note: Included in the advocacy budget.

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MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 21-26

INTRODUCED BY: Prince George's County Medical Society

SUBJECT: Scope of Practice

1 Whereas, MedChi has for many years opposed legislative and regulatory measures that expand the
2 scope of practice of non-physician healthcare practitioners beyond their education and training, and
3

4 Whereas, in recent years this has included opposing efforts by naturopathic doctors to prescribe
5 medications, by psychologists to prescribe medications, by pharmacists to evaluate and treat medical
6 conditions, among others, and
7

8 Whereas, MedChi has always thoroughly and thoughtfully evaluated proposed scope of practice
9 expansions based on the details of the proposal, including the education and training of the profession
10 seeking expansion, the relationship of that profession to physicians, patient safety impacts, and other
11 factors, before taking a position, and
12

13 Whereas, a prime and recent example of this thorough evaluation is when MedChi worked for over
14 two years with the Maryland Academy of Physician Assistants on comprehensive legislation making
15 changes to their licensing statute, which provided for a measured expansion of their scope
16 commensurate with their education and training and which recognized the experience of individual
17 physician assistants, resulting in MedChi's support of legislation adopted by the General Assembly in
18 2024 and in 2026, and
19

20 Whereas, a shortage of health care providers has only intensified the push for scope expansion by many
21 health professionals, with MedChi continuing to caution that a higher quantity of providers should not
22 come at the cost of the quality of care, and that there must be continued focus on producing, recruiting
23 and retaining more physicians to address the workforce shortage, therefore be it
24

25 RESOLVED, that MedChi should continue to evaluate on a case-by-case basis proposals to expand
26 the scope of practice of other health care professionals, including consideration of the education,
27 training and experience of the profession, patient safety impacts, and such other factors that bear upon
28 the proposed scope expansion, before taking a position, and be it further
29

30 RESOLVED, that MedChi will continue to advocate for the State of Maryland to intensify and
31 expand its efforts to produce, recruit and retain more physicians to address health care workforce
32 shortages.
33

34
35 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 22-26

INTRODUCED BY: Anne Arundel County Medical Society, Howard County Medical Association, and Prince George's County Medical Society

SUBJECT: MedChi Advocacy on Tort Reform Remain a Top Priority

1 Whereas, MedChi, The Maryland State Medical Society, has for decades been the leading advocate
2 for fair tort reform and liability protections for physicians and their patients; and
3

4 Whereas, MedChi played a pivotal role in enacting and defending Maryland's expert witness
5 protections, which ensure that medical liability cases are adjudicated on sound medical standards and
6 not frivolous testimony; and
7

8 Whereas, MedChi has consistently fought to preserve Maryland's reasonable cap on non-economic
9 damages, a cornerstone of liability reform that protects patient access to care by maintaining
10 physician practice viability and stabilizing liability insurance markets; and
11

12 Whereas, in each of the past two legislative sessions, MedChi successfully led the coalition that
13 defeated efforts to repeal or weaken the non-economic damages cap, thereby protecting physicians,
14 hospitals, and patients from the destabilizing effects of unlimited liability exposure; and
15

16 Whereas, MedChi's leadership in Annapolis on tort reform has long been recognized by legislators,
17 allied organizations, and the physician community as critical to maintaining a balanced legal
18 environment for the practice of medicine in Maryland; therefore be it
19

20 Resolved, that MedChi reaffirms tort reform as one of its highest advocacy priorities; and be it
21 further
22

23 Resolved, that MedChi continue to vigorously oppose any attempts to weaken Maryland's tort
24 reform protections, including efforts to repeal the cap on non-economic damages or undermine
25 expert witness safeguards.
26

27 Fiscal Note: Included in the advocacy budget.
28
29

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 23-26

INTRODUCED BY: MedChi Public Health & Disaster Preparedness Committee

SUBJECT: Protecting Workers from Wildfire Smoke Exposure

Whereas, wildfire smoke is a significant source of fine particulate matter (PM2.5), which can penetrate deep into the lungs and enter the bloodstream, and exposure is associated with respiratory and cardiovascular illness and other adverse health outcomes; and

Whereas, wildfire smoke poses increased risks to vulnerable populations, including children, older adults, pregnant people, individuals with pre-existing health conditions, lower-income communities, and people who work outdoors; and

Whereas, wildfires are an increasingly significant source of PM2.5 air pollution in the United States, with studies projecting substantial increases in wildfire smoke-related illness and mortality as the climate warms; and

Whereas outdoor workers may experience prolonged exposure to wildfire smoke because they must remain outdoors during periods of poor air quality, and racial and ethnic minorities are disproportionately represented among outdoor workers, potentially contributing to inequities in wildfire smoke-related health outcomes; and

Whereas, farm workers and other outdoor workers may be particularly vulnerable because their occupations can require extended periods of physical activity outdoors during periods of elevated wildfire smoke; and

Whereas, simultaneous exposure to wildfire smoke and extreme heat may compound health risks, including risks of all-cause mortality and cardiovascular hospitalization; and

Whereas, Maryland has established occupational protections addressing heat stress but does not have comparable occupational standards specifically addressing exposure to wildfire smoke and PM2.5; and

Whereas, the American Lung Association recommends workplace protections, worker and employer education, improved air-quality monitoring near outdoor worksites, and continued research to reduce occupational exposure to wildfire smoke and extreme heat; therefore, be it

Resolved, that MedChi, the Maryland State Medical Society, educate physicians about the health effects of wildfire smoke, PM2.5, and concurrent exposure to wildfire smoke and extreme heat; and be it further,

Resolved, that MedChi urges the Maryland Occupational Safety and Health (MOSH) to develop appropriate standards to protect workers from hazardous exposure to wildfire smoke and associated PM2.5.

Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY |
HOUSE OF DELEGATES

Resolution 24-26

INTRODUCED BY: Wicomico County Medical Society

SUBJECT: Council of Employed Healthcare Practitioners

1 Whereas, MedChi's mission is to be the foremost advocate and resource for physicians, their patients
2 and public health.

