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REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-25

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee G

INTRODUCTION

At the 2024 Annual Meeting of the AMA HOD, Policy D-200.971, "Transparent Reporting of Physician Complaints Against Hospitals and Health Systems" was adopted as amended, and in the first directive asked that AMA "supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as The Joint Commission Quality Check reports, to include periodic report back to the HOD with the first update to be given at A-25." This report specifically addresses the report-back requirements of the first directive of this policy. The second directive of the policy is not a topic of this report

BACKGROUND:

AMA's Position

The AMA has consistently opposed making the National Practitioner Data Bank publicly available (Policy H-355.975, "Opposition to the National Practitioner Data Bank") and upheld this position in BOT Report 29-A-24, citing concerns over incomplete and inaccurate information. The AMA also opposes requiring the AMA, FSMB, The Joint Commission, or any state or federal entity to publicly disclose disciplinary actions to avoid potential misinterpretation and misuse of the data. Instead, the AMA supports state medical boards in making general information about disciplinary actions public, and the FSMB Physician Data Center, which provides information to hospitals and health care organizations about licensure history and past regulatory actions for actively licensed physicians (Policy H-355.975, "Opposition to the National Practitioner Data Bank").

The AMA has also traditionally rejected efforts to amend the HCQIA and maintained this position in BOT Report 29-A-24 where no recommendation was made to add monetary penalties for organizations involved in bad-faith peer reviews. The position to not amend the HCQIA was taken to protect the peer review process and the safety of the physicians that participate in them and prevent entities whose interests are not aligned with organized medicine from reintroducing changes that have previously been proposed. It is also a costly and challenging endeavor to provide tangible evidence that a hospital or health care organization has engaged in a bad-faith peer review. Additionally, as it currently stands, the HCQIA already does not provide immunity to organizations found to have conducted a bad-faith peer review. Further, monetary penalties at the state level have not resulted in increased reporting or reduced incident rates.[1,2]

DISCUSSION:

BOT Report 29-A-24

BOT Report 29-A-24 highlighted persistent barriers that prevent physicians from reporting patient care concerns or seeking recourse when subjected to a bad-faith peer review process. It identified interests that often prompt the initiation of bad-faith peer reviews, including retaliation for raising patient care concerns, efforts to limit competition, and racism. The report also outlined existing mechanisms for physicians to report concerns about their health system or hospital employer, as well as relevant AMA policies and resources. It recommended reaffirming these policies and urged the AMA to (1) support and facilitate transparent reporting of final physician complaints against hospitals through publicly accessible channels (e.g., the Joint Commission Quality Check reports), and (2) develop educational materials to help physicians recognize a bad-faith peer review and navigate the peer review process.

Status Update

To fulfill the AMA's responsibility to "support and facilitate transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports," the AMA sent a letter to the President and Chief Executive Officer of The Joint Commission, urging the Joint Commission to facilitate transparent reporting of patient care, safety concerns, or other inappropriate practices that physician employees observe within their hospital or health system.

The letter was sent to The Joint Commission in November 2024 wherein the AMA urged them to collect and publicly share final complaint determinations related to patient and staff safety violations to contribute to efforts to improve patient safety, care quality, and assist physicians in making informed decisions about where to work. The AMA recommended that one way The Joint Commission could achieve this was by developing a new reporting tool or enhancing its existing publicly available Joint Commission Quality Check reports.

The Joint Commission's President and Chief Executive Officer promptly replied, acknowledging receipt of the letter and its important subject matter. The letter was well-received and coincided with current efforts at The Joint Commission to improve transparency around safe practices in health care organizations and their Quality Checks program.

A meeting between the AMA and The Joint Commission occurred in March 2025 to further discuss this issue. Although The Joint Commission is appreciative of the AMA's efforts, they reported that publicly disclosing details about complaints—particularly at the level of disclosing individual organization information—would run counter to the agreements and accountabilities they hold with the organizations they accredit. They are also revising their Quality Check Reports to provide additional metrics by accredited organization, but their revisions will not include information about voluntary complaints. The Joint Commission recommended that the AMA look to the state medical societies and licensing boards to collect and report on such information relevant to health care organizations in their jurisdictions. Additional recommendations discussed include continuing the promotion of existing AMA initiatives (e.g., Joy in Medicine™ Health System Recognition Program) that provide guidance for physicians assessing potential employers and staying informed on emerging employee safety metrics. The AMA will continue exploring additional avenues to facilitate transparent public reporting of physician employees' concerns related to patient or staff safety, or other serious misconduct, by hospital and health system employers.

The AMA considered sending a similar letter to the EEOC; however, since the EEOC is required by law to keep charge information confidential and is prohibited from disclosing information about charges to the public[3], no communication was sent.

RECOMMENDATIONS

The Board of Trustees recommends:

1. That the first directive of Policy D 200.971 be amended by addition and deletion as follows: Our American Medical Association supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports and will report back to the HOD every two (2) years through 2029 any AMA and/or industry efforts to advance this effort. ~~to include periodic report back to the HOD with the first update to be given at A-25.~~
2. That the remainder of this report be filed.

Fiscal Note: Minimal

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REPORT 19 OF THE BOARD OF TRUSTEES (A-25)
Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
Reference Committee G

EXECUTIVE SUMMARY

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy D-460.962, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," was adopted. This report addresses the first directive of this policy which asked that our American Medical Association (AMA) "monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout" (Directive to Take Action). A separate report has been developed that addresses the second directive of this policy.

This report provides a literature review on the use of biometrics to study physician wellbeing. Relevant AMA policies are also detailed. Nine studies published between 2015 and 2025 were included in the review. The inclusion criteria were U.S.-based studies that used and reported biometric data to study professional wellbeing and included physicians as study participants. Various practice settings were studied including neurology, adult and pediatric emergency medicine, surgery, primary care, and academic medicine.

Most studies in the review used a wearable wrist-worn device to measure biometric data. Heart-related biometrics were the most common biometric data collected. Other biometric data included sleep-, respiratory-, exercise-, skin-, hormonal-, and ocular-related biometrics.

The review identified three major themes: (1) the use of biometric data to identify physiological biomarkers of physician stress and burnout; (2) the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations; and (3) the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing.

Limitations identified in the studies reviewed were inconsistent wearing of the devices, technical challenges and inappropriate use of devices, short observation periods, and a lack of systematic use of validated burnout, depression, and anxiety measures.

This review has implications for research, clinical practice, and organizational leadership. Additionally, the studies reviewed shed light on short- and long-term impacts of work-related stressors on physician health. Included studies present the opportunity for efforts that facilitate early detection and mitigation of burnout. Future research using biometric data to measure physician wellbeing should incorporate organizational- and practice-specific variables to better understand factors that contribute to physician burnout.

As the literature review accomplishes the goal of monitoring and reporting on the research around the use of personal and biological data to examine physician wellbeing, the AMA Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded (Rescind HOD Policy).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-25

Subject:	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee G

INTRODUCTION

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy D-460.962, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," introduced by the Integrated Physician Practice Section, was adopted. This report addresses the first directive of this policy which asked that our American Medical Association (AMA) "monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout" (Directive to Take Action). A separate report has been developed that addresses the second directive of this policy.

BACKGROUND:

Physician burnout

Physician burnout is defined as "emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness" and impacts all physicians.[1] The dangers of physician burnout are significant and widespread, resulting in adverse outcomes not only for physicians—such as broken relationships, problematic alcohol use, and suicidal ideation[2]—but also for patients and the health care system at large. For instance, physician burnout has been shown to result in increased medical errors and malpractice suits[3–5], and physicians reducing their clinical hours or leaving the profession altogether.[6–12] Compared to other U.S. workers, physicians work longer hours and experience worse work-life integration.[2] Burnout is also associated with higher health care expenditures.[13–15]

Many factors, both at the system and practice level, can contribute to burnout, including high physician task load[16], poor work-life integration[17], administrative burdens related to electronic health records (EHRs)[15,18–24], and regulatory burden.[25–27] A lack of work control[28] and being unable to take vacation or having to work while on vacation also are associated with increased risk of burnout[29]. Additionally, the politicization of medical care[30] and childcare stress[31] during the COVID-19 pandemic have been associated with burnout.

