MMA TASK FORCE ON

ARTIFICIAL INTELLIGENCE IN HEALTHCARE

SUMMARY REPORT AND

RECOMMENDATIONS

REBECCA THOMAS, MD, CHAIR
STEPHANIE LINDGREN, MMA STAFF
March 4, 2026

MMA Artificial Intelligence Task Force Charge

The purpose of the MMA Artificial Intelligence in Healthcare Task Force is to explore the use of artificial intelligence (AI) in healthcare in Minnesota and identify necessary policy recommendations regarding its use.

Charge

The MMA Artificial Intelligence in Healthcare Task Force is charged with considering the complex landscape of AI in healthcare and identifying and recommending MMA policies and/or principles that will allow for innovation while also ensuring that patients and physicians are protected. The Task Force will focus its work on several key topics related to AI:

- Transparency in the use of AI
- Potential bias in the use of AI
- Liability considerations
- Clinical decision making

Membership and Staff

1. Chairperson appointed by the Chair of the MMA Board of Trustees
2. Membership shall be drawn from the MMA's Ethics & Medical-Legal Affairs Committee and from other MMA members with interest in the issue. The Chair of the MMA Board of Trustees will have final approval of task force membership.
    a. The task force shall have up to 15 voting members, with ad hoc guests invited as needed for content expertise.
    b. Steph Lindgren, JD, Director of Government & Legal Affairs, will support the Task Force

Task Force Deliverables:

1. A summary report describing key considerations of AI in healthcare, focusing on the above identified principles.
2. A set of MMA policy recommendations to inform state legislative or regulatory efforts with respect to each of the above identified topics.

Task Force Membership

Task force membership was solicited according to the Task Force Charge. Dr. Tjaden appointed Dr. Rebecca Thomas, MD, as chair of the task force. Several announcements were made in MMA communications, soliciting interested members. The task force's composition, as well as its most active members, came from a variety of specialties, practice settings, and locations.

Name	Specialty	Organization
Karyn Baum	Internal Medicine	University of Minnesota
Sachin Dave	Internal Medicine	Mayo Clinic Health System
Saam Dilmaghani	Gastroenterology	MNGI Digestive Health
Kushal Parikh	Radiology	Midwest Radiology
Andrea Hillerud	Family Medicine	HealthPartners Bloomington Clinic
Katie McLaughlin	Medical Student	University of Minnesota Medical School
David Newman	Chief Medical Officer	Sanford Health
Thanai Pongdee	Allergy, Immunology	Mayo Clinic Health System
Michael Rigby	Neurology	Mayo Clinic Health System Residency Program
Caleb Schultz	Anesthesiology	University of Minnesota
Keith Stelter	Family Medicine, Primary Care	Mayo Clinic Health System
Shahnaz Sultan	Gastroenterology	University of Minnesota
Rebecca Thomas	Medical Oncology	
Christopher Tignanelli	Acute Care Surgery	University of Minnesota
Brinjikji Waleed	Neuroradiology	Mayo Clinic Health System

Artificial Intelligence in Healthcare

The use of artificial intelligence (AI) in healthcare is expanding at a rate that is far outpacing regulations on its use. While the use of AI in healthcare may improve patient care and relieve administrative burdens on physicians, it also raises issues of health equity, the role of the physician in clinical decision making, and liability concerns. There is currently no national policy or governance structure in place to guide the development and adoption of non-device AI. While the Food and Drug Administration (FDA) regulates AI-enabled medical devices, many types of AI-enabled technologies fall outside the scope of FDA oversight, including AI that may have clinical applications, such as some clinical decision support functions. While the Federal Trade Commission and the Health and Human Services Office for Civil Rights have oversight over some aspects of AI, their authorities are limited and not adequate to ensure appropriate development and deployment of AI generally, and specifically in the healthcare space.

Organizations such as AMA are working within the national landscape to better understand AI in healthcare and what regulations are needed. At their 2024 annual meeting, the AMA established a task force focused on "digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition this task force to a council." With no comprehensive federal oversight, states have begun enacting their own regulations, sometimes directly related to AI in healthcare and sometimes regulating the use of AI generally. Minnesota does not currently have any regulations addressing the use of AI in healthcare or AI use in general. As the use of AI expands, it's only a matter of time until legislation is introduced in Minnesota and it's paramount that Minnesota's physicians are prepared to evaluate such regulations and ensure there are adequate protections for physicians and patients.