3
4 Whereas, the fulfillment of MedChi's mission and the meeting of its goals are promoted through
5 influences on the enactment of legislation and implementation of healthcare policy, 6

7 Whereas a council of employed healthcare practitioners may legally exist,

8
9 Whereas a healthcare practitioners council that advocates solely for policies that enhance value and
10 equity in healthcare, and does not advocate for enhanced practitioner compensation or other policies
11 that only benefit practitioners, should have public support and a favorable reputation in the public
12 eye,

13
14 Whereas, existing healthcare policies have failed to address adequately many healthcare issues
15 including, but not limited to, behavioral health needs, homelessness, access to care, pharmaceutical
16 costs, health insurance costs, health literacy, information technology use, and equity in care, 17

18 Whereas, multiple powerful private and public entities decrease value in healthcare delivery while
19 enjoying extensive access to and influence over our lawmakers that often exceeds that of healthcare
20 practitioners,

21
22 Whereas, unity of practitioner voices fosters the most success in influencing health care policy at all
23 government levels,

24
25 Whereas, a council can potentially enhance the volume and depth of practitioner voices in the halls of
26 government and in public discourse, 27

28 Whereas, a council consisting of physicians and advance practice professionals would unify all
29 practitioners around common goals and inhibit other entities from exploiting the division of
30 practitioners,

31
32 BE IT RESOLVED, that MedChi, through its operational department the Center for Employed
33 Physicians, will assist in evaluating the viability and possible organizational structures and full
34 functions of a council of employed healthcare practitioners. The council mission will include, at
35 minimum, the education of practitioners on their rights as employees and the enhancement of their
36 ability to collectively influence institutional, local, statewide and national health care policy. Further,
37 the mission and goals of this Council will align with those of MedChi and will not engage in any
38 activity the sole purpose of which is to increase practitioner compensation.
39

40
41
42

Fiscal Note: Cost to staff and committee.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 25-26

INTRODUCED BY: MedChi Board of Trustees

SUBJECT: Commercial Insurer Accountability and Compliance

1 Whereas, MedChi has successfully advocated for greater protections for patients and physicians
2 regarding commercial insurers' use of utilization review policies, credentialing laws and payment
3 policies, and
4

5 Whereas, these efforts have led to Maryland having the most comprehensive protections in the fully
6 insured marketplace in the country, and
7

8 Whereas, despite these protections, commercial insurers fail to comply with the requirements,
9 placing undue burden and harm on patients and physicians, and
10

11 Whereas, the burden for reporting non-compliance often falls on the physician to report the
12 commercial insurer to the Maryland Insurance Administration through a lengthy and often confusing
13 complaint process, and therefore be it
14

15 RESOLVED, that MedChi should continue to advocate for stronger compliance and enforcement of
16 Maryland's insurance laws, including stronger penalties, a more streamlined complaint process for
17 physicians, and more routine audits of insurance practices.
18

19
20 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 26-26

INTRODUCED BY: Montgomery County Medical Society

SUBJECT: Protecting Medicaid Coverage During Implementation of Work

1 WHEREAS, changes to Medicaid eligibility and work requirements may result in eligible Maryland
2 residents losing coverage or experiencing gaps in coverage; and

3 WHEREAS, implementation of new work requirements may create significant administrative
4 burdens for Medicaid beneficiaries, providers, and community organizations; and

5 WHEREAS, loss of Medicaid coverage may increase reliance on safety-net providers, community
6 health centers, and hospital emergency departments and further strain already limited health care
7 resources; and

8 WHEREAS, disruptions in Medicaid coverage can interfere with continuity of care and access to
9 medically necessary services; therefore be it

10 RESOLVED, that MedChi support legislative and regulatory efforts to minimize Medicaid coverage
11 losses and administrative barriers associated with new work requirements, including

12 - Improving outreach and education about eligibility and exemptions

13 - Ensuring adequate staffing and resources to process applications and compliance requirements

14 - Addressing coverage gaps for individuals who are unable to meet work requirements because of
15 unemployment or other qualifying circumstances

16 - Supporting patients and community organizations that will face increased demand for assistance

17 - Assessing the impact of Medicaid losses on Montgomery Cares, safety-net providers, hospitals, and
18 other community health resources

19 - Ensuring that implementation does not create unnecessary administrative burdens or disrupt access
20 to ongoing medical care.

21

22 Fiscal note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 27-26

INTRODUCED BY: Montgomery County Medical Society
SUBJECT: Medicaid Coverage for Out-of-State Specialty Care

1 WHEREAS, Maryland Medicaid beneficiaries may experience delays in accessing specialty care due
2 to limited provider availability and appointment capacity within Maryland; and 3

4 WHEREAS, Maryland residents living near the District of Columbia, Virginia, and
5 Pennsylvania may have greater or more timely access to qualified specialty providers across state
6 lines; and
7

8 WHEREAS, current Medicaid policies may create barriers for Maryland Medicaid
9 beneficiaries seeking medically necessary specialty care from qualified providers in

10 neighboring jurisdictions; and 11
12 WHEREAS, reducing unnecessary geographic and administrative barriers to specialty care can
13 improve timely access to medically necessary services and continuity of care; therefore be it 14

15 RESOLVED, that MedChi advocate for policies that allow greater access and flexibility
16 for Maryland Medicaid recipients to access care to be accepted by qualified DC/VA/PA -based
17 specialty providers, particularly when medically necessary specialty care is unavailable or difficult to
18 access in Maryland. 19

20 RESOLVED, that MedChi advocate for the AMA to explore opportunities for interstate Medicaid
21 agreements or other mechanisms to improve specialty-care access for Maryland Medicaid patients.
22

23 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 28-26

Introduced by: Montgomery County Medical Society

Subject: Physician Dispensing

1 WHEREAS, Patient access to prescription drugs is critical to continuity and efficient care and
2 treatment; and

3
4 WHEREAS, Maryland licensed physicians are allowed to personally dispense prescription drugs if
5 they (1) have applied to the Maryland Board of Physicians (MBP); (2)
6 demonstrated to the satisfaction of MBP that the dispensing of prescription drugs or devices by the
7 physician is in the public interest; (3) have received a written permit from MBP to dispense
8 prescription drugs or devices, with the exception of starter dosages or samples without charge; and
9 (4) posts a sign conspicuously positioned and readable regarding the process for resolving incorrectly
10 filled prescriptions or includes written information regarding the process with each