Measuring burnout and wellbeing

Physician burnout is commonly measured using validated survey instruments. One of these surveys is the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), a 22-question instrument

released in 1981 that's considered the "gold standard" for assessing burnout.[32,33] The survey covers three areas—emotional exhaustion, depersonalization, and a low sense of personal accomplishment. Responses to questions covering these areas are rated by frequency: never, a few times a year or less, once a month or less, weekly, a few times a week, or daily. Researchers typically consider respondents to present at least one symptom of burnout if they have high scores on either the emotional exhaustion or depersonalization subscales.[33]

Developed for use in physicians and non-physician providers, the Mini-Z survey is a ten-question tool adapted from the Minimizing Error Maximizing Outcome clinician survey.[34,35] It was designed to assess workplace satisfaction, stress, and burnout. Additionally, it captures factors including work control, value alignment with organizational leadership, teamwork, documentation time pressure, and EHR use. The Mini-Z single item burnout measure has demonstrated good correlation with the MBI-HSS emotional exhaustion subscale[34] and thus, when researchers are solely interested in this subscale, they may use a single-item burnout measure like that from the Mini-Z to reduce survey length and increase response rates.[36] Since its development, it has been adapted for use in nurses, residents, medical students, and others.[35]

The Mini-Z tool is an essential part of the Organizational Biopsy®, an assessment tool offered by the AMA that measures the drivers of burnout and wellbeing at health systems and large practices.[37] The tool provides a comprehensive evaluation across four domains: organizational culture, practice efficiency, self-care, and retention.[38] It includes standardized questions on leadership, team culture, efficiency, and individual wellbeing. It also has demographic questions to aid health systems in identifying vulnerable populations in need of greater support, as well as customizable questions to gain insights into organization-specific concerns.[37]

As single-item burnout measures have been critiqued for providing an incomplete view of physician wellbeing, researchers from Stanford developed and validated the Stanford Professional Fulfillment Index—a comprehensive tool that captures key aspects of professional fulfillment, including satisfaction, engagement, happiness, and meaningfulness.[39] The instrument is a 16-question survey designed for physicians. It measures three areas: professional fulfillment, work exhaustion, and interpersonal disengagement using a five-point Likert scale. Higher professional fulfillment scores indicate greater wellbeing, while higher work exhaustion and interpersonal disengagement scores reflect greater burnout.[33]

The Patient-Reported Outcomes Measurement Information System (PROMIS) is a set of person-centered measures assessing physical, mental, and social health in both the general population and those with chronic conditions. It was designed to enhance clinician-patient communication across diverse research and clinical settings.[40] Although PROMIS has been widely used to measure patient outcomes, some studies have utilized PROMIS measures to evaluate aspects of physician health, including sleep-related impairment and mental health. For instance, one study used PROMIS to examine the relationship between sleep-related impairment and occupational wellness indicators such as work exhaustion, interpersonal disengagement, overall burnout, and professional fulfillment.[41]

In addition to surveys, factors that contribute to physician burnout have also been measured using EHR user audit log data[20,42,43], and through qualitative methods such as interviews[44–46] and focus groups[47,48]

Biometrics

"Biometrics" has emerged as another way of studying burnout and factors that contribute to it. It is the science of using measurable characteristics—often categorized into physiological or behavioral traits—to describe individuals.[49] It provides objective indicators of stress through sensors such as patient monitors or wearable devices that capture physiological changes associated with sympathetic nervous system activity (e.g., heart rate, respiratory rate, finger prints, retinal vessel patterns, and skin temperature).[49,50]

Until recently, studies aimed at measuring physiologic data to track and develop interventions designed to mitigate stress were conducted in a laboratory with participants attached to bulky cable monitor apparatuses to collect biometric data or via self-reported studies. Such methods made the study of live conditions challenging.[49,51] Wrist-worn wearable devices (e.g., the Fitbit) originally marketed to consumers to improve fitness[49] are beginning to be used in research to collect biometric data from study participants, determine associations with stress and burnout, and identify targeted interventions. Recent innovations in wearable technology enable unobtrusive, real-time monitoring of physiological metrics related to wellbeing.[50,51]

A substantial body of literature focuses on the use of biometric data to identify stress and wellbeing in the general population. This research highlights the potential of biometric feedback for promoting self-awareness and positive behavior change, as well as innovative solutions (e.g., smartwatches and machine learning algorithms) for continuous, real-time health monitoring. For example, Ortoleva et al. (2024) found that physical data representations enhanced self-reflection and mental health intentions in university students. Participants' heart rate (HR) data was collected via EEG Muse headbands and Fitbit watches.[52] Khayyat et al. (2024) analyzed streams of physiological and behavioral data to develop a highly accurate machine learning model for monitoring psycho-physiological stress among employees.[53] Matsumoto et al. (2022) also constructed a machine learning model that aimed to improve stress prediction in older adults by correlating daily activities with biometric data. The approach increased prediction accuracy by over ten percent compared to baseline data, highlighting the potential to improve health management, quality of life, and overall wellbeing for older adults through proactive and innovative solutions.[54]

The following literature review outlines research on the use of biometrics to study wellbeing among physicians specifically.

DISCUSSION

Literature review

Objective

The purpose of this review was to evaluate and understand the current state of research on biometric data to assess physician wellbeing and inform organizational interventions to mitigate burnout.

Methods

The literature review was conducted in the Google Scholar, PubMed, and Medline databases. Studies published between the years of 2015 and 2025 were included. The studies included consisted of U.S.-based studies that used and reported biometric data to study professional wellbeing and included physicians as study participants. In Google Scholar and PubMed,

"biometrics physician well-being" and then "biometrics physician stress" were first searched but did not yield studies aligned with inclusion criteria. Studies that met the inclusion criteria were identified in the three databases when the search terms were changed. The terms, "study of clinician burnout with biometrics", "biometrics physician well-being", and "biometrics physician stress", were searched in Google Scholar. The term, "biometrics physician stress", was searched in PubMed, and "physician stress AND biometrics" was searched in Medline. A total of 13 studies were originally identified and a duplicate included from both PubMed and Medline was removed. After the titles and abstracts of the remaining 12 studies were screened, one study was excluded since it was not U.S.-based. Next, the full text of the remaining 11 articles were screened and two were removed since they did not report biometric data. In the end, nine studies were eligible to be included in the review. Figure 1 summarizes this process and can be found in the appendix of this report.

Study Characteristics

Of the nine studies included in the review, the most common type of article was a prospective study, with six studies falling into this category. There were two mixed-methods studies, one of which was a live observational usability study and the other a simulation-based study. The remaining study was a scoping review. Eight of the papers were peer-reviewed journal articles, while one was a preprint. The year of publication ranged from 2018-2024, most of which were published within the last five years.

Regarding study samples, all but one study exclusively included physicians—attendings, trainees, residents, fellows, and faculty—while the remaining study also included nurses and medical students. Specialties and practice settings represented among the studies included neurology, emergency medicine (adult and pediatrics), surgery, primary care, and academic medicine.

Seven of the studies used a wearable device—either wrist-worn or a smart shirt—to measure biometric data, while the remaining two used a wearable eye tracking device and a patient monitor in which physicians were affixed to during surgery and had a blood pressure (BP) cuff, pulse oximeter probe, and nasal cannula placed onto them. The most common biometric data collected were heart-related, including heart rate variation (HRV), heart rate (HR), BP, and rate pressure product. Only one study in the review did not collect and/or report these biometrics. Sleep-related biometrics were also collected (e.g., sleep status level and total nightly sleep time), in addition to respiratory-related biometrics (e.g., oxygen saturation, end-tidal carbon dioxide, and respiratory rate). Physical activity and movement-related biometrics that were collected were strain, workout strain, total workouts per 24-hour period, and accelerometry. Other biometrics that were measured involved the skin (skin temperature and electrodermal activity), hormones (hair cortisol level), and eyes (gaze location/fixation and pupil dilation). Figure 2 in the appendix summarizes the characteristics of the nine studies included in this review.

Three major themes were identified in the studies. The first theme was the use of biometric data to identify physiological biomarkers of physician stress and burnout. The second theme was the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations. The final theme to be addressed in this review is the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing.

