Health Law Developments

The Newsletter of the Health Law Section
State Bar of Georgia
Fall 2025

From the Chair

Wade Pearson Miller

Thank you to all who attended the Advanced Health Law Seminar on October 8, 2025. It was a wonderful day of learning from industry experts on important topics impacting the healthcare industry.

Thank you again to our sponsors:

Bronze: Aligned Health Law
Gold: Alston & Bird, Arnall Golden Gregory, Baker Hostetler, Chilivis Grubman and Parker Hudson

A special thank you to our Platinum sponsor PYA Health Advisors for hosting our networking cocktail reception.

In this issue with have six excellent articles covering timely topics. Thank you to all the authors who contributed to this newsletter. And a special thank you to our newsletter editors Dawn Benson, Kara Silverman, Jennifer Whitton, and Felicia LeRay.

Save-the-Date

Please Save the Date for our upcoming Lunch and Learn discussing the State of AI in Healthcare: A Review of the Current Landscape and What to Expect in 2026.

When : Tuesday, December 2, 2025
from 11:45 – 1:15 pm (CLE from 12 – 1 pm)

Where : Holland & Knight LLP Office
1180 West Peachtree Street, NW
Suite 1800
Atlanta, GA 30309

There is no cost to attend, and participants will receive 1 hour of general CLE credit. Complimentary lunch and parking validation will be provided.

Inside This Issue

Advanced Health Law Seminar

Legal Considerations and Best Practices for AI Scribes in Georgia

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Imagine you're at your annual check-up, ready to discuss your lab results, medications, and overall health. Your provider enters the room with someone else and explains this person is there to take notes during your visit and asks if you're comfortable with that. Would you agree?

This example illustrates the services an AI Scribe would provide. Instead of a person, an AI Scribe is artificial intelligence ("AI") technology that listens to your conversation with your provider and creates a clinical note in real time. The goal is to reduce the time providers spend on paperwork and improve the quality of patient care.[1]

Like any healthcare technology, AI Scribe products come with legal risks. This article provides an overview of some potential risks from a Georgia perspective and offers some best practices for consideration.

Legal Considerations:

HIPAA:

An AI Scribe needs access to individual protected health information ("PHI") to function. Under HIPAA, providers can disclose PHI to other healthcare providers for treatment or to business associates assisting the providers' treatment, payment, or healthcare operations.[2] Using a third-party AI Scribe may seem to fall under "treatment", but a HIPAA business associate agreement ("BAA") is needed with a third party AI vendor.

Georgia Constitutional Right to Privacy:

Georgia courts have held the Georgia Constitution recognizes individuals' right to privacy in their personal medical records.[3]

Georgia Medical Information Confidentiality Statute: Georgia law provides protections for medical information. Generally, physicians and health care providers should not release a patient's medical information unless certain exceptions apply or with the patient's consent.[4]

Sensitive Health Information in Georgia:

There are additional protections in place for sensitive health information, such as HIV, AIDS, mental health, substance use, or genetic information and for certain records under federal law (e.g., 42 CFR Part 2 for substance use disorder records).

Georgia's Mental Health Privileges:
Georgia excludes certain confidential communications from evidence, such as between a patient and a licensed psychiatrist, psychologist, clinical social worker, clinical nurse specialist in psychiatric/mental health, professional counselor, and marriage and family therapist.[5] Is an AI Scribe a "third party" to those communications, which might affect privilege, or is it a vendor bound by a signed HIPAA BAA?

Recording Law and Wiretapping:

In Georgia, it is illegal to record audio or intercept private communications without consent from a party to the conversation, especially in places where there is a reasonable expectation of privacy, such as a medical exam room, unless one of the parties to the conversation provides consent to record.[6] Since Georgia is a "one-party consent" state, the provider can technically consent to the recording using an AI Scribe without the patient's permission.[7] However, relying solely on the provider's consent may create additional reputational and legal risks.

Ethical Considerations:

Ethical position statements have been issued regarding use of AI in clinical settings. For example, the Federation of State Medical Boards recommends providing transparency about AI use, ensuring informed consent before using AI in patient care, and reviewing records for potential inaccuracies and algorithmic bias.[8]

1 Note: This article does not consider AI that assists in clinical decision-making and other potentially "higher-risk" AI activities.

2 See 45 C.F.R. §§164.502; 164.504; 164.506.

3 King v. State, 272 Ga. 788, 535 S.E.2d 492 (2000).

4 O.C.G.A. §24-12-1.

5 O.C.G.A. §24-5-501.

6 O.C.G.A. §16-11-62.

7 O.C.G.A. §16-11-66.

8 See Fed. of State Med. Boards, Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice (April 2024), https://www.fsmb.org/

Best Practices:

1. Authorization / Consent:
    - Obtain patient consent and ideally HIPAA authorization that specifically permits the AI Scribe software vendor to receive the patient's PHI and, if applicable to use the patient's PHI to train the AI.
    - A HIPAA authorization should comply with HIPAA, Georgia law, and applicable federal law.
    - Ensure the authorization is clear, written in plain language, and signed and dated by the patient or their authorized representative.
    - The authorization should expressly permit use and disclosure of health information to the AI Scribe, including health information protected under state law (such as HIV, AIDS, mental health, substance use, confidential communications, and genetic information).
    - At the beginning of the visit, discuss the AI Scribe with third parties present with the patient (e.g., family members and caregivers); obtain their consent if they plan to share their own PHI (medical history) as part of the patient's visit.
2. HIPAA BAA:
    - Ensure the HIPAA covered health care provider signs a HIPAA-compliant BAA with the AI Scribe software vendor.
    - A BAA lists the vendor's HIPAA assurances and outlines how the vendor may use and disclose the PHI to assist the covered entity, but it does not replace the individual written permission required by some state or federal laws for sensitive health information.
    - A signed BAA still would not allow the AI Scribe software vendor to use or disclose PHI for its own purposes, such as the vendor's own marketing.
3. HIPAA Notice of Privacy Practices:
    - Update the covered entity's Notice of Privacy Practices to inform patients that their PHI may be disclosed to AI software providers and for what purposes.
4. Manual Control of AI Scribe:
    - The AI Scribe should not start automatically, or before the provider arrives.
    - Notify everyone in the room before the AI Scribe begins recording. If the patient does not agree to the use of the AI Scribe, then the provider should document the visit by traditional means.
5. Review AI Draft Records:
    - Providers should carefully review and, if necessary, correct the draft records created by an AI Scribe to confirm accuracy and prevent incomplete records. In particular, watch for potential scribing issues that may arise due to rapid speech, speech variations, accents/dialects, slurring/speech impairments, non-native English speakers, individuals interrupting each other, and potential algorithmic bias.
    - Watch for potential AI insertion of erroneous data (i.e., AI "hallucinations"), particularly during pauses or when background noise is present.
    - Ensure the precise details of the assessment, diagnosis, tests, and prescriptions (i.e., drug names, routes, timing, and dosages) are correctly documented.

siteassets/advocacy/policies/incorporation-of-ai-into-practice.pdf ("The physician is ultimately responsible for the use of AI").

Georgia's Big Beautiful Reckoning: Medicaid, Rural Health, and the Legal Landscape Ahead

Sean Sullivan, Partner, Alston & Bird LLP
Grace Nelmes, Associate, Alston & Bird LLP

With the passage of H.R.1, the "One Big Beautiful Bill Act" (OBBBA), in July, significant changes are coming to the nation's health care landscape. This article examines the potential impact on Georgia's hospitals and health care providers.