11 prescription dispensed; and 12

13 WHEREAS, A physician may dispense Medicare-covered prescription or nonprescription
14 drugs where he or she is authorized by the State to dispense such drugs as part of his or
15 her physician's license; and 16

17 WHEREAS, Commercial payers have implemented policies that prevent and or
18 limit physician dispensing of drugs to their patients; and 19

20 WHEREAS, Commercial payers are limiting access to their networks and pharmacy networks in
21 particular to the detriment of a physician's ability to dispense prescriptions to their patients; and 22

23 WHEREAS It is of the highest urgency during this time of economic uncertainty and public health e
24 mergency that payers avoid policies that prevent patients from accessing needed prescription drugs
25 dispensed directly from their physician; therefore be it 26

27 Resolved, that MedChi will support state legislation that would allow for an "any willing
28 provider" policy with respect to commercial insurers pharmacy networks allowing for prescription
29 drugs dispensed by physicians.

31 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 29-26

INTRODUCED BY: Montgomery County Medical Society

SUBJECT: Pharmacist Substitution of Therapeutically Equivalent Insulin Products

1 WHEREAS, health insurers may change their preferred insulin products during a patient's course of
2 treatment, creating administrative barriers and potential interruptions in access to essential insulin
3 therapy; and
4

5 WHEREAS, patients with diabetes may face significant health risks when changes in preferred
6 insulin products result in delays or interruptions in treatment; and 7

8 WHEREAS, physicians and primary care practices spend significant time responding to insurance-
9 mandated medication changes that may not require a change in the patient's treatment plan; and
10

11 WHEREAS, pharmacists have specialized training in medication management and may be able
12 to identify therapeutically equivalent insulin products and appropriate dose conversions; therefore be
13 it
14

15 RESOLVED, that MedChi advocate for legislation, regulation, and/or payer policies permitting
16 pharmacists, within their scope of practice, to substitute a therapeutically equivalent insulin product
17 when required by a patient's insurance formulary, provided that the dose, concentration, route of
18 administration, and clinical indication remain equivalent; and be it further 19

20 RESOLVED, that such substitutions include timely notification to the prescribing physician and
21 patient and require appropriate documentation in the patient's medical record; and be it further 22

23 RESOLVED, that MedChi advocate for policies that prevent formulary-driven insulin substitutions
24 from causing unnecessary treatment interruptions, delays, or administrative burdens for patients and
25 primary care practices.
26

27
28 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 30-26

INTRODUCED BY: Montgomery County Medical Society

SUBJECT: Prior Authorization and Utilization Review — Transparency and
Enforcement

1 WHEREAS, Maryland Appeals and Grievances law is one of the most comprehensive laws in the
2 country.

3
4 WHEREAS, Maryland law requires health insurance carriers to comply with certain timeframes and
5 review processes, such as ensuring that utilization-review decisions are made by a physician with
6 relevant specialty training and clinical experience; and 7

8 WHEREAS, physicians continue to report non-compliance issues, such as peer-to-peer
9 reviews being conducted by pharmacists, nurses, or physicians without appropriate specialty
10 expertise, as well as difficulty obtaining the reviewer's credentials or ensuring the reviewer is the
11 reviewer that made the initial decision and has the authority to overturn a denial; and 12

13 WHEREAS, inconsistent enforcement of these requirements can result in unnecessary delays in
14 patient care and significant administrative burden for physicians and their staff; therefore be it 15

16 RESOLVED, that MedChi advocate for stronger enforcement of Maryland's existing prior-
17 authorization and utilization review requirements to ensure that health insurers are complying
18 with Maryland's Appeals and Grievances law and that appropriate actions and penalties are available
19 to the Maryland Insurance Administration. 20

21 RESOLVED, that MedChi advocate for a clear mechanism through which physicians can report
22 violations of these requirements to the appropriate regulatory authority.

23
24
25

Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 31-26

INTRODUCED BY: Montgomery County Medical Society

SUBJECT: Payment for Clinically Significant Asynchronous Patient Care

1 WHEREAS, Physicians increasingly provide clinically significant care through secure patient portals
2 and other electronic platforms, including reviewing medical information, making clinical decisions,
3 adjusting medications, interpreting results, and developing treatment plans; and 4

5 WHEREAS, Maryland law requires payment for covered services appropriately delivered through
6 telehealth but excludes electronic communications between patients and providers, creating a gap
7 in payment for clinically significant asynchronous care; and 8

9 WHEREAS, physicians should be appropriately compensated for medically necessary clinical
10 services regardless of whether care is delivered in person, synchronously through telehealth, or
11 asynchronously through a secure electronic platform; and 12

13 WHEREAS, payment for asynchronous care should be limited to clinically significant encounters
14 that require assessment or medical decision-making, are documented in the medical record, and are
15 not administrative or duplicative of an immediately related visit; therefore be it 16

17 RESOLVED, that MedChi advocate for Maryland legislation, regulation, and payer policies
18 requiring appropriate payment for clinically significant asynchronous care delivered through secure
19 electronic platforms; and be it further 20

21 RESOLVED, that MedChi advocate for clear standards defining payment for asynchronous care and
22 requiring consistent coverage, payment, documentation, and billing policies among commercial
23 insurers; and be it further 24

25 RESOLVED, that MedChi educate policymakers, regulators, insurers, and physicians on the value of
26 appropriately paying physicians for clinically significant asynchronous care to support timely patient
27 access and sustainable physician practice.
28

29 Fiscal Note: Included in the advocacy budget.

MEDCHI, MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 32-26

INTRODUCED BY: MedChi Medical Student Section;
 Dariush Aligholizadeh; University of Maryland School of
 Medicine

SUBJECT: Safeguarding Patient Autonomy in AI-Assisted Healthcare

1 Whereas, artificial intelligence (AI) technologies are increasingly integrated into healthcare,
2 including electronic health records, clinical decision-support systems, patient triage algorithms,
3 diagnostic tools, clinical documentation, and analysis of patient health information; and

4 Whereas, major Electronic Health Record (EHR) systems, including Epic, are rapidly integrating
5 AI tools into their software architectures; and