Theme 1: Use of Biometric Data to Identify Physiological Biomarkers of Physician Stress & Burnout

Six studies, Barac et al. (2024), Kaczor et al. (2020), Ciraulo et al. (2022), Slamon et al. (2018), Wolfe et al. (2022), and Akbar et al. (2021), sought to identify physiological biomarkers of physician stress and/or burnout using biometric data. Barac et al. broadly focused on health care professionals (physicians, medical students, and nurses), while the other four studies were specialty-specific (emergency medicine and surgery). Barac et al., a scoping review, included ten papers and did not find any reliable associations between physiological measures derived from wearable wrist-worn devices and clinician burnout. However, the scoping review did identify associations between step count and time in bed with depression symptoms, and heart-related biometrics (HR and HRV) with acute stress.[55]

Kaczor et al. aimed to determine whether physiological biomarkers of stress among physicians during their clinical work could detect stress in the emergency medicine setting. All participants successfully wore a wearable sensor for nine clinical shifts over the course of six months. Findings showed that wearable sensors detected stress 20 minutes before individuals self-reported stress. This suggests the possibility of either delayed reporting or delayed stress awareness among physicians, and highlights an opportunity for interventions that support early detection of stress to improve wellbeing.[50]

Similarly, Slamon et al. measured HR and HRV of pediatric critical care physicians during live pediatric intensive care unit scenarios including patient rounds, tracheal intubation, and central line insertion. Compared to physicians' baseline biometric data, tracheal intubation and central line insertion activities resulted in higher levels of sympathetic activation.[49]

Wolfe et al. placed pediatric critical care fellows and faculty in simulated high and low stress roles to examine the relationship between subjective and objective stress measures. Subjective stress was measured via a self-reported anxiety assessment and objective stress was measured via HRV obtained from a wearable device. Significant differences in self-reported, subjective measurements and wearable-obtained, objective stress measurements were observed between low- and high-stress roles, as demonstrated by a strong correlation between HRV markers and anxiety levels.[56]

Additionally, Ciraulo et al. showed that surgeons experienced statistically significant increases in HR, BP, and cellular metabolism while performing operations, shedding light on the potential long-term risks resulting from continuous triggering of sympathetic activation (e.g., heart disease) by job-specific stress.[57]

Finally, Akbar et al. examined the relationship between EHR inbox work patterns and primary care physician physiologic stress. Physicians wore devices that measured HRV for seven days. On average, physicians spent 1.08 hours on inbox work of which patient messages consumed the most time. Findings revealed three periods in which physiological stress were shown to increase: in the first hour of work, early afternoon, and evening. Physicians tending to inbox work after hours experienced the longest average stress duration during work hours, as they were more likely to batch emails, spending more time per message, compared to those who managed their inbox during work hours (e.g., between patient appointments), thus spending less time per message.[51]

Theme 2: Assessing the Feasibility of the Use of Wearable Devices to Study Wellbeing & Identification of Limitations

The literature review also explored the feasibility and limitations of using wearable devices to study physician wellbeing. Niotis et al. (2021) and Kaczor et al. (2020) supported this high feasibility. In Kaczor et al., all emergency medicine physician participants successfully wore the wrist-worn sensors during their shifts. Only a five percent incidence of failure to fully capture data was experienced.[50] Niotis et al. used a wearable device to assess exercise and sleep among neurology residents and examine associations with validated survey measures. The majority of study participants (68.8 percent) were deemed "consecutive wearers" of the wrist-worn device. However, this study only found moderate-to-low correlations between physiological measures and survey responses. Additionally, barriers to wearing the device included participants forgetting and not being motivated.[58]

Barac et al., Akbar et al., and Slamon et al. detailed limitations in using wearable devices to study physician wellbeing. The scoping review by Barac et al. identified methodological issues including short durations of observing participants while wearing the devices which restrict the capture of real-world variations in workplace stressors. Additionally, a lack of systematic use of validated instruments to measure burnout, anxiety, and depression was noted.[55] In the Akbar et al. study, wearable device data for five primary care physicians was lost due to technical issues. Further, the study attempted to control for impacts on HRV measures by removing periods of physical activity recorded by the device. However, a carry-over effect of physical activity may have still been present in sedentary movements. Moreover, by removing periods of physical activity, the ability to capture stress may have been limited. For example, in the scenario of a stressed physician walking to a meeting, their stress would not have been captured due to it coinciding with physical activity, underscoring the need for innovative methods for biometric studies on burnout that account for factors such as exercise that elevate physiologic markers independently of burnout. Additionally, losing contact with the skin during physical activity was a barrier to the collection of biometric data in this study.[51] Slamon et al. also experienced technical difficulties in their use of a smart shirt device. Reliable readings were limited when the smart shirt wasn't worn tight enough to the skin or its elastic straps weren't worn. The study also had a small sample size.[49]

Theme 3: Accounting for Practice-Specific Factors as Confounders When Using Wearables to Study Physician Wellbeing

Many studies highlighted the need to account for practice-specific factors as potential confounders when using wearables to examine physician wellbeing. Cowart et al. (2022), Niotis et al., Ciraulo et al., and Akbar et al. focused on anesthesiology, neurology, surgery, and primary care settings, respectively, while Khairat et al. (2019), Kaczor et al., Slamon et al., and Wolfe et al. focused on the emergency medicine environment.

Barac et al. called attention to the multitude of factors—such as workplace stressors, job demand, patient acuity, shift length, and the availability of support staff—that vary by practice setting. As such, practice setting also impacts burnout biomarkers derived from wearable devices. The study suggested that future research "consider collecting organizational variables to better understand the systemic contributors of burnout".[55] Akbar et al. noted that inbox patterns vary between settings and organizations[51], and Slamon et al. identified plans to compare HRV data between different specialties.[49]

CONCLUSION

Current literature provides only a small amount of research focused on physicians and the health care workforce that uses biometric and personal data to measure wellbeing factors such as burnout. The reviewed literature on the use of personal and biological data to assess physician wellbeing focuses on three major themes: (1) the use of biometric data to identify physiological biomarkers of physician stress and burnout; (2) the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations; and (3) the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing. The studies reviewed show variation in the utility of the tools studied and limitations that may restrict the feasibility of broad-scale or long-term use in measurement across larger populations.

Limitations of the studies included in the review included inconsistent wearing of the devices, technical challenges and inappropriate use regarding devices which restricted data collection, short observation periods, and a lack of systematic use of validated burnout, depression, and anxiety measures.

Future research should incorporate organization- and practice-specific variables to gain deeper insights into factors that contribute to physician burnout. Biometric data provides crucial knowledge for organizational leadership and clinical practice regarding the short- and long-term impacts of work-related stressors on physician health. For instance, Ciraulo et al. discussed that increased physiological demands over time could lead to future cardiovascular and cerebrovascular issues for physicians. Such research included in this review presents the opportunity for early detection of burnout and the identification of prevention strategies.

AMA POLICY

The AMA has several policies regarding the development and use of metrics to study physician wellbeing.

Our AMA will research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians, with report back to the House of Delegates no later than Annual 2026 (Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems").

AMA policy also directs it to study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

Additionally, the AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician wellbeing, particularly for this population of physicians (Policy H-405.948, "Factors Causing Burnout").

RECOMMENDATIONS

The Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded having been accomplished by this report and that the remainder of the report be filed.