Overview

OBBBA's most notable features include steep cuts to federal health care spending. The Congressional Budget Office (CBO) estimates federal Medicaid spending will decrease by $911 billion over the next decade. In Georgia, federal funding comprises 71% of the total Medicaid spend, supporting 2,240,000 children and adults as of May 2025. According to KFF's most recent analysis, Georgia could lose $6-$10 billion in federal funding over the next 10 years. In addition, the uninsured population is projected to increase by roughly 150,000 (about 1%), with 32,000 losing coverage due to Medicaid changes, 120,000 due to changes in the Affordable Care Act (ACA), and 7,500 due to Medicare and policy interactions, according to KFF's calculations.

There are two main provisions in OBBBA that will potentially strain the state's budget: (1) freezing state provider taxes at current rates and preventing states from establishing new provider taxes (Sec. 71115) and (2) capping new directed payment programs in non-expansion states at 110% of the Medicare rate (Sec. 71106). These cuts could force Georgia to raise additional revenue and/or find other funding sources to bridge the gap. The state will likely pursue Medicaid cuts by restricting eligibility for optional populations and/or increasing cost-sharing for enrollees.

The impacts on Georgia will be both significant and distinct.

Georgia's Unique Position

Georgia is one of ten states that have not expanded Medicaid and the only state requiring those not eligible for traditional Medicaid to prove they are working or completing 80 hours per month of other qualifying activities, such as school or volunteering (Georgia Pathways to Coverage). Under the current Georgia Pathways program, enrollees must document eligibility monthly but OBBBA requires eligibility determinations every six months starting December 31, 2026 (Sec. 71107), meaning Georgia would need a waiver to maintain its current system. As of July 21, 2025, 8,633 Georgia adults are enrolled in Pathways.

There are several places in OBBBA that differentiate between expansion and non-expansion states. In Sec. 71115, OBBBA dictates that for Medicaid expansion states, the 6% of net patient revenue safe harbor threshold for existing provider taxes will be gradually reduced to 3.5%. But for non-Medicaid expansion states, like Georgia, the safe harbor threshold for existing provider taxes will stay at 6% of net patient revenues and will not be subject to a gradual phased reduction. Sec. 71106 imposes caps on new state directed payments (SDPs) that have not yet been submitted or approved as of the date of enactment of OBBBA (July 4, 2025). For Medicaid expansion states, the total payment rate for new SDPs is capped at 100% of the Medicare fee schedule, whereas for non-Medicaid expansion states, the cap on new SDPs is 110% of the Medicare fee schedule. Accordingly, Georgia will have more flexibility to administer its Medicaid program (with potentially higher provider taxes and a higher limit for SDPs) than those states (and Washington DC) that have expanded Medicaid pursuant to the ACA.

Addressing Fraud, Waste, and Abuse

Georgia's current eligibility requirements combined with OBBBA's new mandates for expansion states, aim to reduce fraud, waste, and abuse in Medicaid while ensuring resources are available to those who need them most. OBBBA addresses these issues by requiring each state to regularly update beneficiary and provider records, remove deceased individuals, and prevent duplicate enrollments across state programs.

Impact on Rural Hospitals

OBBBA's cuts to Medicaid and federal health care spending are expected to hit rural hospitals particularly hard. Nearly 39% of Georgia hospitals are in rural areas and serve 19% of the state's population. Federal Medicaid spending is projected to decline in rural Georgia by about $1.74 billion over the next 10 years. Though significant, this loss is smaller than the $10 billion projected for states that both expanded Medicaid and have high rural populations. Georgia's lack of

Medicaid expansion makes this change less dramatic.

To mitigate the impact of Medicaid cuts on rural providers, OBBBA establishes a $50 billion "Rural Health Transformation Program," (Sec. 71401). The Centers for Medicare & Medicaid Services (CMS) will distribute half of these funds equally among states with approved applications. The remaining funds will be allocated based on criteria such as rural population, the number of rural health facilities, and the needs of hospitals serving large, rural populations.

Anticipation and Uncertainty in Georgia's Health Care Sector

Although it is too early to determine the full impact of OBBBA on the state's healthcare landscape, the anticipation of funding losses is already affecting Georgia's health care providers. The Atlanta Journal Constitution reported in August 2025 that Evans Memorial Hospital, already facing a $3.3 million budget shortfall in 2026, relies on Medicaid for about $3.4 million of its $20 million in revenue, and a significant number of other patients qualified health plans under the ACA. With anticipated federal cuts under OBBBA, the hospital is considering closing its intensive care unit, searching for other ways to reduce cost, and is "struggling to figure out what the next chapter looks like."

This example reveals that uncertainty may impact health care just as much as financial loss. However, Georgians—and Georgia health care lawyers in particular—may face somewhat smoother waters than their counterparts in other states. Georgia's existing Medicaid landscape means that many of OBBBA's policy changes will be adjustments rather than sweeping reforms. During this period, it is crucial for counsel to guide Georgia providers on compliance and strategic planning as they step into the unknown ahead.

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i One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72. Available at https://www.congress.gov/119/plaws/publ21/PLAW-119publ21.pdf.

ii Rhiannon Euhus, Elizabeth Williams, Alice Burns, and Robin Rudowitz, Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package, KFF, July 23, 2025. Available at https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/.

iii Alice Burns, Jared Ortaliza, Justin Lo, Matthew Rae, and Cynthia Cox, How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?, KFF, Aug. 20, 2025. Available at https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/.

iv Georgia Pathways to Coverage, About Georgia Pathways to Coverage, available at https://pathways.georgia.gov/about-pathways.

v Georgia Pathways to Coverage Data Tracker, Current Enrollment, available at https://www.georgiapathways.org/data-tracker.

iv Scott Hulver, Zachary Levinson, Jamie Godwin, and Tricia Neuman, 10 Things to Know About Rural Hospitals, KFF, April 16, 2025. Available at https://www.kff.org/health-costs/10-things-to-know-about-rural-hospitals/.

vii Heather Saunders, Alice Burns, and Zachary Levinson, How Might Federal Medicaid Cuts in the Enacted Reconciliation Package Affect Rural Areas?, KFF, July 24, 2025. Available at https://www.kff.org/medicaid/how-might-federal-medicaid-cuts-in-the-enacted-reconciliation-package-affect-rural-areas/.

vii Adam Van Brimmer, Georgia's rural hospitals tighten budgets ahead of Medicaid, ACA changes, Atlanta Journal Constitution, Aug. 19, 2025. Available at https://www.ajc.com/politics/2025/08/georgias-rural-hospitals-tighten-budgets-ahead-of-medicaid-aca-changes/.

Navigating HIPAA: A Look at the Reproductive Privacy Rule

Jeff Shaw, In-House Counsel, ProCo, LLC

ProCo, LLC is a management service organization for health care providers including AICA Orthopedics, Atlas Surgery Center, Summit Surgery Center, MDS Imaging, and Motion Rehabilitation. Within the legal department, one of our mandates is staying abreast of changes to HIPAA that necessitate updates to forms and processes. That certainly required agility in the case of the 2024 Privacy Rule, also known as the Reproductive Privacy Rule.

Passed by Congress in 1996, the Health Insurance Portability and Accountability Act (HIPAA) was originally designed to improve the portability of health insurance coverage and streamline the administration of health care. It has since evolved into the primary federal law protecting individuals' health information.