Due to the limited time and scope of this task force, a comprehensive review of artificial intelligence regulation was not possible. The following sections provide a broad overview of the current patchwork of AI regulation focusing on those that concern AI use in healthcare as it relates to patient care. However, the majority of regulations address AI use across all sectors, without mentioning healthcare, even though use in healthcare is impacted. This overview does not include proposed or contemplated regulations.

Current Regulatory Framework

Federal data privacy and patient privacy laws include the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. These laws apply to patient information utilized by AI systems but do

not contemplate the novel questions posed when a patient's information is utilized in the training of an AI system or when the information is put into an AI system and unable to be retrieved and deleted, to name a few. Additional consumer protection and discrimination laws also apply to AI use in the healthcare setting.

The FDA regulates AI as it relates to medical devices. The law giving the FDA authority over this use defines "medical devices" as encompassing machines that are intended for use in diagnosing, treating, or preventing disease—a definition that FDA guidance documents have characterized some types of software as fitting even without being a physical device. However, in the 21st Century Cures Act, Congress made clear that many types of software fall outside the FDA's authority, including software for personal wellness functions, health care administrative functions, and providing clinical information or recommendations (not from image processing) that health care professionals will not rely primarily on.

Recent federal activity surrounding artificial intelligence:[1]

White House	• Executive Orders:
	  ○ December 11, 2025: Executive Order directing federal agencies to take legal and other action to challenge state laws regulating AI that it views as overly cumbersome or unlawful and calling for the development of a "minimally burdensome" national standard.
	  ○ November 24, 2025: Executive Order launching "Genesis Mission," a national effort to use AI in scientific research and discovery.
	  ○ September 30, 2025: Executive Order to advance the use of AI in the NIH's Childhood Cancer Data Initiative. The EO directs the MAHA Commission to identify opportunities within CCDI to strengthen data platforms and fund research that builds AI-ready infrastructure, advances predictive modeling and biomarker discovery, and optimizes clinical trial processes and participant selection, and instructs HHS, OMB, and the APST to use existing federal funds to increase investment in CCDI.
	  ○ January 2025: Executive Order to revoke the Biden Administration's AI Executive Order.
	• Trump Administration released the "Winning the Race: America's AI Action Plan," which declared U.S. global dominance in AI a national imperative and outlines a comprehensive roadmap based on three key pillars: innovation, infrastructure, and international diplomacy.
	• Policies on federal AI use and procurement (April '25).
	• Public comment on AI Action Plan (concluded mid-March '25).

[1] Manatt Health: Health AI Policy Tracker - Manatt, Phelps & Phillips, LLP

	• OMB issued a memo focused on government adoption of AI services. • General de-regulatory approach and emphasis from administration on using AI to identify instances of fraud, waste, and abuse.

Congress	• In November 2025, the House Energy and Commerce Committee's Oversight and Investigations Subcommittee convened a hearing on the risks and benefits of AI chatbots. The hearing focused significantly on the use of general-use AI chatbots for mental health support and health information.
	• In October 2025, the Senate HELP Committee held a hearing to examine opportunities to leverage AI across health care, education, and the workforce, including to streamline clinical trials and reduce administrative burdens.
	• H.R. 1:
	  ○ Initial drafts included a 10-year moratorium on state legislation of AI. After much debate, this provision was struck from final law on July 4, 2025.
	  ○ The Rural Health Transformation Fund – authorized under H.R. 1 – focuses on state investment in technology platforms.
	• Bills to:
	  ○ Establish an AI SANDBOX program (September 2025).
	  ○ Establish the National AI Research Resource initiative (March 2025).
	  ○ Allow AI and machine learning to prescribe medication (January 2025).
	  ○ Allow Medicare payment pathway for AI-enabled devices (April 2025).