6 Whereas, the rapid integration of AI into healthcare creates a need for policies that preserve
7 patient-physician relationships, protect patient autonomy, and ensure technological innovations
8 remain consistent with the ethical practice of medicine;^{1,2} and

9 Whereas, patients have differing preferences on the use of AI in their healthcare,³ including
10 preferences concerning accuracy, explainability, privacy, data security, and the degree to which
11 AI should influence clinical decisions; and

12
13 Whereas, the majority of U.S. adults desire to be notified of the use of AI in their healthcare even
14 when believed to be in their best interest by their physician;^{4,5} and

15
16 Whereas, current EHR systems lack a standardized, easily accessible universal preference toggle,
17 or “opt-out” button, within patient portals (such as MyChart) or clinical interfaces to
18 systematically decline AI-driven data processing, transcription, clinical decision-support
19 systems, or predictive assessment; and

20
21 Whereas, the American Medical Association’s policy H-480.931 states that “Individuals should
22 have the right to opt-out, update, or request deletion of their data from generative AI tools;” and

23
24 Whereas, the 2025 Maryland House Bill 820, “Health Insurance – Utilization Review – Use of
25 Artificial Intelligence,” recognizes the importance of human oversight and accountability when
26 AI is used in healthcare; therefore be it

27

RESOLVED, that MedChi support the implementation of patient-facing opt-out mechanisms for AI technologies used in Maryland EHR systems; and be it further

RESOLVED, that such opt-out mechanisms should, where technically and clinically feasible, permit patients to decline the use of AI functions including, but not limited to, ambient clinical documentation, automated patient triage, AI-generated clinical summaries, AI-assisted diagnostic or treatment recommendations, and other secondary analysis of patient data for AI development or training purposes; and be it further

RESOLVED, that MedChi support the ability of patients, when clinically appropriate, to decline the use of non-essential AI systems in their clinical care without being denied access to medically necessary healthcare or experiencing a reduction in the quality or timeliness of their care; and be it further

RESOLVED, that MedChi support providing patients with clear disclosure when AI is used to meaningfully influence their clinical care, including AI-assisted triage, diagnostics, risk assessment, clinical decision support, or treatment recommendations; and be it further

RESOLVED, that MedChi communicate these principles to relevant Maryland healthcare organizations, policymakers, EHR vendors, AI developers, and other relevant stakeholders to promote patient autonomy and responsible implementation of AI in healthcare; and be it further

RESOLVED, that MedChi directs the MedChi AI Task Force to evaluate and advance policies supporting patient autonomy in AI-assisted healthcare.

Fiscal Note: Included in the advocacy budget.

REFERENCES

Alomari LM, Alshammari MM, Arbaeen AO, Alshehri RA, Almalki HS. Safety and accuracy of AI in triaging patients in the emergency department. *Int J Emerg Med*. 2025;18:243. doi:10.1186/s12245-025-01069-x.

Ploug T, Jørgensen RF, Motzfeldt HM, Ploug N, Holm S. The need for patient rights in AI-driven healthcare – risk-based regulation is not enough. *J R Soc Med*. 2025;118(8):248-252. doi:10.1177/01410768251344707.

Geoghegan S, Bernstein S, Butler A, McBrien T, Tobin-Miyaji M. *Beyond HIPAA: Reimagining How Privacy Laws Apply to Health Data to Maximize Equity in the Digital Age*. Electronic Privacy Information Center; January 2026

Platt J, Nong P, Carmona G, Kardia S. Public attitudes toward notification of use of artificial intelligence in health care. *JAMA Netw Open*. 2024;7(12):e2450102. doi:10.1001/jamanetworkopen.2024.50102

Yam E, Pasquini G, Kikuchi E. Americans want transparency when AI is used in their healthcare. *Pew Research Center*. Published August 25, 2026. <https://www.pewresearch.org/short-reads/2026/08/25/americans-want-transparency-when-ai-is-used-in-their-healthcare/>

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 33-26

INTRODUCED BY: Anne Arundel County Medical Society

SUBJECT: Safeguards for Minors Using Artificial Intelligence

1 Whereas, artificial intelligence technologies are developing rapidly and becoming increasingly
2 integrated into everyday life, including through conversational and companion AI systems capable of
3 sustained, personalized, and apparently human-like communication; and
4

5 Whereas, concerns regarding the use of AI include, but are not limited to, the potential for harmful or
6 inappropriate interactions, emotional dependency, excessive engagement, privacy harms, and
7 inaccurate, inappropriate, or potentially harmful health advice; and
8

9 Whereas children and adolescents may be particularly vulnerable to these potential harms due to their
10 developmental stage and increasing interaction with AI systems; and
11

12 Whereas, emerging technologies warrant proactive evaluation of potential health and
13 safety risks so that appropriate safeguards may be considered before harms become widespread; and
14

15 Whereas, the use of artificial intelligence for diagnostic or treatment purposes raises patient-safety
16 concerns when individuals without medical training may rely on AI-generated information without
17 the ability to fully assess its accuracy, limitations, or applicability, underscoring the importance of
18 appropriate professional medical judgment; therefore be it
19

20 Resolved, that MedChi, The Maryland State Medical Society, support policies and legislation
21 establishing appropriate safeguards to protect minors from potential harm associated with the use of
22 AI generally and AI companion systems in particular; and be it further
23

24 Resolved, that MedChi ask the American Medical Association to adopt policy supporting appropriate
25 safeguards to protect minors from potential harms associated with the use of AI generally and AI
26 companion systems in particular.
27

28
29 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 34-26

INTRODUCED BY: Baltimore County Medical Association

SUBJECT: Advancing Research and Education Regarding Cannabis and Cannabinoid
Therapy

1 WHEREAS, the use of cannabis and cannabinoid-based therapies for medical purposes has expanded
2 significantly in Maryland and across the United States, resulting in increasing numbers of patients
3 seeking information and clinical guidance from physicians regarding the potential benefits, risks,
4 limitations, interactions, and appropriate use of these therapies; and
5

6 WHEREAS, physicians increasingly encounter patients who are currently using, considering using, or
7 seeking advice regarding cannabis and cannabinoid-based therapies, regardless of whether individual
8 physicians recommend or participate in medical cannabis programs; and
9