Fiscal Note: Modest

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APPENDIX

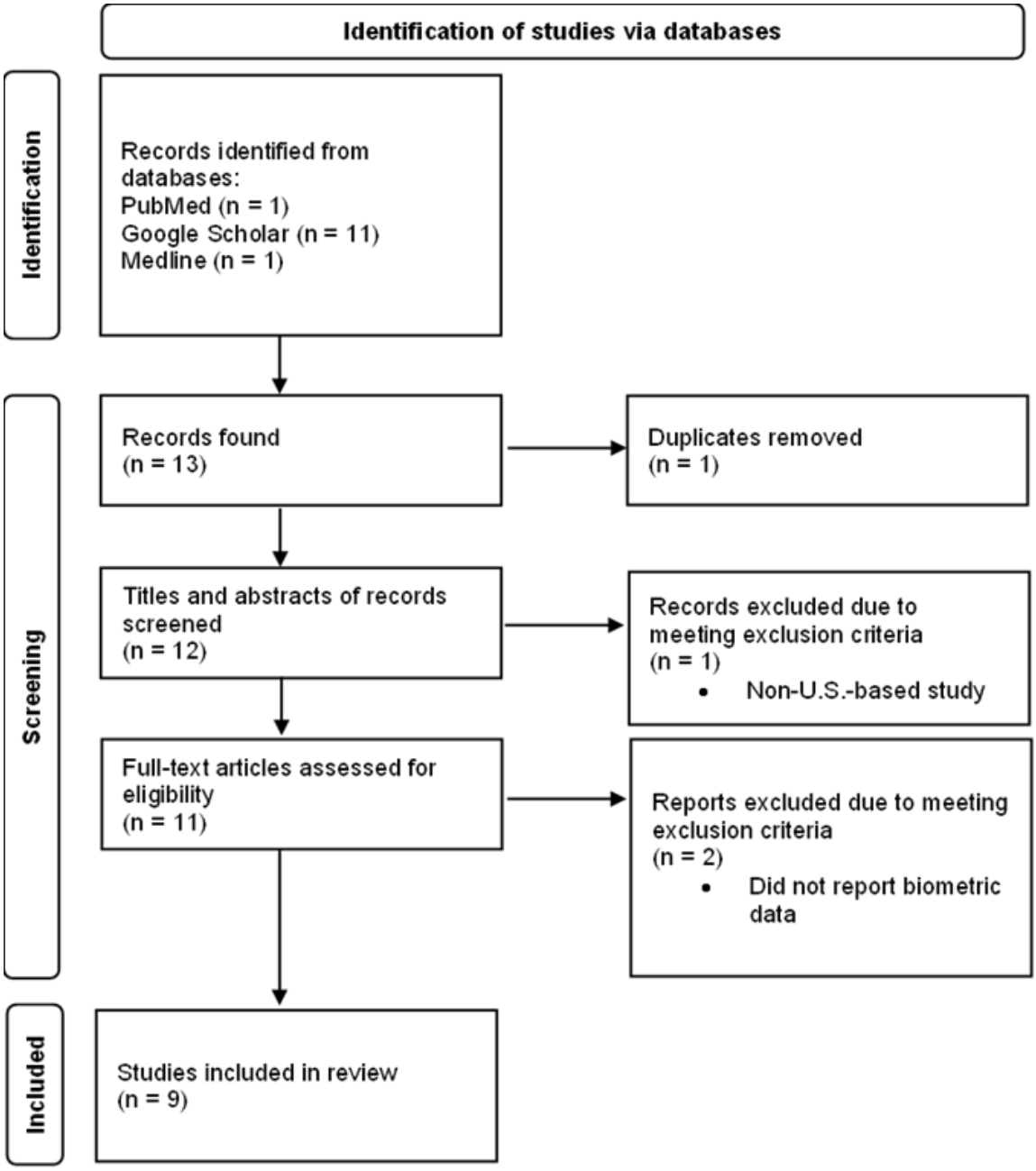

Figure 1: *PRISMA* flow diagram depicting literature review that yielded 9 studies.

Study	Slamon et al. (2018)	Khairat et al. (2019)	Niotis et al. (2020)	Kaczor et al. (2020)	Ciraulo et al. (2020)
Study Type	Prospective	Mixed-methods, live observational usability	Prospective	Prospective	Prospective
Objectives	To measure the biometrics of critical care physicians during clinical scenarios	To propose a framework for understanding EHR-related information overload by identifying areas of poor usability and clinician frustration	To evaluate a wearable biosensor's feasibility in characterizing exercise and sleep in neurology residents, its relationship to validated survey measures, its impact on well-being, and barriers to use	To characterize digital biomarkers of stress among emergency medicine physicians using a wearable sensor	To quantify the physiological impact of surgery on acute care surgeons
Sample	Pediatric critical care attendings/ fellows	Intensive care unit physicians	Neurology residents	Emergency medicine physicians	Surgeons
Biometric Data Collection Device	Hexoskin biometric smart shirt	Tobii Pro Glasses	WHOOP Strap	Empatica E4 wristband	Philips IntelliVue MP5 Patient Monitor
Biometrics Measured	HR, respiratory rate, and HRV	Pupil dilation and gaze location/fixation	Resting heart rate, HRV, strain, exercise frequency/ intensity, and total nightly sleep time	Accelerometry, electrodermal activity, skin temperature, and HR	BP, HR, rate pressure product, oxygen saturation, and end-tidal carbon dioxide
Primary Findings	Critical care activities requiring technical skills led to greater sympathetic activation, with significant increases in mean and maximum heart rate during central venous catheter or	Residents completed tasks more quickly than attending physicians; poor usability, complex interface screens, and navigation difficulties significantly correlated with high frustration levels; and more error messages were associated with longer completion times	Consecutive wearers had significantly higher baseline HRV, HR strain, and workout strain, while nonconsecutive wearers had longer total nightly sleep time. The data supported the feasibility of using these devices as a wellness	Wearable sensor data collected 20 minutes prior to a self-reported stress episode was indicative of stress, suggesting that wearable sensors can detect stress before it is reported or recognized by the individual.	Statistically significant differences were found between baseline data and maximum recordings during surgery for BP, HR, oxygen saturation, and end tidal carbon dioxide, suggesting potential long-term cardiovascular and

	breathing tube insertion in pediatric patients. Researchers found no statistically significant difference in stress levels between tracheal intubation and central line insertion.	due to increased temporal demand.	intervention for select resident groups.		cerebrovascular consequences due to increased physiological demand.

Study	**Akbar et al. (2021)**	**Cowart et al. (2021)**	**Wolfe et al. (2022)**	**Barac et al. (2024)**
Study Type	Prospective	Prospective	Mixed methods, simulation-based	Scoping review
Objectives	To collect EHR use and physiological stress data via unobtrusive means, identify EHR inbox work patterns, and evaluate their association with physicians' stress	To demonstrate the biophysical and psychological benefits of incorporating a mindfulness-based stress reduction program into an urban anesthesiology residency curriculum	To quantify stress differences between low- and high-stress roles and assess the impact of trainee preparedness and self-efficacy on stress levels	To identify physiological burnout biomarkers and highlight current gaps in using wearable technologies to predict burnout among health care professionals
Sample	Primary care physicians	Anesthesiology residents	Pediatric critical care fellows and faculty	Physicians, residents, medical students, and nurses
Biometric Data Collection Device	Garmin Vivosmart wrist-worn device	FitBit	Hexoskin biometric smart shirt	HealthPatch and FitBit
Biometrics Measured	HRV	Hair cortisol level, sleep status level, exercise, and HRV	HRV	HR, HRV, resting HR, respiratory rate, skin temperature, sleep, step count, and activity levels from a work shift
Primary Findings	Physiological stress patterns across the three groups increased during the first hour of work, early afternoon,	Depersonalization scores were significantly lower in the intervention group. Clinical anesthesia residents in PGY-3 had	Significant changes in subjective and objective stress measurements were observed between low- and	The studies found no relationship between wearable physiological data and burnout or anxiety, and a short observation

	and evening, with Group 1 physicians experiencing the longest stress duration during work hours. Factors such as inbox work duration, EHR window switching rate, and the proportion of inbox work done outside of work hours were independently associated with daily stress duration.	significantly higher emotional exhaustion and depersonalization scores than PGY-2 residents, with no significant differences in biophysical outcomes between cohorts.	high-stress roles. Two HRV markers were significantly correlated with State-Trait Anxiety Inventory levels. Participants who felt more confident discussing code status experienced a notable decrease in stress during both observer and hot seat roles.	duration was a major limitation.

Figure 2: Summary of nine studies included in literature review.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-25

Subject: Council on Medical Service Sunset Review of 2015 House Policies

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum 10-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-120.977	Medicare Patient Access to Implantable Morphine Pumps	Our AMA, in collaboration with appropriate medical societies, will continue to work to address the need for appropriate treatment of patients requiring long-term pain management.	Rescind. Numerous AMA policies address pain management, including H-185.931, D-120.976, and H-120.960. **Workforce and Coverage for Pain Management H-185.931** 1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living. 2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets. 3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. 5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within

POLICY #	Title	Text	Recommendation
			multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process. 6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable. **Pain Management D-120.976** Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06),"Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain). **Protection for Physicians Who Prescribe Pain Medication H-120.960** Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or

POLICY #	Title	Text	Recommendation
			administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations. Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.
D-160.933	Payment Mechanisms for Physician-Led Team-Based Health Care	Our AMA will develop educational programs to assist members wishing to develop and implement physician-led team based care payment methodologies at the individual team, practice, accountable care organization, hospital and health system levels.	Rescind. Accomplished by several *Advocacy Issue Briefs* and other resources on the AMA website: 1) Physician-Led Team-Based Care 2) AMA Advocacy Resource Center – Physician-Led Health Care Teams 3) Models of Physician-Led Team-Based Care 4) Summary of physician payment & delivery models 5) Ed Hub Module – Physician Payment Models Guide 6) Ed Hub Module – Physician-Led Models to Achieve the Quadruple Aim 7) AMA/AHIP/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements
D-165.954	Update on HSAs, HRAs, and Other Consumer-	Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection	Retain.

POLICY #	Title	Text	Recommendation
	Driven Health Care Plans	of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.	
D-280.988	Observation Status and Medicare Part A Qualification	Our AMA will advocate for Medicare Part A coverage for a patient's direct admission to a skilled facility if directed by their physician and if the patient's condition meets skilled nursing criteria.	Rescind. Superseded by Policy H-280.947. **Three Day Stay Rule H-280.947** 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement. 4. Our AMA advocates that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients.
D-290.987	Early and Periodic Screening, Diagnosis, and Treatment	Our AMA recognizes the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will advocate for EPSDT to remain intact as critical to the health and well-being of children.	Retain.