Health care providers face significant penalties for noncompliance with HIPAA's privacy and security requirements. As a result, they must remain vigilant, routinely updating their forms, workflows, and staff training. This can be especially challenging as HIPAA standards shift with new presidential administrations, federal rulemaking, and judicial interpretations. When enacting HIPAA, Congress directed the U.S. Department of Health and Human Services (HHS) to develop standards for safeguarding individually identifiable health information. Information is considered protected health information (PHI) when it (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; (2) relates to an individual's past, present, or future physical or mental health condition, the provision of health care, or payment for such care; and (3) identifies—or can reasonably be used to identify—the individual [see 45 C.F.R. § 160.103].

In 2000, HHS issued the Standards for Privacy of Individually Identifiable Health Information (commonly referred to as the "Privacy Rule"), which created foundational safeguards for the use and disclosure of PHI. It generally prohibits disclosures without individual authorization, except for specified purposes such as treatment, payment, health care operations, public health, and certain legal proceedings [45 C.F.R. §§ 164.502, 164.512].

Subsequent updates included the 2003 Security Rule, which established national standards for protecting electronic PHI (ePHI) [45 C.F.R. Part 164, Subpart C], and the HITECH Act of 2009, which imposed breach notification requirements, extended liability to business associates, strengthened enforcement mechanisms, and expanded individual access rights [42 U.S.C. §§ 17921–17954].

One of the most consequential recent changes came in 2024, when HHS—under the Biden administration—issued the HIPAA Privacy Rule to Support Reproductive Health Care Privacy (the "2024 Rule"). This rule was promulgated in response to the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), which overturned *Roe v. Wade* and returned abortion regulation to the states. The 2024 Rule sought to prevent HIPAA-regulated entities from disclosing reproductive health records to law enforcement or others in states that had banned or restricted abortion. It defined "reproductive health care" (RHC) as "health care that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes" [89 Fed. Reg. 40874 (May 8, 2024)]. It also defined "person" as "a natural person (meaning a human being who is born alive)," thereby excluding embryos and fetuses from the protections of HIPAA as applied in this context.

The rule prohibited the use or disclosure of PHI to investigate or impose liability on an individual for seeking, obtaining, providing, or facilitating lawful RHC. Covered entities were required to presume that RHC was lawful unless they had actual knowledge—or were presented with credible evidence—to the contrary. Operationally, this rule imposed new burdens on both requestors and custodians of health records. For example, personal injury attorneys seeking their clients' records had to submit signed attestations that the request was not for a prohibited purpose under the 2024 Rule. Health care providers, in turn, were required to confirm the presence of these attestations before

releasing records.

In addition, the rule mandated that HIPAA-regulated entities revise their Notices of Privacy Practices (NPPs) by February 16, 2026, to include disclosures about reproductive health protections—prompting providers to begin internal compliance and legal reviews across departments.

However, while many entities were implementing these changes, the 2024 Rule was vacated in federal court. In *Purl v. U.S. Department of Health and Human Services*, 760 F.Supp.3d 489 (2024), a Texas physician and his clinic challenged the rule, arguing that it interfered with their state-mandated obligations to report suspected child abuse. The clinic had treated minors who were pregnant or sexually active and frequently received PHI requests from Texas Child Protective Services.

The plaintiffs raised three key arguments: (1) that the 2024 Rule conflicted with federal law by hindering child abuse reporting; (2) that the redefinitions of statutory terms such as "person" were unlawful; and (3) that HHS exceeded its statutory authority by using HIPAA to create special protections tied to abortion.

Notably, HHS—now under the Trump administration—declined to defend the rule on the merits, citing internal review. The U.S. District Court ultimately agreed with the plaintiffs on all three points and vacated the 2024 Rule in its entirety, finding it arbitrary, capricious, and inconsistent with the Administrative Procedure Act. *Purl v. HHS*, No. 5:24-cv-00029 (N.D. Tex. July 3, 2025)

Reflecting on the issuance of the 2024 Rule—and its judicial invalidation within 12 months—serves as a powerful reminder of the dynamic nature of HIPAA compliance. It is not a static checklist. HIPAA continues to evolve and, like much of health law, is increasingly shaped by political, legal, and ideological forces.

Those of us practicing in the health law space must help build internal compliance infrastructures that are nimble and responsive to change. The circumstances surrounding the 2024 Rule underscore the importance of legal vigilance and flexible strategies. As practitioners, we play a critical role in translating regulatory shifts into operational reality—and helping clients stay ahead of an ever-moving target.

The Landscape of AI Regulation in Healthcare

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Artificial intelligence (AI) is rapidly transforming the healthcare industry, driving improvements in administrative efficiency and enhancing the delivery of clinical care. However, the regulatory environment surrounding the use of AI in healthcare is evolving more slowly and in a fragmented manner. Given limited federal oversight and a patchwork of state laws, legal professionals must stay continually informed. Because technology is advancing faster than the law, understanding both federal and state frameworks is essential to advise clients effectively.

Federal Regulatory Landscape

To date, federal regulation of AI in the healthcare industry remained limited. At the executive level, former President Joe Biden issued Executive Order (EO) 14110 in October 2023, directing agencies such as the U.S. Department of Health and Human Services (HHS) and the National Institute of Standards and Technology (NIST) to develop regulatory frameworks that encourage AI innovation while minimizing risks to safety and privacy.[1] For example, the EO directed HHS to determine how AI could be safely used in the coverage determination process – including quality improvement, benefits administration, and healthcare delivery and financing – and issue regulations governing the use of AI in these areas.[2] However, President Donald Trump rescinded EO 14110 on his first day in office, eventually replacing it with a new AI Action Plan.[3] While the AI Action Plan broadly supports AI policy and innovation, it does not meaningfully address healthcare-specific concerns.[4]

As a result, only a limited number of Biden-era measures remain in effect. One key provision that survived rescission or amendment is the rule implementing Section 1557 of the Affordable Care Act (ACA), which prohibits Medicare-participating entities from discriminating on the basis of race, gender, age, or other protected class through the use of AI-based patient care decision support tools.[5] Additionally, the Centers for Medicare & Medicaid Services (CMS) has issued rules that permit Medicare Advantage plans to use AI in the prior authorization process, provided that AI accounts for the beneficiary's clinical condition and does not rely solely on population-level datasets.[6] Ultimately, however, no comprehensive, agency-level federal framework governs AI in healthcare, leaving providers and insurers to navigate a regulatory gap as they integrate AI tools into their operations.

At the congressional level, despite numerous hearings and proposed bills in the 118th Congress, lawmakers have yet to pass legislation directly regulating the use of AI in healthcare.[7] A proposed federal moratorium, included in early drafts of the One Big Beautiful Bill Act (OBBB), would have blocked states from enacting or enforcing AI regulations for ten years, to allow time for Congress to implement a statutory framework governing AI use.[8] However, the moratorium was ultimately removed from the final version of OBBB.[9]

State-Level Regulation

With limited federal action, states have taken the lead in regulating AI in healthcare, focusing on areas where they have long held authority, such as oversight of commercial health insurance and the establishment of professional standards for healthcare providers. In 2024, 31 states enacted legislation impacting the use of AI, including measures affecting healthcare.

States have taken different approaches to regulating AI in healthcare reflecting differing legislative priorities. For example, several states have focused on disclosure requirements. In June 2025, Texas enacted the Texas Responsible AI Governance Act (TRAIGA), which requires healthcare providers to disclose to patients

1 Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence, 88 Fed. Reg. 75191.

