

## April 18, 2025: National Advocacy Update



### House introduces AMA-supported legislation to alter portions of physician-owned hospital ban

Ever increasing hospital consolidation is one of myriad factors contributing to rising costs within the American health care system. The effort to utilize congressional intervention to promote more competition within the hospital sector took a major step forward following the introduction of H.R. 2191, the Physician Led and Rural Access to Quality Care Act, toward the end of the opening quarter of the 119th Congress. The AMA officially renewed its support of this bipartisan legislation that seeks to partially remove the current ban on physician-owned hospitals in an [April 9 letter](#) (PDF).

Introduced by Representatives Morgan Griffith (R-VA), Vicente Gonzalez (D-TX), Kevin Hern (R-OK) and Lou Correa (D-CA), this bipartisan legislation permits physician ownership of rural hospitals so long as these facilities are more than a 35-mile drive from a main patient campus or critical access hospital (CAH). The legislation also stipulates more lenient criteria for physician ownership of hospitals in extremely remote localities, specifically within a 15-mile drive of a CAH in the case of mountainous terrain or areas that only have secondary roads. Finally, H.R. 2191 permits the expansion of all physician-led hospitals built before the current ban went into effect following enactment of the 2010 Affordable Care Act. Introduced on March 18, H.R. 2191 currently has 16 bipartisan House cosponsors.

Senator James Lankford (R-OK) introduced a Senate companion bill, S. 1390, on April 9. Six additional GOP senators joined as original cosponsors of this important legislation. This compromise bill should attract more Democratic support as it seeks targeted, incremental changes rather than a full repeal of the current ban on physician-owned hospitals. As a result, the AMA is working diligently with other members of the Federation to identify a democratic senator willing to serve as a co-lead on this crucial legislation, as well.

### Practices continue to experience issues in wake of Change Healthcare cyberattack

In an April 11 [letter to Optum](#) (PDF), the AMA asked for help for physician practices that are still suffering severe financial distress as a result of the Change Healthcare (CHC) cyberattack nearly 14 months after the breach was first discovered. The AMA has been hearing from practices about



Optum's strict measures related to repayment/recoupment of loans to practices after the cyberattack and the resulting outage, as well as how claims from the period associated with CHC's outage are being rejected for not meeting UnitedHealthcare's (UHC) timely filing deadlines.

In line with UnitedHealth Group CEO Andrew Witty's testimony before the Senate Finance Committee on May 1, 2024, the AMA urged Optum to utilize an individualized, practice-by-practice approach for recouping CHC cyberattack-related loans and not ask for loan repayment until the physician determines that their business is back to normal. Loan repayment issues have been further compounded as many practices continue to see claims rejected because they could not meet timely filing deadlines from the period associated with the cyberattack when CHC was not operational. The letter also encouraged Optum to work with UHC to suspend all claim filing deadlines associated with the cyberattack when practices were unable to appropriately file claims and other payers to follow UHC's lead.

In a written response to the AMA, Optum stated that it has and will continue to actively work with providers to identify flexible repayment plans based on the individual circumstances of providers and their practices. Optum maintained its collaborative approach includes multiple opportunities for provider engagement on repayment conversations and possibilities around payment plans.

In addition, Optum agreed that payers should be flexible in their review of claims for services delivered immediately before or during the period when Change Healthcare's systems were disrupted. The letter also describes how Optum is working with UnitedHealthcare to ensure the claims it receives are reviewed in light of the challenges providers experienced, including waiving timely filing requirements for the plans under their control. Optum offered to work with the AMA to discuss what more could be done to support physicians.

## **Conrad 30 expansion legislation reintroduced in House**

The AMA sent an April 11 [letter](#) (PDF) in support of the Doctors in our Borders Act (H.R. 1201), reintroduced in the 119th Congress by Reps. Michael Lawler (R-NY) and Yvette Clarke (D-NY). This legislation would expand the Conrad 30 program by increasing the number of waivers a state or regional commission can receive from 30 to 100.

Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country for two years after their residency has ended. The Conrad 30 program allows these physicians to remain in the U.S. without having to return to their home country if they agree to practice in an underserved area for three years. With a pending U.S. physician shortage of nearly 86,000 by 2036, support for and expansion of the Conrad 30 program is crucial to ensure continued care in medically underserved communities. With many communities, including rural and low-income urban districts, already experiencing problems meeting their patient care needs 70



additional physicians in these areas would greatly increase patient access to these much-needed physicians.

## CMS Administrator Oz shares vision for the agency

On April 10, the newly sworn-in Centers for Medicare & Medicaid Services (CMS) Administrator Mehmet Oz, MD, shared his vision for the agency. Specifically, Dr. Oz outlined four priorities as follows:

- Empowering the American people with personalized solutions so they can better manage their health and navigate the complex health care system. As a first step, CMS will implement the President's Executive Order on Transparency to give Americans the information they need about costs.
- Equipping health care providers with better information about the patients they serve and holding them accountable for health outcomes, rather than unnecessary paperwork that distracts them from their mission. For example, CMS will work to streamline access to life-saving treatments.
- Identifying and eliminating fraud, waste and abuse to stop unscrupulous people who are stealing from vulnerable patients and taxpayers.
- Shifting the paradigm for health care from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management. For example, CMS operates many programs that can be used to focus on improving holistic health outcomes.

The AMA wrote (PDF) to Dr. Oz to congratulate him on his confirmation and to highlight opportunities to work together to advance his goals for improving patient care for those insured by the federal programs under his leadership based on his testimony at his confirmation hearing. The letter highlighted the AMA's work to improve Americans' health outcomes, particularly to prevent cardiovascular disease and type 2 diabetes, and emphasized our agreement on the excessive utilization of prior authorization.