POLICY #	Title	Text	Recommendation
D-375.996	Peer Review Immunity	Our AMA: (1) recommends that medical staffs adopt bylaws that provide for a peer review process that is consistent with HCQIA criteria and AMA policy; (2) recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician; (3) recommends that if physicians believe that negligent or misdirected peer review is a problem, legislative action be considered at the state level to assure a fair due process proceeding for physicians subject to review; and (4) shall continue to monitor the legal and regulatory challenges to peer review immunity and non-discoverability of peer review records and proceedings, as well as consider legislative remedies, including the feasibility and impact of amending HCQIA to provide the option for external peer review for hospital medical staff physicians.	Rescind: Superseded by Policy D-375.997. **Peer Review Immunity D-375.997** 1. Our American Medical Association will recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions. 2. Our AMA will monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process. 3. Our AMA will continue to work to provide peer review protection under federal law.
D-450.958	Pain Medicine	Our AMA: (1) continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2) continues to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and (3) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link	Retain.

POLICY #	Title	Text	Recommendation
		physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.	
D-450.962	Pain Management and the Hospital Value-Based Purchasing Program	1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain. 2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.	Retain.
D-510.991	Requiring The Joint Commission to Conduct Root-Cause Analysis to Determine How its Surveys Allowed Veterans Administration Hospitals to Cause Delay in Treatment and Harm Veterans	Our AMA supports The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety.	Rescind: This has been completed.
D-70.945	ICD-10 Implementation	1. If a delay of ICD-10 implementation is not feasible, our American Medical	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		Association will ask the Centers for Medicare & Medicaid Services (CMS) and other payers to allow a two-year grace period for ICD-10 transition, during which physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. Physician payments will also not be withheld based on ICD-10 coding mistakes, providing for a true transition where physicians and their offices can work with ICD-10 over a period of time and not be penalized. 2. Our AMA will educate physicians of their contractual obligations under Medicare and insurance company contracts should they decide to not implement ICD-10 and opt to transition to cash-only practices which do not accept insurance. 3, Our AMA will aggressively promote this new implementation compromise to Congress and CMS since it will allow implementation of ICD-10 as planned, and at the same time protect patients' access to care and physicians' practices. 4. Our AMA will provide the needed resources to accomplish this new compromise ICD-10 implementation and make it a priority. 5. Our AMA will seek data on how ICD-10 implementation has affected patients and changed physician practice patterns, such as physician retirement, leaving private practice for academic settings, and moving to all-cash practices and that, if appropriate, our will AMA release this information to the public.	
D-70.946	Physician Participation as the 5th	1. Our American Medical Association will advocate for a group with strong physician	Retain; still relevant, as it references "future ICD systems" (e.g., ICD-11).

POLICY #	Title	Text	Recommendation
	Cooperating Party in the International Classification of Diseases System in the United States	participation to be the 5th Cooperating Party for ICD-9-CM and ICD-10-CM with equal power of the current four Cooperating Parties in the planning, interpretation and deployment of ICD-9-CM, ICD-10-CM and future ICD systems. 2. Our AMA will seek to be invited by the United States Department of Health and Human Services to submit nominee[s] for physician group[s] or a group with strong physician participation to be designated as the 5th Cooperating Party for ICD-9-CM, ICD-10-CM and future ICD systems.	
D-70.947	Uncoupling of CPT from ICD-10	Our American Medical Association recommends that the Comptroller General of the Government Accountability Office not address uncoupling the ICD diagnosis code from the CPT procedure code at the present time but this may be reconsidered in the future if new mechanisms are developed for payment of physician services.	Retain; still relevant, as it outlines reconsideration "if new mechanisms are developed for payment of physician services."
D-70.948	ICD-10 Transparency and Conversion	1. The provisions of the Protecting Access to Medicare Act of 2014 delaying the compliance date for the ICD-10 transition are consistent with and supported by existing AMA policy. 2. During the delay in implementation of the ICD-10 transition our AMA will seek and support efforts to ensure that any health plan (commercial, Medicare, Medicaid, or other) operating in the United States, shall provide to their provider network sufficient and timely information apprising providers of all planned changes, including coverage, guidelines, authorization, certifications, claims adjudications, pricing, payment, reporting, incentives and other rules, as well as	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		resources such as crosswalks or maps, based on the conversion from ICD-9 to ICD-10.	
D-70.949	Stop the Implementation of ICD-10	1. Our AMA will continue to work diligently and actively with Congress to permanently remove the unnecessary administrative burden on physicians of ICD-10 implementation. 2. Our AMA will advocate that Congress ask the Comptroller General of the United States, in consultation with stakeholders in the medical community, to conduct a study to identify steps that can be taken to mitigate the disruption on health care providers resulting from a replacement of ICD-9 in the future; and that the Comptroller General shall submit to each House of Congress a report on such study no later than May 1, 2015 and such report shall include appropriate recommendations. 3. The Comptroller General's report should at least address these issues: 1) decreasing the massive number of codes down to a reasonable number such as Canada did; 2) putting the replacement of ICD-9 on hold until physicians fully implement the new Electronic Medical Record systems, the new government regulations and the Affordable Care Act regulations; and 3) consider adopting a policy for Medicare that provides a two year implementation period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code.	Rescind: ICD-10-CM was implemented on 10/1/15.
D-70.951	Alleviating the Financial Burdens Associated with ICD-10 Implementation	1. Our AMA will seek federal legislative and regulatory reform to require funding assistance be provided to physician practices to alleviate the financial burdens associated with the implementation costs, upgrades	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		and staff training necessitated as part of the transition to ICD-10. 2. Our AMA will work toward the goal of having insurance companies and governmental entities reimburse physicians for the extra cost of increasingly complex and mandatory changes in coding.	
D-70.952	Stop the Implementation of ICD-10	1. Our AMA will: (A) vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine; (B) do everything possible to let the physicians of America know that our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; (C) work with other national and state medical and informatics associations to assess an appropriate replacement for ICD-9; and (D) evaluate the feasibility of moving from ICD-9 to ICD-11 as an alternative to ICD-10 and report back to the House of Delegates. 2. In order to alleviate the increasing bureaucratic and financial burden on physicians, our AMA will vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10. 3. Our AMA will immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication will be sent to all in Congress and displayed prominently on our AMA website. 4. Our AMA: (A) will educate US physicians on the burdens of ICD-10 and how our AMA is fighting to repeal the onerous ICD-10 requirements on their	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		behalf; (B) supports federal legislation to stop the implementation of ICD-10 and remain with ICD-9 until ICD-11 can be properly evaluated; and (C) supports federal legislation to mandate a two-year "implementation" period by all payers, including CMS, if ICD-10 or ICD-11 is implemented. During this time, payers will not be allowed to deny payment based on specificity of ICD-10/11 diagnosis. However, they will be required to provide feedback for incorrect diagnosis. In addition, no payer will be allowed to ask for "takebacks" due to lack of ICD-10/11 diagnosis code specificity for the aforementioned two-year implementation period.	
D-70.960	Implementation of ICD-10-CM	Our AMA will work for delayed implementation of a simplified, modified ICD-10-CM coding system which is less burdensome on practicing physicians, hospitals, and the health insurance industry.	Rescind: ICD-10-CM was implemented on 10/1/15.
D-90.994	Threats Against Physicians Based on Americans With Disabilities Act	Our American Medical Association encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA's Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.	Retain-in-part: Our American Medical Association encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA. ~~'s Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.~~
H-120.933	Emergency Prescription Drug Refills	Our AMA will advocate the following principles to guide the dispensing of emergency refills of prescription drugs: 1. Emergency refills should only be authorized if, in the pharmacist's professional judgment, failure to refill the prescription might result in an important interruption of a therapeutic regimen that could cause patient harm. 2. Emergency refills should only be dispensed if the pharmacy is	Retain.

POLICY #	Title	Text	Recommendation
		unable to readily obtain refill authorization from the prescriber; prior authorization cannot be obtained in a timely manner from the patient's health plan; or when an emergency order or a proclamation of a state of emergency is declared by a state's governor. 3. Schedule II controlled substances can be dispensed on an emergency basis as allowed under Drug Enforcement Administration protocol. 4. In general, the pharmacist may dispense a sufficient supply of the medication to maintain the prescribed treatment until prescriber authorization can be achieved. 5. If an emergency order or proclamation of a state of emergency is issued by a state's governor, an executive order may allow pharmacists to dispense up to a 30-day supply of a prescription drug, or other amount as provided for under existing state law. 6. The dispensing pharmacist should notify the prescriber of the emergency refill within 72 hours of dispensing. 7. Emergency refills should not be a regular occurrence. 8. The pharmacist should inform the patient or the patient's agent at the time of dispensing that the refill is being provided without the prescriber's authorization and that authorization of the prescriber is required for a future refill. 9. The pharmacist should notify the patient or the patient's agent of any cost-sharing responsibilities prior to dispensing. 10. A prescriber should not be subject to liability for any damages resulting from an emergency refill of a prescription drug by a pharmacist.	