2 Id. at 75212-4.

3 See, generally, White House, America's AI Action Plan (July 2025).

4 See id.

5 See 89 Fed. Reg. 37522, 37648-9.

6 Dep't of Health & Hum. Servs., Ctrs. For Medicare & Medicaid Servs., FAQ related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) (Feb. 6, 2024).

7 Laurie A. Harris, Cong. Rsch. Serv., R47644, Artificial Intelligence: Overview, Recent Advances, and Considerations for the 118th Congress (Aug. 4, 2023).

8 See S. Amdt. 2814 to S. Amdt. 2360, to H.R.1, 119th Cong. (2025).

9 Id.

when AI is used in delivering clinical services.[10] The medical boards in New Mexico and Mississippi have promulgated similar disclosure requirements by regulation.[11] Other states, such as California, have passed laws more limited in scope, requiring only that providers disclose their use of generative AI in patient communications.[12]

States have also enacted laws regulating the use of AI in clinical practice. Both Texas and North Carolina permit healthcare professionals to use AI for diagnosis and treatment, provided clinicians review AI recommendations and retain final clinical judgment—i.e., maintain a "human-in-the-loop" safeguard.[13] In the behavioral health context, Illinois enacted the Wellness and Oversight of Psychological Resources Act. The law prohibits licensed professionals from using AI to make independent therapeutic decisions, directly interact with clients in therapeutic communication or generate treatment plans without review and approval by a licensed professional.[14] Notably, Georgia has not – as of the date of this writing – passed any significant legislation directly impacting the use of AI by healthcare providers.

States are also actively regulating the use of AI in the insurance sector, particularly in areas such as claims review and prior authorization (PA) processes. In response to high-profile class action lawsuits over unfair AI-driven claims practices, several states have taken legislative action: Georgia, California, Illinois, Texas, Arizona, Maryland, Nebraska, and Oklahoma have all enacted laws prohibiting insurers from relying solely on AI to deny PA requests.[15] These laws require licensed healthcare professionals to make the final determinations to deny a PA request. However, some states have taken this initiative further. Colorado, California, and Maryland require insurers to implement risk mitigation plans and conduct regular assessments to identify and prevent algorithmic bias.[16] These examples underscore the diversity of state-level approaches to regulating AI in healthcare.

Implications for Legal Practice

In the absence of congressional action, states have assumed the primary role in shaping the regulatory landscape for AI in healthcare. Legal professionals must remain vigilant in guiding clients through this complex and evolving environment. The proliferation of state-level AI laws demands tailored compliance strategies that reflect the unique regulatory requirements of each jurisdiction. Staying current with legislative updates and guidance from state professional licensing boards is essential to maintaining compliance across jurisdictions. For healthcare organizations operating in multiple jurisdictions, coordinated compliance efforts are critical. These efforts should include the development of state-specific protocols, regular policy reviews, and comprehensive staff training to address varying requirements and risk-mitigation obligations.

10 Tex. H.B. 149.

11 N.M. Med. Bd., Artificial Intelligence Policy Statement, https://www.nmmb.state.nm.us/wp-content/uploads/2025/01/NMMB-AI-Policy-statement-11-24-1.pdf (Nov. 24, 2024); 30 Code Miss. R. Pt. 2635, R. 13.1 et seq.

12 Cal. Health & Saf. Code § 1339.75(a).

13 See N.C. Med. Bd., Position Statement: 5.1.4: Telemedicine, https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine (amended March 2024); Tex. Bd. of Nursing, Position Statement 15.31: Artificial Intelligence (AI) in Nursing, https://www.bon.texas.gov/pdfs/practice_dept_pdfs/position_statements_pdfs/BON%20Position%20Statements%202025.pdf (January 2025).

14 Ill. H.B. 1806, Pub. Act 104-0054.

15 Cal. Health & Saf. Code § 1367.01; Cal. Ins. Code § 10123.135; 215 ILCS 5/143.31; Tex. Ins. Code § 4201.156; Ariz. H.B. 2175; MD. Code Ann., §15-10B-05.1; LB77, 109th Leg., 1st Sess. § 12 (Neb. 2025); 36 Okla. Stat. Ann. § 6570.11; Ga. Comp. R. & Regs. 33-46-1 et seq.

16 Colo. Rev. Stat. § 6-1-1701 et seq.; Cal. Health & Saf. Code § 1367.01; Cal. Ins. Code § 10123.135; MD. H.B. 820.

Vaccination in Georgia: History, Hesitancy, and Legal Pathways Forward

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In April 2025, Georgians gathered in Warm Springs to celebrate the 70th anniversary of the announcement that Jonas Salk's polio vaccine was "safe and effective."[1] Held at the site where President Franklin D. Roosevelt sought rehabilitation treatment from the effects of polio that ultimately took his life, the commemoration honored the breakthrough that helped relegate one of the most feared diseases of the 20th century to near-eradication.[2]

Yet even as Warm Springs remains emblematic of the triumph of public health and science over a crippling disease, the county in which it sits—Meriwether County—is one of the 47 Georgia counties falling below the statewide total vaccination average of 75.5% for 19-35 month olds, and the 13th lowest of 159 counties for the inactivated polio vaccine, according to data from the Georgia Registry of Immunization Transactions and Services (GRITS).[3] The concern extends statewide: kindergarten vaccination coverage in Georgia has fallen dramatically from 96.6% in 2011 to 86.8% in 2024.[4] Because many vaccine-preventable diseases spread quickly, even a small decline in coverage can erode herd immunity. With a precipitous drop of nearly ten percentage points, children are left more vulnerable to serious illness, hospitalization, long-term debilitation, or even death.

Herd Immunity

Herd immunity occurs when a sufficient portion of a population becomes immune to a pathogen, either through vaccination or prior infection, so as to limit further spread of disease.[5] Its importance lies in protecting those who are vaccinated, as well as shielding those newborns and individuals with medical contraindications who cannot be vaccinated, as well as people with incomplete immune responses to vaccination.

National data from the CDC reveal that coverage for routine childhood vaccines has slipped beneath the threshold necessary to keep outbreaks at bay.[6] The vaccination coverage required to obtain herd immunity varies by pathogen, depending on how contagious it is. For measles, among the most infectious diseases, about 95% of people must receive two doses of the vaccine to interrupt transmission.[7] Yet, CDC data shows that national kindergarten coverage for the measles, mumps,

1 Lowry, *Lawmakers Huddle: Warm Springs Commemorates 70th Anniversary of Polio Campaign*, Ga. Pub. Broad. (last updated Apr. 12, 2025), https://www.gpb.org/news/2025/04/11/lawmakers-huddle-warm-springs-commemorates-70th-anniversary-of-polio-campaign; *1955 Polio Vaccine Trial Announcement*, Univ. of Michigan Sch. of Pub. Health (last visited Sept. 17, 2025), https://sph.umich.edu/polio/.

2 Minchew, *Warm Springs*, New Ga. Encyclopedia (last updated July 2, 2022), https://www.georgiaencyclopedia.org/articles/counties-cities-neighborhoods/warm-springs/.

3 *Immunization Study Reports: GA Immunization Report for Children 19-35 Months, Child Report 2022*, Ga. Dep't of Pub. Health, https://dph.georgia.gov/immunization-study-reports (Select 'Report Sections Drop-Down', Select 'Data by County.' Data for all four quarters of 2023 is now available but not yet compiled into an annual report. According to the 2022 report, Meriwether is 25th of 159 counties for the 7-series vaccines with 72.1%.).