The AMA strongly agreed with Dr. Oz's comments about rethinking the way value-based payment models have been designed, the need to provide more real-time information to physicians at the point of care, and the importance of continuing Medicare coverage of telehealth. The AMA appreciated Dr.



Oz's recognition of the country's tragic maternal mortality crisis and outlined solutions to prevent unnecessary deaths. The AMA also offered to be a resource, including in his efforts to advance policies that strengthen oversight of Medicare Advantage plans while maintaining fair reimbursement for physicians and to reduce the prices paid by patients for prescription drugs.

## **AMA weighs in on FDA AI draft guidance**

On April 1, the AMA submitted comments on the Food and Drug Administration's (FDA) draft guidance *Artificial Intelligence-enabled Software Functions: Lifecycle management and Pre-Market Submissions*. The guidance, released in early January, was a long-awaited next step toward comprehensive guidance for AI-enabled medical devices. Importantly, the guidance outlined FDA recommendations for elements such as performance validation, device cybersecurity, user interface design, product labeling and others. The AMA welcomed the proposed recommendations as a critical step towards providing additional information about AI-enabled devices to end users. The AMA has long advocated for mandated transparency for AI-enabled health care technologies and in particular has urged FDA to update its labeling recommendations to provide additional transparency and clarity for physicians utilizing AI-enabled devices. The AMA recommended that FDA move toward finalization of this guidance, suggesting that the agency engage with physician organizations to ensure that final recommendations meet the needs of physicians and other end users.

## **People nearing 65 should be informed of Medicare late enrollment penalty**

In a [letter to CMS \(PDF\)](#), the AMA urged that the agency work with the Social Security Administration to ensure that people nearing the age of 65 understand the deadlines for enrolling in Medicare Part B so that they do not unknowingly face late enrollment penalties. The law provides a seven-month window for people to enroll in Part B, from three months before the month they turn 65 until three months after. People who do not enroll during that window must pay late enrollment penalties that are added to their Part B premiums for the rest of their lives. Previous generations of Medicare enrollees were less likely to face these penalties because 65 used to be the age of eligibility for both Medicare and Social Security. Now, however, some people elect to receive Social Security at age 67, so it is easier to miss the deadline to enroll in Medicare.

The letter also noted problems for people who retire and decide to get their health insurance through COBRA instead of Medicare. Besides being expensive, reliance on COBRA can lead people to miss the deadline for Medicare enrollment and be subject to late enrollment penalties. A third concern described in the letter is the need to provide better information to people about their enrollment



choices when they become Medicare eligible, specifically the differences between traditional Medicare and Medicare Advantage. For example, many people are not informed about the differences and implications of networks, prior authorization, cost-sharing, and access to Medicare supplemental insurance, depending on coverage by traditional Medicare or a Medicare Advantage plan. The AMA recommends that the government create a comprehensive checklist for people approaching age 65 and widely distribute it to help close these knowledge gaps.

## **CMS releases rules on Medicare Advantage and Part D**

CMS recently finalized several Medicare Advantage (MA) and Part D policies for 2026 with significant implications for physicians. In the [CY 2026 Final Rate Announcement](#) (PDF), CMS provided a 5.06% average expected revenue increase for MA plans, driven by a 9.04% effective growth rate. The AMA had previously highlighted such sizable payment increases in a [press statement](#) in response to the [CY 2026 Advance Notice](#) (PDF), noting that plans continue to receive substantial increases while physician payments remain under strain.

The [CY 2026 MA & Part D Final Rule \(CMS-4208-F\)](#) (PDF) finalized several MA reforms including prior authorization-related updates, such as requiring MA plans to honor inpatient prior authorization approvals through discharge and applying appeal rights to decisions made during ongoing treatment. CMS also finalized guardrails for Special Supplemental Benefits for the Chronically Ill (SSBCI), as well as policies to improve the experience for dual-eligible enrollees.

However, CMS declined to finalize several key [AMA-backed](#) (PDF) proposals, including expanded Part D coverage of anti-obesity medications, expanded guardrails for artificial intelligence, and utilization management reforms aimed at bolstering transparency. Additional AMA-supported provisions to improve the Medicare Plan Finder and agent/broker oversight were also deferred. The AMA will continue to monitor regulatory activity and seek opportunities to continue to advocate our positioning on any non-finalized proposals.

## **AMA urges Trump administration to ensure functionality of student loan programs**

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. Therefore, on April 14, the AMA sent a letter (PDF) to the U.S. Department of Education and the Small Business Administration (SBA) noting strong concerns surrounding the continued delay on the processing of income-driven repayment plan applications as well as apprehension concerning potential changes to the Public Service Loan Forgiveness program. The AMA also noted apprehension about switching federal student loans over to the SBA. The AMA



advised the administration to consider the negative repercussions of changes in this space and to minimize disruptions to borrowers.

## **CMS reminds physicians to report managing employees**

CMS reminded physicians to report all current managing employees. Managing employees are general managers, business managers, administrators, directors or other individuals who exercise operational or managerial control or directly or indirectly conduct day-to-day operations either under contract or through some other arrangement, whether or not the individual is a W-2 employee. While not an exhaustive list, CMS also provided these titles as examples of managing employees: Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Compliance Officer, Regional Manager, Clinical Manager, Operations Manager, Care Coordination Manager, Location Manager, Administration Manager, Compliance Director and Clinical Director. To make updates about current managing employees, physicians or their staff members should submit an 855 enrollment application in [PECOS](#) or mail a paper application to their [Medicare Administrative Contractor](#) (PDF). If this information is out of date, CMS may deactivate a physician's enrollment. For more information, CMS points to the [Medicare Program Integrity Manual, Chapter 10](#) (PDF).

## **More articles in this issue**

- April 18, 2025: State Advocacy Update