10 WHEREAS, the U.S. Department of Justice's 2025 action rescheduling cannabis from Schedule I to
11 Schedule III reflects a federal acknowledgment of its accepted medical use under appropriate medical
12 supervision, and is a federal scheduling determination only — it does not legalize cannabis for general
13 use and does not alter the legal status of state medical cannabis programs; and
14

15 WHEREAS, the Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) has
16 launched the Substance Access Behavioral and Emotional Improvement (BEI) pilot, delivering
17 standardized, physician-supervised, non-intoxicating cannabinoid therapies to Medicare beneficiaries,
18 demonstrating that federally authorized healthcare programs are already capable of incorporating this
19 model of care; and
20

21 WHEREAS, the AMA's most recently adopted cannabis policy supports the development of clinician
22 education and encourages expanded research into the therapeutic use of cannabis in older adults,
23 particularly for managing agitation associated with cognitive impairment, showing that AMA policy
24 has already begun to evolve in this direction; and
25

26 WHEREAS, research directly responsive to that call is already underway, including a 2026
27 randomized, controlled clinical trial demonstrating reduced agitation in dementia patients from a
28 standardized cannabinoid combination, and ongoing research into cannabinoid therapies for older-
29 adult populations, illustrating that the evidence base the AMA has called for is actively being built;
30 and
31

32 WHEREAS, the evolving scientific and clinical literature regarding the endocannabinoid system,
33 cannabinoid pharmacology, dosing, routes of administration, therapeutic applications, adverse effects,
34 drug interactions, and contraindications creates an ongoing need for objective, evidence-based
35 physician education, separate and apart from any position on legalization or the broader hemp-versus-
36 marijuana debate, and separate and apart from existing AMA policy addressing adult-use legalization
37 or hemp-derived intoxicating products; and
38

WHEREAS, the University of Maryland School of Pharmacy operates the nation's first Master of Science program in Medical Cannabis Science and Therapeutics, giving Maryland an existing academic foundation on which to build expanded physician education in this area; and

WHEREAS, physician education curricula already in development, including modules addressing cannabinoid pharmacokinetics and pharmacodynamics, patient titration, safe dosing, drug contraindications and interactions, and the use of cannabinoid-based therapies in special populations such as geriatric patients, demonstrate that the evidence-based education called for above is achievable and already underway; and

WHEREAS, the National Compassionate Care Council (NCCC) is a healthcare-aligned nonprofit organization that brings together physicians, clinical researchers, continuing medical education providers, and patient advocates to advance evidence-based standards of care, standardized dosing, provider education, and real-world evidence supporting the responsible integration of cannabinoid therapies into mainstream healthcare; and

WHEREAS, NCCC works in strategic partnership with the Society of Cannabis Clinicians (SCC) to support clinical expertise, provider outreach, and educational development, and SCC educational resources are currently recommended to Maryland physicians through MedChi's Medical Cannabis Education Central resource; and

WHEREAS, this existing educational and clinical connection, together with NCCC's Medical Advisory Board and Continuing Medical Education Working Group, provides a strong foundation for collaboration with MedChi to advance physician education and evidence-based clinical guidance regarding cannabinoid therapies; NCCC's Chief Medical Advisor and members of the Continuing Medical Education Working Group are also alumni of the University of Maryland School of Pharmacy's Master of Science program in Medical Cannabis Science and Therapeutics, further connecting NCCC's clinical leadership to Maryland's existing academic foundation in this field; and

WHEREAS, gaps in physician education and clinical guidance make it more difficult for physicians to counsel patients effectively regarding the potential benefits and risks of these therapies and to incorporate such discussions into the broader context of a patient's medical care; and

WHEREAS, existing AMA policy already supports federal immunity protections for physicians who recommend the use of cannabis in accordance with state law, reflecting the AMA's recognition that physician conduct in this area warrants specific, protective policy attention; and

WHEREAS, the AMA's own cannabis and cannabinoid research policy already calls for further adequate and well-controlled clinical studies and urges review of cannabis's federal scheduling status to facilitate that research, while expressly clarifying that such research should not be viewed as an endorsement of state-based medical cannabis programs or of legalization, confirming that the research and education requested in this resolution is squarely within the AMA's own stated approach; and

WHEREAS, MedChi has an important role in identifying emerging issues affecting physicians and patients and in bringing those issues before the AMA House of Delegates; and

WHEREAS, MedChi and the AMA have an important role in developing national physician policy, advocating for appropriate research, and providing evidence-based guidance in emerging areas of medical practice, and existing AMA policy concerning cannabis, having developed over many years amid rapidly changing state laws, federal policy, and scientific research, is appropriate for periodic review and modernization; therefore, be it

RESOLVED, that MedChi support the development and expansion of continuing medical education regarding the endocannabinoid system, medical cannabis, cannabinoids, and cannabinoid-based therapeutics; and be it further

RESOLVED, that MedChi support high-quality clinical and scientific research regarding cannabis, cannabinoids, and cannabinoid-based therapeutics, including research conducted by programs such as the CMS Substance Access BEI pilot; and be it further

RESOLVED, that MedChi support the efforts of interested stakeholders in advancing evidence-based physician education and clinical guidance regarding cannabinoid therapies in Maryland; and be it further

RESOLVED, that our AMA update its policy concerning cannabis and cannabinoid-based therapies to reflect current scientific evidence and contemporary medical practice; and be it further

RESOLVED, that our AMA support policies that advance evidence-based physician education, clinical guidance, and research regarding medical cannabis and cannabinoid-based therapeutics.

Fiscal Note: This resolution directs advocacy and educational support activity and does not require the expenditure of MedChi funds already budgeted.

REFERENCES

1. U.S. Department of Justice, Drug Enforcement Administration, Final Rule rescheduling marijuana to Schedule III (2025). [Cite exact Federal Register citation before submission.]
2. Centers for Medicare & Medicaid Services Innovation Center, Substance Access Behavioral and Emotional Improvement (BEI) Model program materials. [Cite exact CMS program page/document before submission.]
3. 2026 randomized, double-blind, placebo-controlled crossover trial on THC/CBD combination therapy and agitation in hospice-eligible dementia patients ("LIBBY" trial), and related research into cannabinoid therapies in older-adult populations. [Full journal/study citations to be confirmed with NCCC Research and Data Collection Working Group before submission.]
4. University of Maryland School of Pharmacy, Master of Science in Medical Cannabis Science and Therapeutics program materials.
5. Physician continuing medical education curriculum materials addressing cannabinoid pharmacokinetics and pharmacodynamics, patient titration, safe dosing, drug interactions, and use in geriatric and other special populations. [Cite specific current program/provider before submission.]