4 *Vaccination Coverage and Exemptions among Kindergarteners*, U.S. Ctrs. for Disease Control & Prevention (July 31, 2025), https://www.cdc.gov/schoolvaxview/data/index.html (Click 'Vaccination Trend', Select 'MMR', Select 'Georgia').

5 *Coronavirus Disease (COVID-19): Herd Immunity, Lockdowns and COVID-19* (last updated Dec. 31, 2020), World Health Org. https://www.who.int/news-room/questions-and-answers/item/herd-immunity-lockdowns-and-covid-19 (explaining the concept of 'herd immunity').

6 *Measles Cases and Outbreaks*, U.S. Ctrs. for Disease Control & Prevention (last updated Sept. 30, 2025), https://www.cdc.gov/measles/data-research/index.html ("[V]accination coverage among U.S. kindergartners has decreased from 95.2% during the 2019–2020 school year to 92.7% in the 2023–2024 school year, leaving approximately 280,000 kindergartners at risk during the 2023–2024 school year.").

7 *Global Measles Vaccination: About Global Measles*, U.S. Ctrs. for Disease Control & Prevention (July 14, 2025), https://www.cdc.gov/global-measles-vaccination/about/index.html ("Because measles is so contagious, it can easily cross borders and cause outbreaks in any community where vaccination coverage rates are below 95%.").

and rubella (MMR) vaccine has fallen to 92.5%.[8] Once coverage dips below the herd immunity threshold, the protective barrier begins to break down and even a single case of measles—capable of generating 12 to 18 secondary infections in an unprotected population—can trigger an outbreak.[9]

To date in 2025, there have been more than 1500 confirmed cases across the US, more than 5 times the number of cases in all of 2024, with 12% requiring hospitalization and 3 reported deaths.[10] Many of these cases stem from an outbreak originating in Texas. In Georgia, 10 cases have been confirmed in 2025.[11] Measles causes a high fever, cough and runny nose, and distinctive rash, as well as ear infections and diarrhea. Serious side effects can include pneumonia, encephalitis, and pregnancy complications. Measles may result in deafness, intellectual disability, and death.[12]

Measles and other disease outbreaks also require intensive public health and health care resources and staff time. A 2020 review of 10 studies (11 outbreaks) found the median cost per measles case to be $32,805 (range, $7,396-$76,154)[13] In September, an unvaccinated student at Georgia State University who had not traveled out of the country but had traveled domestically was diagnosed with measles. The Department of Public Health conducted contact tracing and found 220 close contacts. After investigating, 7 of these were found to be unvaccinated or of unknown vaccination status, requiring active monitoring by the department for the incubation period (time period during which a person exposed to a disease might begin to demonstrate signs of the illness), and 3 of these contracted the disease and are isolating.[14]

Different from other states, Georgia only reports kindergarten vaccination in the aggregate to CDC.[15] Although vaccination rates for 19-35 month olds are reported by county, lack of more granular data can mask risk of outbreaks. While some counties approach the herd immunity thresholds for some vaccines, others fall far below it.[16] Even within counties, unvaccinated or under-vaccinated people are often clustered in particular schools, neighborhoods, or communities. Because statewide averages conceal these disparities, effective responses require localized data and context-specific strategies. In practice, that means addressing the drivers of vaccine hesitancy that vary from place to place.

Vaccination Hesitancy and the Post-COVID Landscape

Public skepticism toward vaccination is not new. In the 19th century, organized opposition to the smallpox vaccine focused on themes that continue today: distrust of government, anxiety about "unnatural" substances, and appeal to bodily autonomy.[17] What sets the present apart is not the substance of these arguments but their reach. Anti-vaccine stances have become politically salient, magnified by the speed and scale of modern

8 Id.

9 Do & Mulholland, *Measles 2025*, New Eng. J. Med. (June 25, 2025), https://www.nejm.org/doi/full/10.1056/NEJMra2504516#:~:text=Measles%20is%20a%20highly%20contagious,and%20of%20growing%20vaccine%20hesitancy. ("Measles is a highly contagious virus with a primary case reproduction number (i.e., the average number of secondary cases per case patient) of 12 to 18.").

10 *Measles Cases and Outbreaks*, supra note 6.

11 Id.

12 *Measles Symptoms and Complications*, U.S. Ctrs. for Disease Control & Prevention (May 9, 2024), https://www.cdc.gov/measles/signs-symptoms/index.html.

13 Pike, Leidner, Gastañaduy, *A Review of Measles Outbreak Cost Estimates From the United States in the Postelimination Era (2004–2017): Estimates by Perspective and Cost Type, Clinical Infectious Diseases*. (15 September 2020), https://doi.org/10.1093/cid/ciaa070.

14 Grapevine, *Measles spreads from Georgia State student to three others*, Healthbeat Atlanta (Sept. 24, 2025), https://www.healthbeat.org/atlanta/2025/09/24/measles-outbreak-georgia-state-student/.

15 *Vaccination Coverage and Exemptions among Kindergarteners*, U.S. Ctrs. for Disease Control & Prevention (July 31, 2025), https://www.cdc.gov/schoolvaxview/data/index.html (Click 'Vaccination Trend', Select 'MMR', Select 'Georgia').

16 *Immunization Study Reports: GA Immunization Report for Children 19-35 Months, Child Report 2022*, Ga. Dep't of Pub. Health, https://dph.georgia.gov/immunization-study-reports (Select 'Report Sections Drop-Down', Select 'Data by County.' Data for all four quarters of 2023 is now available but not yet compiled into an annual report. According to the 2022 report, only 4 counties reach the threshold 95% vaccination rate among 19-35 month olds).

17 Eichman & Bichianu, *From Cotton Mather to Dr. Fauci: Historical Markers of Vaccine Hesitancy*, Am. Acad. of Pediatrics (Apr. 1, 2024), https://publications.aap.org/neoreviews/article/25/4/e187/196976/From-Cotton-Mather-to-Dr-Fauci-Historical-Markers?autologincheck=redirected.

communication. The COVID-19 pandemic pushed vaccination debates into mainstream political discourse and onto social media platforms where misinformation spreads rapidly and is reinforced by partisan voices and advocacy networks.

The political climate since COVID-19 has also intensified public skepticism toward vaccination. In February 2025, Robert F. Kennedy Jr., a longtime critic of vaccination, was appointed Secretary of Health and Human Services (HHS). Within months, all 17 members of the Advisory Committee on Immunization Practices (ACIP) were dismissed and replaced, with several new appointees lacking expertise in vaccines or infectious disease and some openly critical of immunization.[18] For decades, ACIP's consensus recommendations provided a stable foundation for CDC guidance and state school-entry requirements.[19] Its wholesale replacement has left a gap in nationally recognized standards that once served as a point of trust across the system.

Also under Kennedy's direction, HHS has narrowed recommendations for COVID-19 vaccination for children and during pregnancy, launched an autism study led by a figure who previously promoted discredited vaccine links, and canceled contracts for new mRNA vaccine development.[20] These changes to HHS policy, combined with an amplified vaccine skepticism in public discourse, leave decades worth of public health achievement vulnerable to growing anti-vaccine sentiment.