HHS Appointments and Announcements	• In December 2025, HHS released an agency-wide AI strategy. • In September 2025, HHS announced it doubled funding for the Childhood Cancer Data Initiative at the National Cancer Institute, designed to accelerate the development of improved diagnostics, treatments, and prevention strategies by leveraging AI, in line with President Trump's EO on AI. • In May 2025, HHS designated Peter Bowman-Davis acting Chief AI Officer at HHS. • In May 2025, Secretary Kennedy indicated that HHS is already leveraging AI in standard operations, with attention to advancing novel treatments. The week before inauguration in January, HHS announced they'd hired three executive positions: Chief AI Officer (Dr. Meghan Dierks), Chief Data Officer (Kristen Honey), and Chief Technology Officer (Alicia Rouault), all central to Biden's AI strategy roadmap. In mid-February, it was reported that all three executives were on administrative leave. As of December 8, 2025, the HHS Employee Directory indicates Kristen Honey remains an HHS employee, serving as Chief Data Officer. Alicia Rouault and Dr. Meghan Dierks left HHS in May 2025.
OCR	• Non-Discrimination rule is subject to ongoing litigation; the first Trump Administration reversed a prior version of the rule.

ONC	• In May 2025, ONC and CMS issued a request for information seeking public feedback on digital tools—including AI—that can improve Medicare beneficiary access, improve interoperability, and reduce administrative burden.
CMS	• In December 2025, CMS launched a new model, the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS). • In September 2025, released updated CMS Artificial Intelligence Playbook. • CY2026 Proposed Medicare Physician Fee Schedule requested public comments on appropriate payment strategies for software as a service and artificial intelligence. • On June 27, CMS launched a new model, the Wasteful and Inappropriate Service Reduction (WISeR) Model, to partner with technology companies to use AI to "improv[e] and expedit[e]" prior authorization process compared to Original Medicare's existing processes to reduce fraud for several services/products. • In final rule for CY 2026, CMS chose not to finalize provisions regarding Medicare Advantage use of AI but acknowledged the "broad interest" in AI and "will continue to consider the extent to which it may be appropriate to engage in future rulemaking in this area." • In May 2025, ONC and CMS issued a request for information seeking public feedback on digital tool—including AI—that can improve Medicare beneficiary access, improve interoperability, and reduce administrative burden. • Under the Meaningful Measures 2.0 strategy, CMS is prioritizing digital quality measures, including using AI to identify and address quality issues. • Dr. Mehmet Oz, the new administrator for CMS, has been reported as promoting the use of artificial intelligence at CMS, in particular to combat fraud, waste and abuse, and possibly using AI avatars instead of frontline health care workers as a way to reduce costs without compromising quality. • MACPAC presented study findings on the use of AI in prior authorization processes in Medicaid (Feb '25)
FDA	• On December 5, 2025, FDA published a regulatory notice announcing the Technology Enabled Meaningful Patient Outcomes (TEMPO) Pilot, in connection with the CMMI ACCESS model (described above). • In November 2025, the FDA's Digital Health Advisory Committee, together with relevant staff, discussed defining the line between "AI companions," mental-health chatbots, and clinical decision-support tools.

	• In September 2025, FDA issued a request for public comment on approaches to measuring and evaluating AI-enabled medical device performance in the real world. • Draft guidance for developers of AI-enabled medical devices. • In June 2025, launched "Elsa" to support departmental efficiency • In May 2025, FDA announced completion of its first AI-assisted scientific review pilot and agency-wide AI rollout. • In May 2025, Jeremy Walsh was hired as FDA's chief AI officer and head of IT.
NIH	• In June 2025, NIH requested public comment to inform an institute-wide AI strategy.
DOJ	Litigation continues over alleged use of AI to deny Medicare Advantage claims. In June 2025, DOJ announced charges against over 300 defendants for participation in health care fraud schemes, with a parallel announcement from CMS on the successful prevention of $4 billion in payments for false and fraudulent claims.
FTC	• In September 2025, FTC announced the launch of an inquiry into AI chatbots acting as companions, with particular attention to the impact of these chatbots on children and teenagers. • In September 2025, FTC issued a request for public comment on measuring and evaluating the performance of AI-enabled medical devices. In January 2025, FTC published a blog post noting department's focus on potential AI harms and also reinforced that existing laws apply to AI technologies. This post, and other posts focused on AI, were taken down in October 2025.