RELEVANT AMA POLICY

H-95.893, Cannabis Use in Older Adults: Our AMA supports the development and publication of educational resources on cannabis directed towards clinicians, and encourages expanded research into the therapeutic uses of cannabis in older adults, such as for managing agitation in individuals with cognitive impairment. [Res. 512, A-26]

H-95.952, Cannabis and Cannabinoid Research: Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients with serious conditions for which evidence suggests possible efficacy, and urges that marijuana's federal scheduling status be reviewed to facilitate clinical research — expressly noting this should not be viewed as an endorsement of state-based medical cannabis programs or legalization. [CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed: Res. 212, A-23; Modified: Speakers Rep. 02, I-24; BOT Action in response to referred for decision: Res. 503, A-24]

D-95.969, Cannabis Legalization for Medicinal Use: Our AMA opposes legalizing the medicinal use of cannabis through the state legislative, ballot initiative, or referendum process, and supports federal immunity protections for physicians who recommend the use of cannabis in accordance with state law. [CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19; Reaffirmed: Res. 212, A-23; BOT Action in response to referred for decision: Res. 503, A-24]

H-95.924, Cannabis Legalization for Adult Use: Cited for context only; this resolution's requests are limited to physician education, clinical research, and federally authorized programs, and should be affirmatively distinguished from the "Derived Psychoactive Cannabis Products" and "Hemp-Derived Intoxicating Cannabinoids" this policy addresses. [CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20; Reaffirmed: Res. 212, A-23; Modified: Speakers Rep. 02, I-24; BOT Action in response to referred for decision: Res. 503, A-24]

H-120.922, Improved Access and Coverage to Non-Opioid Modalities to Address Pain: Our AMA advocates for increased access to and coverage of non-opioid pain treatment modalities, of which a CMS-covered, physician-supervised cannabinoid therapy is a concrete

example. [Not confirmed against NCCC's master AMA cannabis-policy compilation — this policy addresses pain modalities generally rather than cannabis specifically, so verify current PolicyFinder language and standing directly before citing.]

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 35-26

INTRODUCED BY: Baltimore County Medical Association

SUBJECT: Public Health Education about Iron Deficiency in Pregnancy

1 Whereas, over 30% of women have iron deficiency; and

2
3 Whereas, this condition is more prevalent among poor women and women of color; and

4
5 Whereas, iron deficiency is relatively straightforward to diagnosis; and

6
7 Whereas, iron deficiency puts pregnant women at risk of “higher rates of preeclampsia, placenta previa,
8 and cesarean delivery”ⁱⁱ; and

9
10 Whereas, iron deficiency leads to adverse outcomes for the baby including “low birthweight,
11 prematurity, or intrauterine growth restriction”²; and

12
13 Whereas, iron deficiency put leads to a “greater risk of autism in the offspring, and “low iron intake
14 during the second trimester increases the risk of schizophrenia”³; and

15
16 Whereas, the oral replacement of iron is well tolerated and effective when taken every other day; and

17
18 Whereas, the cost of oral replacement is about \$10/year; and

19
20 Whereas, some women will require iron infusions; and

21
22 Whereas, this is well documented in the medical literatureⁱⁱ; therefore be it

23
24 Resolved, MedChi urges Maryland physicians, other clinicians, and the general public to recognize
25 and address the substantial prevalence of iron deficiency in women, especially pregnant ones, the
26 impact on them and their offspring, and the safe and affordable ways to diagnose and treat this; and be
27 it further

28
29 Resolved, MedChi work with the Governor, the General Assembly, County leaders, and health
30 departments to take such actions as would support the above.

31
32
33 Fiscal Note: *Included in the advocacy budget.*

References:

¹ Journal of Gynecology & Obstetrics: Volume 162, Issue S2, August 2023 Special Issue: Our Path from AUB to Iron Deficiency to Impaired Fetal Development: A Long and Winding Road
<https://obgyn.onlinelibrary.wiley.com/toc/18793479/2023/162/S2>

² Journal of the American Medical Association Iron Deficiency in Adults A Review Michael Auerbach, MD1,2; et al; MD4 JAMA. March 30, 2025. doi:10.1001/jama.2025.0452
<https://jamanetwork.com/journals/jama/fullarticle/283213>

³ Iron Deficiency in Pregnancy: Am J Obstet Gynecology, 2020 Oct;223(4):516-524
doi: 10.1016/j.ajog.2020.03.006. Epub 2020 Mar14 [https://www.ajog.org/article/S0002-9378\(20\)30328-8/fulltext](https://www.ajog.org/article/S0002-9378(20)30328-8/fulltext)

ⁱ American Society of Hematology summit released a statement about iron deficiency (ID) and the need for the healthcare system and providers to address this. <https://www.hematology.org/iron-deficiency-initiative>

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 36-26

INTRODUCED BY: Baltimore County Medical Association

SUBJECT: Empowering Patients with Clear, Accurate, and Actionable Costs &
Prior Authorization Requirements

1 Whereas, patients and providers face administrative confusion, leading to unpredictable out-of-
2 pocket costs and delayed medical care due to hidden prior authorization rules; and
3

4 Whereas, healthcare remains one of the few industries where consumers are expected to agree to a
5 service before knowing its true cost and estimation tools only provide vague, inaccurate averages;
6 and
7

8 Whereas, while technology exists to provide pricing and prior authorization requirements for
9 individual codes insurer deployment is inconsistent and arbitrary; and
10

11 Whereas, some Maryland's private health insurance companies have started to implement solutions
12 by developing their own applications, while others use clearinghouses, lack of requirements forces
13 medical office staff to learn dozens of completely different workflows with inconsistent information;
14 and
15