Yet most Georgians who delay or decline vaccines are not committed anti-vaccination activists. Rather, their choices are better understood as vaccine hesitancy, a spectrum that ranges from acceptance to delay to outright refusal.[21] Public health researchers describe this phenomenon through the "5C model,"[22] which identifies five key drivers of hesitancy:

- Confidence
- Complacency
- Calculation of risk
- Convenience/constraints
- Collective responsibility

In Georgia, each of these factors contributes to declining vaccination rates. Vaccine hesitant Georgians may lack confidence in public health institutions and individuals, including government agencies and scientists. They may also question the credibility of local physicians or community leaders. Complacency refers to the mistaken belief that there is a greater risk of harm from vaccines than from the diseases they protect from. This is reinforced by the absence of lived memory of diseases like measles or polio, which can make vaccination appear less urgent. People may calculate the risk of not vaccinating based on misinformation being shared on social media rather than reputable sources. Convenience/constraints reflect the practical obstacles to vaccine access that many Georgians face. For example, some rural counties are health care deserts: residents may have longer travel times to pediatricians or limited appointment availability at local health departments. Taking time off of work or finding transportation may also be challenging for low-income parents. Finally, the sense of collective responsibility may vary, with some communities viewing vaccination as a civil obligation while others frame it as a matter of personal preference.

The significance of these dynamics becomes even clearer when viewed within the framework of federal and state authority, since the weight of individual choices depends, in part, on how vaccination policy is structured and enforced.

18 *HHS Takes Bold Step to Restore Public Trust in Vaccines by Reconstituting ACIP*, U.S. Dep't of Health & Hum. Servs. (June 9, 2025), https://www.hhs.gov/press-room/hhs-restore-public-trust-vaccines-acip.html.

19 Ctr. For Health Law & Pol'y Innovation, *HHS Moves Overhaul the Advisory Committee for Immunization Practices (ACIP): What this Means for Vaccine Access*, Harvard L. Sch. (June 25, 2025), https://chlpi.org/wp-content/uploads/2025/06/HCIM-ACIP_FINAL_6.25.25.pdf.

20 Secretary Kennedy (@SecKennedy), X (May 27, 2025, 10:16 AM), https://x.com/seckennedy/status/1927368440811008138?s=46 (announcing the removal of healthy children and healthy pregnant women from the recommended vaccine schedule for COVID-19); *NIH, CMS Partner to Advance Understanding of Autism Through Secure Access to Select Medicare and Medicaid Data*, U.S. Dep't of Health & Hum. Servs. (May 7, 2025), https://www.hhs.gov/press-room/nih-cms-partner-to-research-root-causes-of-autism.html (announcement study linking autism to vaccines); *HHS, CMS Eliminate Financial Pressure Tied to Staff Vaccination Reporting*, U.S. Dep't of Health & Hum. Servs. (Aug. 1, 2025), https://www.hhs.gov/press-room/hhs-cms-end-vaccine-reporting-incentives.html (canceled mRNA contracts).

21 Kestenbaum & Feemster, *Identifying and Addressing Vaccines Hesitancy*, Nat'l Libr. of Med. (Apr. 10, 2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4475845/.

22 Eitze, Felgendreff, Horstkötter, Seefeld & Betsch, *Exploring pre-pandemic patterns of vaccine decision-making with the 5C model: results from representative surveys in 2018 and 2019*, BMC Pub. Health (Apr. 30, 2024), https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-18674-9.

Federal and State Roles

The U.S. vaccine system is shaped by a federal-state balance of authority. At the federal level, the Food and Drug Administration (FDA) approves vaccines as safe and effective after rigorous testing, the Centers for Disease Control and Prevention (CDC) issues the immunization schedule based on recommendations of the Advisory Committee on Immunization Practices (ACIP), and both FDA and CDC monitor safety of vaccines.[23] Federal programs such as Vaccines for Children (VFC) provide coverage.[24] The Affordable Care Act requires insurance coverage of vaccines recommended by the ACIP without cost sharing as preventive services.[25] Health Resources & Services Administration (HRSA) administers the Vaccine Injury Compensation Program (VICP), a no-fault system for investigating and compensating people who have been injured by vaccines.[26] States, however, play the central role in implementation. State law sets vaccine requirements for school and childcare entry, determines which exemptions are permitted, authorizes certain professions to vaccinate, and manages immunization registries and emergency response to outbreaks. All states must recognize medical exemptions to school-entry vaccination requirements, but the handling of non-medical exemptions varies.[27] Despite the fact that stricter exemption laws and administrative policies are associated with fewer exemptions and fewer disease outbreaks,[28] twenty-nine states allow non-medical exemptions for religious beliefs, and an additional sixteen states also allow non-medical exemptions for philosophical objections or personal beliefs.[29] Five states only allow for medical exemptions. Mississippi and West Virginia stood out for decades by recognizing only medical exemptions. But both states have recently faced legal challenges.[30]

Georgia requires vaccines for school and childcare entry, and parents may claim a religious exemption, but philosophical or personal-belief claims are not recognized.[31] Georgia religious exemptions require a one-time completion and notarization of a state form, compared to other states' requirements of annual forms, education on vaccination, and detailed statements of beliefs and/or signatures from medical or religious professionals.[32] Recent data show that Georgia's religious exemption rate is climbing. In the 2024-2025 kindergarten cohort, 4.8% of Georgia children claimed exemptions, up from 1.6% in 2011-2012. Nearly all of Georgia's exemptions are for religious reasons.[33]

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23 Kates & Michaud, *How HHS, FDA, and CDC Can Influence U.S. Vaccine Policy*, Kaiser Fam. Found. (Nov. 20, 2024), https://www.kff.org/covid-19/how-hhs-fda-and-cdc-can-influence-u-s-vaccine-policy/.

24 *About the Vaccines for Children (VFC) Program*, U.S. Ctrs. for Disease Control & Prevention (June 26, 2024) https://www.cdc.gov/vaccines-for-children/about/index.html.

25 Forsberg, Cong. Rsch. Serv., IF13010, The ACA Preventative Services Coverage Requirement (May 23, 2025), https://www.congress.gov/crs-product/IF13010.

26 *National Vaccine Injury Compensation Program*, Health Res. & Servs. Admin. (last updated Sept. 2025), https://www.hrsa.gov/vaccine-compensation.

27 *Jacobson v. Massachusetts*, 197 U.S. 11 (1905); Oliphant & Steenhuysen, *Florida Plans to End All State Vaccine Mandates, Including for Schools*, Reuters (Sept. 4, 2025), https://www.reuters.com/business/healthcare-pharmaceuticals/florida-plans-end-all-state-vaccine-mandates-including-schools-2025-09-03/. Florida became the first U.S. state to announce plans to repeal all vaccine mandates for children and adults, with Governor Ron DeSantis and Surgeon General Joseph Ladapo declaring on September 3, 2025, that the Florida Department of Health would work to eliminate existing requirements. *Id.*

28 Yang & Silverman, *Legislative Prescriptions for Controlling Nonmedical Vaccine Exemptions*, JAMA Network (Jan. 20, 2015), https://jamanetwork.com/journals/jama/fullarticle/2091313.

29 *State Non-Medical Exemptions From School Immunization Requirements*, Nat'l Conf. of State Legislatures (last updated July 24, 2025), https://www.ncsl.org/health/state-non-medical-exemptions-from-school-immunization-requirements.