Regulating liability in the use of AI is not straightforward and unfortunately, physicians and hospitals may bear the brunt of liability. There are several ways that private parties have attempted to define liability; first, private contracting has already emerged as a leading governance mechanism. The licensing agreements that AI developers execute with health care organizations can unknowingly attempt to dispel a developer of any liability by providing boilerplate language disclaiming or limiting liability and warranties. These agreements may go as far as to say that the health care organization purchasing the AI has the responsibility for conducting post-deployment monitoring and training of clinicians who are using the AI. Developers may even insert broad restrictions on model use that disregard the reality of how models are used. For example, OpenAI's terms of use for ChatGPT state that users "must not use" model output in making medical decisions.

Physicians may well bear the brunt of liability for tools they use, even though hospitals and developers are better positioned to exert control over safety. This lack of a clear and robust regulatory framework, as showcased above, is what makes it vitally important that physicians be intimately involved in all discussions of AI regulation within the healthcare sector.

State Law Comparison

The task force relied upon information compiled by Manatt tracking healthcare AI legislation across the country.[2] As of June 30, 2025, Minnesota was not one of the 17 states with healthcare AI legislation.[3] States have taken various approaches to regulating the use of AI. State regulation has generally fallen under one of several themes, including heightened attention on AI chatbots (particularly related to mental health); use of AI in clinical care; transparency; payor use of AI; and the emergence of "AI Sandboxes" for testing of innovative AI tools.

MMA Task Force on Artificial Intelligence in Healthcare Work and Recommendations

The task force met five times virtually. The task force was provided with an overview presentation on the status of AI regulation. In order to reach common nomenclature, the task force generated a list of definitions for key AI terms. The task force then generated a set of principles for the use of AI in healthcare in Minnesota as it relates to each of the four identified key topics in the task force charge. Once those principles were finalized, the task force identified gaps and barriers that exist between the status quo and the realization of the principles; the task force identified and built policy recommendations to address these gaps and barriers.

The first meeting of the task force was an overview of the charge, introductions, and an overview of the current state of AI in healthcare. The task force had a presentation from Kimberly Horvath, JD, Senior Attorney, American Medical Association.

At their second meeting, the task force addressed transparency in the use of AI. Transparency involves what information must be communicated about AI use between relevant entities engaging in such use, such as between a physician and a patient; a physician and a hospital or state; and/or from a hospital, state, or AI developer to a physician. The task force heard a presentation from Shannon Curtis, JD, Assistant Director for Federal Affairs, American Medical Association.

The third meeting was dedicated to the potential for bias in the use of AI in healthcare. The task force heard a presentation from Christopher Tignanelli, MD MBA MS FACS FAMIA, Associate Dean, Data Science, UMN Medical School; Scientific Director, Program for Clinical Artificial

[2] communications.manatt.com/l/745343/2025-07-30/49ryy8/745343/1753893668PWsiePez/Manatt_Health_AI_Tracker_All_Passed_Bills_2025.07.25.pdf
[3] Manatt Health: Health AI Policy Tracker - Manatt, Phelps & Phillips, LLP

Intelligence, UMN Center for Learning Health Systems Science; Director, UMN Center for Quality Outcomes, Discovery and Evaluation.

At their fourth meeting, the task force considered both liability and clinical decision making in the use of AI in healthcare. These topics were combined due to the inevitable overlap. Liability focuses on what liability, if any, does a physician potentially face for the use or non-use of AI tools in an administrative or clinical setting. The topic of clinical decision-making focuses on who is making the ultimate clinical decision that will impact the patients' care and what considerations were made when coming to that decision.

The task force then received a draft report of this summary report, including the principles and policies for review and consideration.

The last meeting of the task force took place on February 26, 2026. At this meeting, the task force reviewed their final report and recommendations. A quorum was not present, so the report was sent out via electronic communication to the task force members for a vote. The task force unanimously voted to approve and propose their recommendations to the MMA's Board of Trustees.

Artificial Intelligence Definitions

The task force agreed on several key definitions related to AI. The task force also approved of the use of the term "artificial intelligence" as opposed to "augmented intelligence." However, the task force did not approve of a standard definition of AI. Definitions vary widely in regulations and statutes. Because of this the task force thought it best to not limit what is considered AI and instead agreed that AI refers to the ability of computers to perform tasks that are typically associated with a rational human being.

Automated Decision-Making

A type of AI in which data and algorithms are used to make decisions without human intervention.

Bias

Prejudices in favor of or against a person, thing, or entity. Algorithm bias occurs when there is an underlying problem or flaw with the algorithm used to deliver outputs. Data bias occurs when the data used to train AI systems is biased in some way.