16 Whereas, CMS has already required impacted insurers (Medicare Advantage, Medicaid, and ACA
17 Marketplace plans) to have a fully implemented an online, self-service system tracking real-time
18 accumulated deductible and out-of-pocket costs and instantly calculated real-time accumulated
19 deductible on all covered services, procedures, and prescription drugs; and
20

21 Whereas, the CMS Interoperability & Prior Authorization Rule is being implemented with an
22 upcoming January 1, 2027 deadline that requires impacted insurers to provide standardized
23 Application Programming Interfaces that connect prior authorization data directly to patient
24 accessible mobile apps and electronic health records for instant, real-time calculations;
25

26 Whereas, the American Medical Association has outlined ways how transparency can empower
27 patients by helping them make informed care decisions and prior authorization transparency is an
28 essential protection for patients, a tool for holding payers accountable and a prerequisite for fair
29 evaluating prior authorization use^{i ii iii}; and
30

31 Whereas, a patient's insurance card can provide immediate clarity, not all insurers print co-pay and
32 co-insurance amounts, which leaves patients unaware of what they owe upfront leading to confusion
33 and check-in delays to investigate the patient's specific plan;
34

35 Whereas, having real-time data will eliminate care delays, reduce confusion and staff burnout, avoid
36 surprise costs, reduce red tape, and make health insurers comply with normal consumer standards by
37 knowing the exact cost before a scheduled service; therefore, be it
38

Resolved, MedChi work legislatively to require all Maryland health insurance companies to list online all physician services that require prior authorization and provide online access to real-time patient out-of-pocket costs; be it further

Resolved, MedChi work legislatively to require all Maryland health insurance companies to print copay and co-insurance amounts on all subscriber's health insurance cards.

Fiscal Note: Included in the advocacy budget.

References:

i. How transparency can empower patients: 8 ways to increase transparency. AMA Sept. 20, 2018.<https://www.ama-assn.org/health-care-advocacy/advocating-public-health/8-ways-improve-health-care-price-transparency>

ii. Medicare Advantage prior auth rule a good start, but needs refining. AMA Jun 30, 2026 <https://www.ama-assn.org/practice-management/prior-authorization/medicare-advantage-prior-auth-rule-good-start-needs>

iii. AMA Policy Price Transparency D-155.987 Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 37-26

INTRODUCED BY: Baltimore County Medical Association and the
Maryland Academy of Family Physicians

SUBJECT: Commercial Insurance Payer Transparency

1 Whereas, Maryland physicians are among the lowest compensated in the United States despite
2 practicing in a highly regulated, high-cost healthcare environment; and
3

4 Whereas, this is not because care is less complex or less valuable, but it is largely due to structural
5 market dynamics; and
6

7 Whereas, Maryland's All-Payer Model successfully stabilizes hospital reimbursement, but it does not
8 extend similar protections to physician services; and
9

10 Whereas, at the same time, Maryland has one of the most concentrated insurance markets in the
11 country, creating inequality of bargaining power and sustained financial pressure on physicians; and
12

13 Whereas, Maryland Health Care Commission reports Maryland's private payers pay physicians 40%
14 less on average than states nationallyⁱ, which makes it difficult to recruit physicians; and
15

16 Whereas, physician value-based incentive programs like the Maryland Primary Care Program and
17 Episode Quality Improvement Program developed by MedChi and the State of Maryland have been a
18 lifeline to physicians and publication of the Primary Care Investment Report have indicated a shift in
19 policy, still Medicare payments continue to fall with private payers following; and
20

21 Whereas, this is not simply a compensation concern, it is a structural market imbalance with direct
22 implications for workforce stability, recruitment and retention, patient access, system sustainability,
23 and long-term cost control; and
24

25 Whereas, physicians lack funds to employ departments with contract analysts, data teams, and
26 dedicated negotiators with deep payer expertise to rebalance bargaining power with private payers; and
27

28 Whereas, data does exist that could help with balance structural market dynamics, like the Maryland
29 Medical Care Database (MCDB) retrospective claims information and the federal Transparency in
30 Coverage (TiC) Machine-Readable Files (MRFs) repository database with prospective negotiated
31 private insurance payer rates, but they are opaque, massive, and difficult to navigateⁱⁱ; be it therefore
32

33 Resolved, that MedChi work legislatively to require the Maryland Health Care Commission to analyze,
34 compare, and publish Maryland's private commercial payers rate data annually.

35
36 Fiscal Note: Included in the advocacy budget.

ⁱ Payments for Professional Services in Maryland (in-Network services only) 2023. Maryland Health Care Commission https://mhcc.maryland.gov/sites/default/files/reports/2023_psr_rpt.pdf

ⁱⁱ Considerations for federal agencies tasked with improving health plan price transparency data. 2025. Center on Health Insurance Reforms. Georgetown University. McCourt School for Public Policy.
<https://chir.georgetown.edu/considerations-for-federal-agencies-tasked-with-improving-health-plan-price-transparency-data/>

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 38-26

INTRODUCED BY: Baltimore City Medical Society, submitted by Dr. Ben Lowentritt

SUBJECT: Protecting Physician Clinical Autonomy and the Prohibition
Against the Corporate Practice of Medicine

1 Whereas, the common law of Maryland has long recognized the prohibition against the corporate
2 practice of medicine, protecting physicians from unlawful interference in their clinical decision-
3 making; and
4

5 Whereas, decisions at the core of clinical decision-making—such as the need for referrals to or
6 consultation with other licensees, the selection of diagnostic tests appropriate for a particular
7 condition, the number of patients a physician sees in a given period or the hours a physician works,
8 and the formulation of a patient’s care plans and treatment options—should remain within the
9 exclusive professional control of licensed physicians; and
10

11 Whereas, certain clinical operations within a medical practice—including the setting of clinical
12 standards or policies, determining the clinical content of medical records, hiring or firing licensees
13 based in whole or in part on clinical competency or proficiency, setting the parameters under which
14 physicians or health care entities enter into contractual relationships with third-party payers, setting
15 the clinical competency or proficiency parameters under which licensees enter into contractual
16 relationships with other licensees, making diagnostic coding decisions for patient care services, and
17 approving the selection of medical equipment and supplies—bear directly on clinical decision-
18 making and should not be controlled by non-licensed persons; and
19