POLICY #	Title	Text	Recommendation
H-120.935	Medication Administration in Assisted Living Facilities	Our AMA supports medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications.	Retain.
H-155.956	Make Simplicity the Foremost Criteria for Any CMS Program	Our American Medical Association will: (1) continue to advocate for simplicity in any current or future programs initiated by the Centers for Medicare & Medicaid Services (CMS) that impact physicians; and (2) continue to advocate by all means necessary that any current or future programs initiated by the Centers for Medicare and Medicaid Services be summarized into an executive summary format or other format that is easily comprehensible to physicians, medical staff and administration in a medical office.	Retain.
H-155.965	Health Care Rationing	The AMA defines "health care rationing" as follows: "a process of allocating health care resources that results in limitations or denials of medical services."	Retain.
H-155.980	Patient and Public Education about Cost of Care	The AMA, as a part of its program to strengthen the US health care system, supports intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns.	Retain.
H-155.994	Sharing of Diagnostic Findings	The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending	Retain.

POLICY #	Title	Text	Recommendation
		physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.	
H-160.922	Physician and Health Plan Provision of Uncompensated Care	The AMA: (1) continues to urge physicians to share in the provision of uncompensated care to the uninsured indigent. (2) opposes any health plan-originated prohibition or discouragement of the provision of any uncompensated care by the plan's employed or participating physicians, in the absence of any external legislative or regulatory prohibition of such pro bono activities. (3) supports legislation prohibiting health plan-originated attempts to prohibit the provision of any uncompensated care by the plan's employed or participating physicians. (4) encourages physicians to contract wherever possible only with those health care delivery or financing plans that contribute in some way to care of the uninsured indigent and/or other community health needs, and that allow individual participating physicians to provide uncompensated care. (5) encourages all health care delivery or financing plans that control the source of covered services and the amount of payment for such services, including plans owned or sponsored by physicians, to contribute to the care of the uninsured indigent or to other community health needs through such means as: (a) Offering direct plan enrollment to individuals and families lacking group coverage and/or offering special coverages or premium subsidies for older, lower-income, and/or less healthy populations; (b)	Retain.

POLICY #	Title	Text	Recommendation
		Provision of preventive or basic care services to disadvantaged populations at reduced or no charge; (c) Health education programs for the community at large; and (d) Provision of professional staff services, training, equipment and/or other assistance to public health clinics, community health centers or other care resources serving the disadvantaged. (6) encourages organizations and entities that accredit or develop and apply performance measures for health plans to consider inclusion of recognition for such contributions in their evaluation criteria. (7) urges state medical societies to collect information on, recognize, and publicize the pro bono activities of health plans. (8) encourages state medical societies to support development of state assistance with malpractice premiums, caps on liability, or immunity from liability for services provided to uninsured indigent patients. (9) continues to support state legislation requiring diversion of assets to charitable causes by non-profit health plans converting to for-profit status.	
H-160.945	Subacute Care Standards for Physicians	AMA guidelines for physicians' responsibilities in subacute care include: (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week. (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care. (3) Physicians are responsible for coordinating care for their patients with other physicians	Retain.

POLICY #	Title	Text	Recommendation
		including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings. (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care. (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations. (6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life. (7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs. (8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.	

POLICY #	Title	Text	Recommendation
		(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit. (10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.	
H-160.971	Uncompensated Care	Our AMA supports (1) communicating to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens; and (2) publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care.	Retain.
H-165.854	Health Reimbursement Arrangements	It is the policy of the AMA: (1) to support Health Reimbursement Arrangements (HRAs) as one mechanism for empowering patients to have greater control over their health care decision-making; and (2) that employers offering HRAs be encouraged to consider: (a) making HRAs into real (rather than notional) accounts; (b) allowing rollover of all unspent HRA balances annually; and (c) making unspent HRA balances available to employees upon their retirement or departure from the company.	Retain.
H-165.863	Flexible Spending	1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a	Retain.

POLICY #	Title	Text	Recommendation
	Accounts (FSAs)	top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account. 2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts.	
H-170.991	Information on Products and Services	The AMA strongly urges firms advising purchasers to seek medical advice regarding use of any product or service to include the name, address and telephone number of a responsible contact from whom information can be readily accessible to physicians on request (e.g., toll-free access or prompt delivery of printed matter about the product or service).	Retain.
H-180.956	Physician Privileges Application - Timely Review by Managed Care	Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.	Retain.

POLICY #	Title	Text	Recommendation
H-185.928	Burdensome Paperwork for Breast Pumps	Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.	Retain-in-part: Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions.~~; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.~~
H-185.930	Notification to Physicians Regarding COBRA Grace Period	Our American Medical Association will advocate for notification to physicians where patients are within the 45-day or 30-day COBRA grace periods in a manner similar to the ACA-required insurance marketplace 90-day notifications to physicians and, if possible, require such information to be provided in real-time.	Retain.
H-185.944	Subscriber Identification Cards	Our AMA: (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits.	Retain.
H-185.952	Elimination of Lifetime Maximums of Health Insurance Benefits	It is the policy of our AMA that employers and health insurers should eliminate the lifetime maximums of health insurance benefits.	Retain.
H-185.953	Health Insurance Coverage of Specialty Pharmaceuticals	Our AMA supports complete transparency of health care coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined.	Retain.

POLICY #	Title	Text	Recommendation
H-185.955	Pap Smears as a Clinical Laboratory Test	The AMA: (1) advocates that it is imperative that Pap smear screening have sufficient payment levels to support the technology and personnel costs required to provide the service, and (2) seeks legislative and regulatory change in the Medicare payment policy for Pap smears so that payment for the technical component of the service is adequate to cover the cost of providing the service, and that pathologists are reimbursed for interpretation of abnormal Pap smears based on the RBRVS.	Retain.
H-185.956	Health Plan Coverage for Over-the-Counter Drugs	Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications.	Retain.
H-185.957	Coverage for Strabismus Surgery	Our American Medical Association supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated.	Retain.
H-185.958	Equity in Health Care for Domestic Partnerships	Our AMA: (1) encourages the development of domestic partner health care benefits in the public and private sector; and (2) supports equity of pre-tax health care benefits for domestic partnerships.	Retain; Policy H-140.901 is identically titled; recommend amending title by addition as follows: "Equity in Health Care Benefits for Domestic Partnerships."
H-185.959	Health Care Benefit Discrepancies for Small Employers Under COBRA	Our AMA supports the principle that small employers who provide their employees with a group health insurance benefit, and who can afford to do so, should be encouraged to provide continuation coverage for their former employees, ideally	Retain.

POLICY #	Title	Text	Recommendation
		consistent with the 18 months of coverage under COBRA.	
H-210.978	Improving Home Health Care	Our American Medical Association: (1) supports the appropriate training of home health aides to ensure the quality of services they provide, guided by the standards of the Medicare Conditions of Participation, accreditation entities and the Institute of Medicine; (2) supports regulatory oversight of home health agencies that employ home health aides; and (3) will work with interested state medical associations to support state legislation that requires home health aides to obtain appropriate training before caring for patients.	Retain.
H-215.967	For-Profit Conversions of Health Care Organizations	The AMA adopts as policy the following principles regarding the for-profit conversion of not-for-profit health care organizations: (1) Representatives of state government (e.g. state attorney general, state insurance commissioner) should oversee all for-profit conversions of health care organizations; (2) Public notice and subsequent public hearings should be required prior to the approval of a for profit-conversion; (3) The health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance commissioner) overseeing the for-profit conversion; (4) For-profit conversions should be structured to prohibit private inurement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals; (5) If the establishment of a charitable foundation is required	Retain.