30 *ACLU-WV Refiles Lawsuit to Block Governor's Vaccine Exemption Order, Seeks Emergency Relief as Schools Reopen*, ACLU W. Va. (Aug. 18, 2025), https://www.acluwv.org/en/press-releases/aclu-wv-refiles-lawsuit-block-governors-vaccine-exemption-order-seeks-emergency; Lacey Alexander, *U.S. District judge rules Mississippi public schools must honor religious exemptions to vaccines*, Miss. Pub. Broad. (Apr. 21, 2023), https://www.mpbonline.org/blogs/news/us-district-judge-rules-mississippi-public-schools-must-honor-religious-exemptions-to-vaccines/.

31 O.C.G.A. § 20-2-771; Ga. Comp. R. & Regs. 511-2-2-.02, -.07.

32 Yang & Silverman, supra note 28.

33 *SchoolVaxView Interactive!*, U.S. Ctrs. for Disease Control & Prevention (last accessed Sept. 3, 2025), https://www.cdc.gov/schoolvaxview/data/index.html (click "Exemption Trend', select "Select All' exemptions, select 'Georgia', then select 'Select All' school years).

State laws facilitate adult and childhood vaccinations in a variety of ways. States maintain immunization information systems (IIS) or registries, such as GRITS, in which providers record patient vaccinations and verify which vaccinations are needed and when. Public health professionals can also use this data for identifying areas of the state for targeting vaccination campaigns to prevent outbreaks. State scope of practice laws specify which health care professionals may vaccinate and under what circumstances. These laws increase the number of eligible vaccinators and thus expand access to vaccines, particularly in rural communities. For example, in Georgia, pharmacists and pharmacy technicians may administer vaccines to adults and older youth tied to ACIP recommendations under vaccine protocol agreements with supervising physicians.[34] While states do not generally mandate adult vaccinations, some states do mandate vaccinations for certain groups, such as college students, health care providers, nursing home facility staff, foster parent and group home staff. Emergency responders in Georgia, for example, are required to be vaccinated, unless they have a medical exemption or religious or personal belief exemption.[35]

Current Efforts and Opportunities

With federal leadership in flux, professional organizations have stepped in. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists have issued updated immunization guidance, particularly for maternal, influenza, and RSV vaccines.[36] Some states are also exploring new models; Colorado, for instance, recently introduced legislation to maintain coverage requirements independent of federal ACIP recommendations.[37] In some regions, states have banded together to issue public health guidance. California, Washington, and Oregon have formed the West Coast Health Alliance, and 9 states now comprise the Northeast Public Health Collaboration.[38]

In Georgia, improving vaccination rates will require a multifaceted, science-informed strategy, with support from attorneys. Recommendations include:

- Improving Data Collection and Transparency: More granular reporting could help identify under-vaccinated communities, allowing public health professionals to focus efforts in areas vulnerable to outbreaks. Attorneys can assist with ensuring that individual data privacy of individuals continues to be protected.
- Building Community Partnerships: Schools, local health departments, and community organizations could collaborate under clear memoranda of understanding, to host school-based vaccination sites, with attorneys helping to navigate parental consent and HIPAA and FERPA constraints.
- Collaborating Across States: Diseases do not respect political boundaries. Collaboration with neighboring states to maintain consistent vaccination guidance will help to prevent public confusion. Negotiation of data sharing agreements may also be beneficial, particularly for border counties, to mitigate risk of differing vaccination rates, as well as to help providers know whether people have been vaccinated across state lines.
- Using Evidenced-Based, Plain Language Messaging: Avoiding politicized language while focusing on disease prevention and child health will help sustain community support. Federal law requires use of plain language. States should also use plain language to ensure understanding by people of all literacy levels.
- Addressing the 5Cs: Interventions that build trust, remove barriers to access, and reinforce collective responsibility may be more effective than direct confrontation of anti-vaccine rhetoric.

Conclusion

Georgia's public health history is both proud and instructive, from Warm Springs' legacy of polio rehabilitation[39] to the CDC's location in Atlanta

34 O.C.G.A. §§ 43-34-261; 26-4-52.

35 O.C.G.A. § 31-35-11.

36 Shaw, *Vaccine Integrity Project Steps Into Void Left by ACIP Purge: AAP, ACOG Issue Vaccine Recommendations Amid Concerns Over ACIP's Scientific Integrity*, Infectious disease special edition. (Aug. 27, 2025), https://www.idse.net/Immunology-Vaccination/Article/08-25/AAP-Immunization-Schedule-Differences/78055.

37 Brumer, *Federal vaccine guidance is changing, but Colorado was prepared to push back*
State leaders work to circumvent vaccine skepticism from RFK Jr. appointees, Colorado Newsline. (June 30, 2025), https://coloradonewsline.com/2025/06/30/vaccine-colorado-was-prepared/.

38 Goodman, *States band together to issue public health guidance after 'destruction' of the CDC*, CNN Health. (Sept. 3, 2025), https://www.cdc.gov/measles/data-research/index.html.

39 Minchew, *Warm Springs*, New Ga. Encyclopedia (last

originally to combat malaria.[40] Vaccines are one of the greatest successes of public health. Yet the state's declining coverage rates are a reminder that legal frameworks and public trust must continually be renewed. Attorneys, public health leaders, and policymakers have an opportunity to help Georgia avoid preventable outbreaks by supporting data-driven strategies, fostering community collaboration, and protecting the integrity of school vaccination requirements. With sustained effort, Georgia can once again lead by example in public health, ensuring that the public health triumphs of the past remain protections for the future.

updated July 2, 2022), https://www.georgiaencyclopedia.org/articles/counties-cities-neighborhoods/warm-springs/.

40 Grapevine, *Why is the CDC located in Atlanta and not D.C.? History tied to Coca-Cola and mosquitoes*, GPB. (May 20, 2025), https://www.gpb.org/news/2025/05/20/why-the-cdc-located-in-atlanta-and-not-dc-history-tied-coca-cola-and-mosquitoes#:~:text=During%20World%20War%20II%2C%20malaria,Credit:%20Courtesy%20of%20CDC.

Academic Medical Center Boards and the Shifting Healthcare Federal Policy Landscape

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Academic Medical Centers (AMCs) face unprecedented regulatory and financial challenges as federal policy shifts threaten their tripartite mission of providing clinical care, educating medical professionals, and advancing research. These institutions, which comprise teaching hospitals, medical schools, and research facilities and combinations thereof, are responsible for training approximately 40% of U.S. physicians[2] and conducting the majority of NIH-funded research[3]. Recent federal policy developments present complex legal and operational challenges that require sophisticated governance responses to maintain AMCs' vital role in the healthcare ecosystem.

Impact of Federal Policy Changes

Research Funding Cuts: The federal government proposes a 40% reduction in NIH's budget for FY2026, equivalent to approximately $18 billion[4]. This includes consolidating NIH Institutes, cutting grants by 43%, and limiting indirect cost reimbursements to 15%, jeopardizing the infrastructure and workforce of research programs[5]. These cuts threaten ongoing projects and institutional capacity, forcing institutions to subsidize research from strained clinical revenues.

Securities on Patient Revenue: Proposed budget cuts to HHS funding and revisions to Medicare and Medicaid policies threaten clinical income[6]. Efforts to promote Medicare Advantage plans may limit coverage for complex AMC treatments like transplants and rare diseases. Policy shifts also include revised site-neutral payment rules, affecting hospital outpatient services, and phase-outs of inpatient-only procedures, further squeezing revenues. At the same time, proposals to recoup previous reductions from the 340B drug discount program increase pressure.