20 Whereas, the corporate practice of medicine occurs when a non-licensed person or entity interferes
21 with clinical decision-making through policy, discipline, punishment, threats, adverse employment
22 actions, coercion, retaliation, or similar pressure; and
23

24 Whereas, physicians must increasingly collaborate with other licensed health professionals and non-
25 licensed individuals and entities to maintain access to care delivery across care settings; and
26

27 Whereas, the corporate practice of medicine can arise in any care setting and through any
28 arrangement in which physicians and non-licensed persons work collaboratively; and
29

30 Whereas, Maryland’s prohibition against the corporate practice of medicine should be codified in
31 statute to better protect patients and preserve physicians’ clinical autonomy; and
32

33 Whereas, responsible prohibitions against the corporate practice of medicine need not inhibit
34 innovative practice models or arrangements that support and expand patient access to care; therefore,
35 be it
36

37 Resolved, that MedChi supports corporate practice of medicine protections for physicians across all
38 care settings that prohibit non-licensed individuals and entities from interfering with physicians'
39 professional judgment and from controlling clinical decision-making; and be it further
40

41 Resolved, that MedChi supports legislation codifying Maryland's existing prohibition against the
42 corporate practice of medicine in order to preserve physician control over clinical decision-making
43 and to encourage physician leadership and engagement in practice management.
44

45
46 Fiscal Note: Included in the advocacy budget.

MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY
HOUSE OF DELEGATES

Resolution 39-26

INTRODUCED BY: MedChi Board of Trustees

SUBJECT: Enhancing Legislative Priorities and Bill Review Procedures

1 WHEREAS, the Maryland General Assembly now considers approximately 2,500 bills each
2 legislative session, making it essential for MedChi to strategically focus its political capital on the
3 legislative issues of greatest importance to Maryland physicians and patients; and
4

5 WHEREAS, resolutions adopted by the House of Delegates constitute official MedChi policy and
6 represent the highest expression of the organization's priorities; and
7

8 WHEREAS, the annual Council on Legislation Report reflects MedChi policy and could be
9 strengthened by identifying a limited number of overarching legislative priority categories that
10 represent the issues of highest importance for MedChi to advocate for during the upcoming
11 legislative session; and
12

13 WHEREAS, the establishment of targeted legislative priorities by the House of Delegates would
14 provide additional guidance to MedChi's advocacy team in identifying, monitoring, and pursuing
15 legislation that advances adopted policy and objectives as set for by the House of Delegates; and
16

17 WHEREAS, the Council on Legislation and its Boards and Commissions Subcommittee, Health
18 Insurance Subcommittee, and Public Health Subcommittee play a critical role in evaluating
19 legislation and taking positions, or declining to take a position, on important legislation before the
20 Maryland General Assembly based on MedChi policy; and
21

22 WHEREAS, additional processes and resources can further build on this established foundation and
23 support the Council on Legislation and its subcommittees in aligning advocacy activities with House
24 of Delegates policy and MedChi's targeted strategic legislative priorities; and
25

26 WHEREAS, an enhanced review process for requests to extract bills from the FYI Calendar or add
27 bills for consideration would assist in focusing MedChi's advocacy resources and political capital on
28 issues of greatest importance to the organization and its members along with promoting consistency,
29 efficiency, and transparency; and now, therefore, be it
30

31 RESOLVED, that the annual Fall Council on Legislation Report shall include a limited number of
32 overarching legislative priority categories reflecting the issues of highest importance for MedChi to
33 advocate for during the upcoming legislative session; and be it further
34

35 RESOLVED, that the annual Fall Council on Legislation Report shall state that resolutions adopted
36 by the Fall House of Delegates are incorporated into MedChi's legislative agenda and constitute part
37 of MedChi's legislative priorities for the upcoming legislative session; and be it further
38

39 RESOLVED, that an Executive Legislative Committee be established under the Council on
40 Legislation consisting of: (1) the President; (2) the Immediate Past President; (3) the President-Elect;
41 (4) the Co-Chairs of the Council on Legislation; and (5) the Chairs of each Council on Legislation
42 Subcommittee; and be it further
43

44 RESOLVED, that the Executive Legislative Committee shall review requests to extract bills from the
45 FYI Calendar and requests to add bills for consideration during the legislative session to determine
46 whether such bills warrant referral to a Council on Legislation subcommittee for review and
47 recommendation; and be it further
48

49 RESOLVED, that any member seeking to extract a bill from the FYI Calendar or add a bill for
50 consideration shall submit a written request to staff no later than twenty-four (24) hours prior to the
51 applicable Council on Legislation meeting explaining: (1) the reasoning behind why the bill should
52 be considered by a subcommittee and (2) how a potential MedChi position on the bill would advance
53 MedChi policy and priorities or how a MedChi non-position on the bill would be inconsistent with
54 MedChi's policy and priorities; and be it further
55

56 RESOLVED, that the requesting member may present the extraction or bill addition request during
57 the Council on Legislation meeting; and be it further
58

59 RESOLVED, that immediately following a Council on Legislation meeting where a extraction or bill
60 addition is requested that the Executive Legislative Committee meet to determine whether the bill
61 should be referred to a subcommittee for further review; and be it further
62

63 RESOLVED, that bills approved by the Executive Legislative Committee shall be referred to the
64 appropriate Council on Legislation subcommittee for consideration through the normal legislative
65 review process; and be it further
66

67 RESOLVED, that if the Executive Legislative Committee determines that a bill should be considered
68 and the applicable testimony deadline occurs before the relevant subcommittee can meet, the
69 Executive Legislative Committee shall have authority to establish MedChi's position on that bill; and
70 be it further
71

72 RESOLVED, that the existing requirement that a member requesting extraction or addition of a bill
73 attend the applicable subcommittee meeting shall remain in effect; and be it further
74

75 RESOLVED, that MedChi's lobbyists, in consultation with the Council on Legislation leadership,
76 shall continue to periodically review and update the orientation materials and scripts used by Council

77 on Legislation Chairs to promote consistent application of Council procedures and efficient conduct
78 of Council business.

79

80

81 Fiscal Note: Included in the advocacy budget.