POLICY #	Title	Text	Recommendation
		as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion; (6) The mission of a charitable foundation resulting from a for-profit conversion should closely reflect the original mission of the not-for-profit health care organization; (7) A designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation; (8) The level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations; (9) Representatives of state government (e.g., state attorney general, state insurance commissioner) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions; (10) Once a charitable foundation has been established as a result of a for-profit conversion, ongoing community liaison with the foundation should occur on a regular basis (e.g., community advisory committees, periodic public reports); and (11) There should be meaningful physician presence on the board of directors of a charitable foundation formed as a result of the conversion of a not-for-profit health care organization to a for-profit organization	

POLICY #	Title	Text	Recommendation
H-215.992	Hospital Security	Our AMA supports efforts by physicians and other hospital staff to encourage all hospitals to institute and/or maintain appropriate and adequate security measures, such as general identification, patrols, visual monitoring systems and metal detectors, in order to protect staff and patients.	Retain.
H-215.993	Medical Society-Governing Body (Trustee) Liaison Program	Our AMA (1) encourages state medical associations to maintain this activity to assure ongoing communication with hospital governing bodies; and (2) encourages state medical associations to draw upon all sources, including national level activities, to enhance their own direct communication with hospital governing bodies.	Retain.
H-220.980	Credentialing Procedure	The AMA encourages The Joint Commission to continue to monitor medical staff credentialing procedures to include clearly delineated authority to an elected physician of the medical staff for access, review and judgment over contents, to ensure that the individual medical staff member's credentials file contains only well documented and appropriate data and does not include information that is immaterial, misleading or of questionable value.	Retain.
H-220.989	Physician Credentialing	The AMA encourages The Joint Commission to develop standards that permit hospital medical staffs to establish educational needs as one of the criteria for medical staff privileges in teaching hospitals, to assure an appropriate number and variety of patients for educational purposes	Retain.
H-220.990	Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation	The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout	Retain.

POLICY #	Title	Text	Recommendation
	Manual for Hospitals"	the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.	
H-225.945	Temporary Medical Staff Privileges	Our AMA: (1) supports the use of temporary privileges in the following situations: (a) to fulfill	Retain.

POLICY #	Title	Text	Recommendation
		an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a 'clean' application is awaiting review and approval by the medical staff executive committee and the governing body; and (2) will work with other stakeholders to preserve the use of temporary privileges in the following situations: (a) to fulfill an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a 'clean' application is awaiting review and approval by the medical staff executive committee and the governing body.	
H-225.987	Reporting of Incidents	The AMA believes that (1) all hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting; (2) hospital medical staffs should be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients; and (3) the organized medical staff should seek the assurance of the state agency or outside authority that the report will remain strictly confidential.	Retain.
H-225.988	Hospital-Medical Staff Joint Ventures	The AMA believes it is vital for physicians to appraise responsibly the benefits and risks of specific hospital medical staff joint venture activities in light of their individual circumstances and the advice of knowledgeable and independent financial advisors and legal counsel.	Retain.
H-225.993	Medical Staff Policy Determination	The AMA believes that only fully licensed physicians on the medical staff should establish overall medical staff standards and policy for quality medical care, where consistent with local, state and federal laws.	Retain.

POLICY #	Title	Text	Recommendation
H-230.955	Clarification of Medical Staff Rights in Granting Clinical Staff Privileges	Our AMA: (1) policy is that medical staffs may establish any method of granting clinical privileges that complies with The Joint Commission standard MS.06.01.05; and (2) requests that its Commissioners to The Joint Commission ask The Joint Commission to notify all hospitals and medical staffs that there can be multiple ways to comply with The Joint Commission standards.	Retain.
H-230.957	Access to Hospital Records	Our AMA will support legislation guaranteeing that physicians engaged in staff privileges disputes have free and full access to all medical records related to those disputes so they can adequately defend themselves.	Retain.
H-230.958	Economic Loyalty Criteria for Medical Staff Privileges	Our AMA strongly opposes the implementation of economic loyalty criteria for medical staff privileges.	Retain.
H-230.971	Economic Credentialing	Our AMA will work with The Joint Commission to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care.	Retain.
H-230.985	Medical Staff Privileges	The AMA believes that if, under the principle of self-governance, a medical staff determines that productivity, as it has a direct relationship to quality of care, is a reasonable criterion to use in its consideration of reappointment, it should be permitted to do so. However, the AMA does not believe that economic productivity should be a factor in medical staff reappointment.	Retain.
H-230.987	Hospital Decisions to Grant Exclusive Contracts	Our American Medical Association supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body.	Retain.

POLICY #	Title	Text	Recommendation
H-230.988	Guidelines for Maintenance and Exchange of Credentialing Information	The AMA supports the development of guidelines for the maintenance and exchange of credentialing information and encourages all health care facilities, including the military, the Veterans Administration and the Public Health Service, to comply with such guidelines.	Retain.
H-230.993	Physician Credentialing	The AMA recommends that hospital medical staffs adopt bylaws which enable them to retain the prerogative and responsibility, as granted by the hospital governing body, for credentialing all physicians and other licensees who apply for clinical privileges, including those who seek to enter into contractual arrangements with hospitals.	Retain.
H-235.980	Hospital Medical Staff Self-Governance	1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights. 2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the	Retain.

POLICY #	Title	Text	Recommendation
		principles of medical staff self-governance. 3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following: (a) Application, reapplication, credentialing and privileging standards; (b) Fair hearing and appeal process; (c) Selection, election and removal of medical staff officers; (d) Clinical criteria and standards which manage quality assurance, utilization review; (e) Structure of the medical staff organization; (f) Rules and regulations that affect the entire medical staff. 4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.	
H-235.983	AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance	The AMA (1) reaffirms its policy in support of medical staff self-governance, including the process of electing and seating officers of the staff in accordance with medical staff bylaws, and its policy in opposition to improper interference by the governing body in that process; and (2) supports working with state hospital medical staff sections, state medical societies, and individual medical staffs to support medical staff self-governance in appropriate situations.	Retain.

POLICY #	Title	Text	Recommendation
H-235.993	Representation of the Medical Staff on All Committees of the Governing Board and Administration of American Hospitals	The AMA supports (1) medical staff representation on all committees of the governing board and administration of American hospitals; and (2) hospital administration representation on administrative committees of the medical staff.	Retain.
H-235.996	Bylaws and Rules and Regulations - No Incorporation by Reference	The AMA encourages medical staffs to develop their own bylaws, rules and regulations and not to incorporate other documents by reference.	Retain.
H-240.979	Intrusion by Hospitals into the Private Practice of Medicine	The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of "facility" costs.	Retain.
H-240.995	Diagnostic Related Groups	The AMA (1) supports input by hospital medical staffs into the DRG process to insure that quality of care is not compromised; and (2) supports the concept that the individual hospital medical staff's responsibility is to ensure appropriate quality of care for patients.	Retain.
H-245.970	Early Hearing Detection and Intervention	Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.	Retain.
H-280.974	Medically Necessary	Our AMA (1) defines a "medically necessary" visit to a	Retain.

POLICY #	Title	Text	Recommendation
	Nursing Facility Visits	Medicare/Medicaid resident in a nursing facility as any physician visit necessary to complete comprehensive nursing facility assessments and other assessments that are required as a condition of Medicare or state statute, as well as those visits that respond to a patient's development of a significant complication or a significant new problem which requires the creation of a new medical plan of care or visits that respond to the reported possibility of a change in patient condition; (2) supports the concepts embodied in the CPT Evaluation and Management codes for Nursing Facility services, including the concept that counseling and/or coordination of care that are provided consistent with the patient and/or family's needs be recognized as medically appropriate and necessary; (3) will monitor the use of the CPT codes for Nursing Facility Services and Medicare's determination of medical necessity to determine if revisions to the definitions of medical necessity are necessary; (4) supports eliminating the Medicare established arbitrary visit frequency parameters (inclusive of multiple same day visits where quality of care and severity of condition necessitates such encounters); (5) supports eliminating required documentation for obtaining such payments which place a significant burden on physician endeavors to provide quality care; (6) urges carrier refrainment from references to bona fide multiple patient visits on the same day as "gang visits," which unjustly	

POLICY #	Title	Text	Recommendation
		impugn the quality of medical care provided; (7) supports establishment of a moratorium by CMS on any carrier collection of past "overpayments" for such multiple visits, and (8) will use whatever means necessary to achieve these objectives.	
H-280.995	Medicare Coverage of "Skilled Nursing Care"	The AMA encourages CMS to (1) clarify the Medicare definitions of "skilled nursing care" and "custodial care"; (2) identify and implement appropriate measures to assure greater consistency in the administrative interpretation of rules governing coverage of nursing home care; and (3) better explain to beneficiaries the exclusion for custodial care services.	Rescind: Accomplished by Centers for Medicare & Medicaid Services document that explains the definitions of "skilled nursing care" and "custodial care."
H-285.906	Protecting Against Forced Network Exclusivity of Specialist Physicians	Our AMA supports allowing specialty physicians to have primary contract status in more than one network.	Retain.
H-285.907	Out of Network Restrictions of Physicians	Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.	Retain.
H-285.969	Managed Care Education	The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care.	Retain.
H-285.970	Physician Office Review by Third Party Payers	The AMA supports development of standardized criteria to be used in managed care contracts for reviewing physicians' office and medical records in order to avoid multiple review.	Retain.