Workforce and Immigration: The healthcare workforce is facing a crisis caused by immigration restrictions, burnout, and shortages—expected to result in a shortage of up to 86,000 physicians by 2036, with an overall healthcare worker deficit exceeding 4 million by 2028[7]. Immigration policies that limit access for non-citizens and DACA recipients hinder the recruitment of international medical graduates essential for staffing.

Strategic Actions for AMC Boards

To preserve their institutional missions while adapting to federal policy shifts, AMC Boards should ensure their senior management teams address strategic priorities across five key areas:

1. **Enhance Financial Stability:** Conduct detailed financial modeling of potential revenue losses and diversify income sources—via philanthropy, industry partnerships, and cost management—to buffer against federal funding cuts.

2. **Align Research and Education Missions:** Strategic realignment involves prioritizing federally aligned research, exploring alternative funding, fostering industry collaborations, and innovating educational pathways, including fast-tracking international medical graduates and updating curricula to meet evolving standards.

Workforce Management[8]**:** Address shortages by leveraging visa options, investing in staff development, and cultivating a resilient culture. Clear protocols for immigration enforcement and technological solutions can help manage strain and burnout.

3. **Advocacy and Community Engagement:** Effective advocacy involves active engagement with policymakers, alliances with industry groups, and strategic legal preparations. Highlighting AMCs' contributions to innovation, training, and safety-net care helps shape policy and public opinion.

4. **Community and Equity Focus:** Despite policy pressures, AMCs should reaffirm commitments to health equity by embedding diversity, equity, and inclusion into governance and operational strategies. Enhancing telehealth, partnering with community organizations, and conducting community health assessments are key.

Strategic Corporate Governance: A Framework for Organizational Excellence

In today's complex regulatory environment, implementing a robust governance framework is essential for sustainable organizational success for

AMCs. This framework must address three critical dimensions of corporate stewardship by AMC Boards:

- Boards must reinforce fiduciary duties—care, loyalty, and obedience—to ensure informed, compliant decision-making.
- Scenario planning and adaptability are crucial to face uncertainties.
- Transparent communication channels between boards and leadership are essential for aligned responses.

Building a Future-Ready Board

The evolving landscape requires a diverse and highly skilled board. Key expertise includes:

- Healthcare industry insight
- Financial and investment acumen
- Research and academic leadership
- Medical education and workforce expertise
- Legal, regulatory, and compliance proficiency, especially around immigration and Medicare policies
- Technology and cybersecurity leadership, given increasing digital threats
- Artificial intelligence expertise, as AI integration accelerates in clinical and regulatory spaces
- Public policy and community engagement skills to advocate effectively and uphold institutional missions

Conclusion

The evolving federal policy landscape presents AMCs with complex regulatory, operational, and financial challenges that require sophisticated governance responses. Success will depend on boards' ability to navigate intricate legal and regulatory frameworks while pursuing strategic initiatives in research funding, clinical operations, and educational programs. AMCs must develop comprehensive compliance frameworks that enable innovation and operational efficiency while maintaining adherence to evolving federal requirements. The future effectiveness of these vital healthcare institutions will largely depend on their ability to adapt governance structures and operational models to this new regulatory reality while preserving their essential mission of advancing medical education, research, and patient care.

Footnotes

1. The following article is a summary update to my original full-length article, published on the Stakeholder Impact Foundation's LinkedIn page on June 13, 2025, *available at* https://www.linkedin.com/pulse/academic-medical-center-boards-shifting-federal-policy-rambert-bctwe/?trackingId=Dh8i%2B1byk8EsczdESImtuA%3D%3D

2. ASS'N OF AM. MED. COLLS., PHYSICIAN SPECIALTY DATA REPORT (2025), https://www.aamc.org/data-reports/workforce/report/physician-specialty-data-report; *see also* Press Release, Ass'n of Am. Med. Colls., *Academic Health Centers Save Millions of Lives* (Feb. 13, 2025), https://www.aamc.org/news/academic-health-centers-save-millions-lives.

3. *See* Press Release, Ass'n of Am. Med. Colls., *Academic Health Centers Save Millions of Lives* (Feb. 13, 2025), https://www.aamc.org/news/academic-health-centers-save-millions-lives (noting AMCs conduct majority of NIH-funded research).

4. U.S. DEP'T OF HEALTH & HUM. SERVS., FISCAL YEAR 2026 BUDGET IN BRIEF 21 (2025), https://www.hhs.gov/sites/default/files/fy-2026-budget-in-brief.pdf [hereinafter HHS FY2026 BUDGET]; *see also* Press Release, Am. Ass'n for Cancer Research, *AACR Calls on Congress to Summarily Reject the President's FY2026 Budget Proposal for NIH* (May 6, 2025), https://www.aacr.org/about-the-aacr/newsroom/news-releases/aacr-calls-on-congress-to-summarily-reject-the-presidentsfy2026-budget-proposal-for-nih/ (analyzing proposed NIH budget reductions).

5. HHS FY2026 BUDGET, *supra* note 4, at 21; *see also* Adam Ruben, *New HHS Document Details Deep NIH Cuts as Part of Trump Budget Request*, STAT NEWS (May 30, 2025), https://www.statnews.com/2025/05/30/nih-cuts-new-details-18-billion-budget-reduction-outlined-in-congressional-budget-justification/; Rylee Wilson, *HHS Releases More Detailed 2026 Budget Disclosing Scope of Cuts*, HEALTHCARE DIVE (June 2025), https://www.healthcaredive.com/news/hhs-2026-budget-nih-cuts-trump-healthcare/749510/.

6. *See, e.g.*, HHS FY2026 BUDGET, *supra* note 4, at 24-27 (proposing changes to Medicare and Medicaid payment policies and 340B drug program).

7. ASS'N OF AM. MED. COLLS., ADDRESSING THE PHYSICIAN WORKFORCE SHORTAGE (2025), https://www.aamc.org/advocacy-policy/addressing-physician-workforce-shortage (projecting shortage of up to 86,000 physicians by 2036); Mercer, *Future of the U.S. Healthcare Industry: Labor Market Projections by 2028* (2024), https://www.mercer.com/en-us/about/newsroom/future-of-the-us-healthcare-industry-labor-market-projections-by-2028/ (projecting overall healthcare worker deficit exceeding 4 million by 2028).

8. Recent executive action significantly impacts this workforce management strategy. On September 19, 2025, President Trump signed a proclamation imposing a $100,000 fee requirement for new H-1B visa applications, which would substantially increase the cost of recruiting international medical graduates. *See* Proclamation No. [number], Restriction on Entry of Certain Nonimmigrant Workers, 90 Fed. Reg. [page] (Sept. 19, 2025), *available at* https://www.whitehouse.gov/presidential-actions/2025/09/restriction-on-entry-of-certain-nonimmigrant-workers/. The proclamation allows the Secretary of Homeland Security to grant exemptions "if the Secretary determines, in the Secretary's discretion, that the hiring of such aliens to be employed as H-1B specialty occupation workers is in the national interest and does not pose a threat to the security or welfare of the United States." *Id.* at § 1(c). AMC boards should work with legal counsel to: (1) evaluate whether their institutions qualify for national interest exemptions based on critical healthcare workforce needs; (2) assess the financial impact of the $100,000 fee on international physician recruitment budgets; (3) explore alternative visa categories for medical professionals; and (4) advocate for healthcare sector exemptions given physician shortages and AMCs' unique role in training international medical graduates who serve underserved populations.