Black box

The inability of a user to understand the specific steps taken by an algorithm that lead to an algorithm's final output.

Generative AI
Artificial intelligence systems that are capable of generating novel text, images, videos, or other outputs, typically based on foundation models. Foundation models are models trained on large datasets – and thus broadly applicable – and can be adjusted for specific applications.

Machine Learning
A subtype of AI in which complex algorithms are trained to make predictions about future outcomes. Machine learning can be supervised or unsupervised.

Transparency
Refers both to the ability to access information about an AI model's training data and model details as well as the disclosure and documentation of the utilization of AI in health care decision-making.

MMA Task Force on Artificial Intelligence in Healthcare Principles and Policy Recommendations

The MMA Task Force on Artificial Intelligence in Healthcare believes that the MMA should encourage the appropriate use and regulation of AI in the provision of healthcare in Minnesota. AI use will continue to expand and evolve, and it is important that physicians take this opportunity to ensure that the needs of physicians and patients are considered.

The task force was guided by the belief that AI should be used to complement medical practice, not to replace a physician's role in medical decision making. The task force felt strongly that AI should not be used to make final healthcare determinations. Those decisions must continue to be made by a healthcare professional.

Principle 1: Artificial intelligence is a rapidly evolving aspect of medical practice, and physicians need to be prepared to understand and, as appropriate, adapt to the changing landscape.

Policy:

a) The MMA advocates for the continued evaluation and monitoring through a state sponsored advisory committee to continually review and improve regulation of AI in healthcare.
b) The MMA advocates for the inclusion of comprehensive AI education in medical school, post graduate curricula, and continuing professional development.
c) The MMA supports the development of a comprehensive regulatory framework for the use of AI in healthcare.
d) The MMA aims to monitor AI regulations that impact healthcare and educate its members on their impact.

Principle 2: Individuals have the right to transparent, honest, and timely information pertaining to their healthcare.

Principle 3: Physicians have a responsibility to educate themselves on artificial intelligence enabled tools utilized in their medical practice.

Policy:

a) The MMA encourages clinical uses of AI that have the potential to impact patient care, or a physician's clinical decision, be disclosed to a patient.
b) The MMA advocates for disclosure of the use of AI in clinical decision communications that have not been reviewed and approved by a healthcare professional.
c) The MMA encourages specialty societies to educate their members on specific AI tools and how to best evaluate and apply them.
d) The MMA encourages developers of AI to provide detailed information about an AI tool including, the AI's intended uses, training data, data collection practices, and risk and discrimination mitigation strategies, to deployers of AI in an effort to promote transparency and accountability.
e) The MMA encourages facilities to make available to their clinicians detailed information about AI tools utilized within the facility.

Principle 4: All patients have a right to receive unbiased healthcare.

Policy:

a) The MMA supports equitable access to the benefits of AI by all patient populations.
b) The MMA acknowledges that the use of AI in healthcare carries a considerable risk of codifying and/or exacerbating existing social inequities.

c) The MMA acknowledges that accounting for bias in AI model design, training, and use is essential in helping to mitigate biases.
d) The MMA encourages policies requiring rigorous and continuous evaluation of AI models for bias when they are used in the healthcare setting.
e) The MMA expects that immediate action will be taken to correct or mitigate encountered bias.

Principle 5: Artificial intelligence should not replace a physician's recommendation for the provision of healthcare.

Policy:

a) The MMA supports efforts to ensure that healthcare professionals always make the final decision regarding the provision of healthcare.
b) The MMA opposes coverage denial processes that utilize AI to deny coverage for a healthcare service without the meaningful input of a healthcare professional.
c) The MMA opposes requirements from payors, hospitals, health systems, or governmental entities mandating the use of an AI tool for clinical decision making as a condition of licensure, participation, payment, or coverage.

Principle 6: Liability for harm involving artificial intelligence should be focused on the party that is in the best position to identify and mitigate the harm.

Policy:

a) The MMA acknowledges the evolving role of AI in healthcare and therefore, the evolving understanding of liability for the use of AI in healthcare. The MMA supports policies that hold physicians liable only for their own clinical decision making.
b) The MMA encourages multidisciplinary governance structures within systems that monitor and evaluate the performance and use of AI tools within their system and provide transparent information to clinicians within the system.