POLICY #	Title	Text	Recommendation
H-285.987	Guidelines for Qualifications of Managed Care Medical Directors	The AMA has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations": To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall: (1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state; (2) meet credentialing requirements equivalent to those met by plan providers; (3) be familiar with local medical practices and standards in the plan's service area; (4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations; (5) possess good interpersonal and communications skills; (6) demonstrate knowledge of risk management standards; (7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management; (8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review; (9) be able to establish fair and effective grievance resolution mechanisms for enrollees; (10) be able to review, advise, and take action on questionable hospital admissions, medically	Retain.

POLICY #	Title	Text	Recommendation
		unnecessary days, and all other medical care cost issues; and (11) be willing to interact with physicians on denied authorizations. The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors.	
H-285.989	AMA Opposition to All Products Clauses	Our AMA will seek legislative action to prohibit tying a physician's membership in an insurance product (e.g., a PPO) to that physician's participation in any other insurance product (e.g., an HMO, workers' compensation, automobile personal injury protection insurance, Medicare and Medicaid).	Retain.
H-290.974	Status Report on the Medicaid Program	1. It is the policy of our AMA that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups. 2. Our AMA advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance. 3. Our AMA urges Congress and the Administration to develop proposals and enact solutions to address the pending growth of long-term care needs of the American population.	Retain.
H-290.995	Case Management System for Outpatient Clinics	The AMA has adopted the following policy: (1) That states be given the authority to establish primary care case management programs for populations whose medical care is provided through	Retain.

POLICY #	Title	Text	Recommendation
		Medicaid or other public welfare funding: (a) on a voluntary basis with incentives provided toward a prudent choice of care source; and (b) on a mandatory basis only for those recipients in a given area who have been identified as overutilizers or misutilizers of services; and (2) that comparative analyses of these programs be undertaken to determine their relative effectiveness regarding patient access, quality of and satisfaction with care, and cost reduction.	
H-320.955	Conflict of Interest in Care Review	AMA policy is that utilization review organizations make every effort to avoid potential conflicts of interest for physician reviewers by not assigning cases to a physician reviewer who (1) is an associate or competitor of the physician under review, (2) actively practices in the same hospital as the physician under review when feasible, (3) participated in the development or execution of the patient's treatment plan, or (4) is a member of the patient's family.	Retain.
H-320.969	Concurrent Review Procedures of Inpatient Care by HMO Representatives	The AMA encourages state regulation of third party reviewers who are on site in hospitals evaluating inpatient management so that these representatives: (1) must accrue clinical data in the hospital only under the control of hospital-based utilization review/quality assurance (UR/QA) personnel; (2) must not be enabled to have any direct inpatient contact; (3) must both communicate such suggestions directly to the attending physician and document all actions in the hospital's utilization office if they wish to provide input regarding patient management; (4) it is the role of the utilization review program or managed care plan to credential/certify that its reviewers are appropriately licensed and have the required	Retain.

POLICY #	Title	Text	Recommendation
		experience to perform review; (5) prior to the on-site review, the utilization review program or managed care plan should provide upon request the name(s), credentials and background of their reviewers to the medical staff credentials committee and/or quality assurance/utilization review committee; and (6) the medical staff should have: (a) established protocol for reviewers entry into the hospital and (b) a process for monitoring the reviewer's activities and the confidentiality of the records they review.	
H-320.993	Utilization Management	The AMA encourages physicians to take a leadership role in implementing and maintaining utilization management programs within their hospitals.	Retain.
H-330.881	Medicare Coverage for Evidence-Based Lymphedema Treatment	Our AMA supports Medicare coverage for appropriate and evidence-based treatment of lymphedema.	Retain.
H-330.882	Oppose Local Coverage Determination for Lower Limb Prostheses	Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and (2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients.	Retain.
H-330.883	Parity of Payment for Administering Biologic Medications	Our AMA supports and encourages interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions.	Retain.
H-373.994	Patient Navigation Programs	1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to	Retain.

POLICY #	Title	Text	Recommendation
		care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs: a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities. b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team. c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team. d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide. e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.	

POLICY #	Title	Text	Recommendation
		2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care. 3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.	
H-375.994	Peer Review in All Health Care Facilities	The AMA supports the provision of comparable peer review systems of medical services offered in public, private and governmental hospitals.	Retain.
H-385.915	Integrating Physical and Behavioral Health Care	Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating	Retain.

POLICY #	Title	Text	Recommendation
		behavioral health care services into primary care settings.	
H-385.955	Denial of Payment for Treatment of Immediate Family Members	The AMA calls upon CMS to amend its regulations denying payment for physician services and services incident to a physician's professional services for treatment of immediate family members by permitting an exception applicable to the services of any physician who is the single source of medical care in the community.	Retain.
H-385.989	Payment for Physicians Services	Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third-party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current	Retain.

POLICY #	Title	Text	Recommendation
		legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.	
H-390.840	Update on Payment Mechanisms for Physician-Led Team-Based Health Care	1. Our AMA encourages public and private health insurers to develop and offer a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care. 2. Our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to ensure that Medicare Alternative Payment Models (APMs) do not require physicians to assume responsibility for costs they cannot control because such a requirement could potentially create an ethical conflict of interest. 3. Our AMA will continue to actively advocate to CMS that physicians in all specialties and modes of practice must have at least one Medicare APM in which they can feasibly participate. 4. Our AMA will advocate to CMS that any review process of alternative payment models proposed by stakeholders be completed in a timely manner, include an administratively simple appeals process and access to an ombudsman.	Retain.
H-390.841	Value Based Modifier and Flawed Drug Cost Attribution	Our American Medical Association will work with the Centers for Medicare & Medicaid Services to modify Value Based Modifier cost attribution with regard to all drug costs, to ensure	Retain.

POLICY #	Title	Text	Recommendation
		the cost calculation does not unfairly disadvantage certain providers.	
H-390.842	Include Physicians in CMS Rate Increases to Medicare Advantage Plans	Our American Medical Association (1) encourages Medicare Advantage plans to be transparent with respect to the allocation of their rate increases, and (2) encourages individual physicians to negotiate rate increases that parallel or improve upon the percentage increases received by the Medicare Advantage plans with which they contract.	Retain.
H-390.843	Physician-Led, Single and Multi-Specialty, Organized Group Practice Models	1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care. 2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost.	Retain.
H-390.872	Compensation for Physicians Who Accompany Seriously Ill or Injured Patients to Hospitals	The AMA: (1) urges CMS to allow payment for the services of physicians who accompany seriously ill or injured patients in the ambulance to hospitals and who report the appropriate level of evaluation and management service along with Prolonged Physician Service with Direct (Face-to-Face) Patient Contact (codes 99354 and 99355) or the	Retain.

POLICY #	Title	Text	Recommendation
		Critical Care Services codes (99291 and 99292); and (2) urges CMS to expand its guidelines to carriers to allow payment for a physician's return trip from accompanying an ambulance-borne patient, consistent with above, using code 99082, Unusual travel (e.g., transportation and escort of patient).	
H-390.880	Interest Rates Charged and Paid by CMS	1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation. 2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.	Retain.
H-390.921	Uniformity of Operations of Medicare Administrative Contractors	It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement.	Retain.
H-390.991	CMS Reimbursement Policy for Physicians in Solo Practice "Covering" Medicare	The AMA supports permitting physicians in solo practice, and those in different groups, to "cover" Medicare patients for each other, and making it possible for the personal physicians of Medicare patients	Retain.

POLICY #	Title	Text	Recommendation
	Patients for Each Other	to bill and to receive reimbursement for professional services rendered by their colleagues who "cover" for them.	
H-400.955	Establishing Capitation Rates	1. Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use. 2. Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care. 3. Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations. 4. Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for	Retain.

POLICY #	Title	Text	Recommendation
		equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts.	
H-400.956	RBRVS Development	(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.	Retain.
H-405.956	Transparency of Health Care Provider Profiles in Commercial and Federal Physician Comparison Databases	1. Our AMA encourages accurate and transparent listings of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services, in accordance with existing AMA policy.	Retain.

POLICY #	Title	Text	Recommendation
		2. Our AMA urges commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post graduate specialty education, and naming of the certifying board(s), in accordance with existing AMA policy.	
H-405.995	Administration and Supervision of Rehabilitation Units	The AMA believes that (1) third party coverage for the administration and supervision of patient rehabilitation in the office, hospital, and free-standing units should continue to be determined by physician competence based on training and experience, and should not be denied on the basis of specialty certification; and (2) the determination of criteria for qualification in the administration and supervision of rehabilitation units should be based on competence gained by training and experience, and should not be arbitrarily restricted by specialty designation.	Retain.
H-406.993	Development and Use of Physician Profiles	The AMA: (1) urges state medical associations, national medical specialty societies, hospital medical staff, and individual physicians to seek active involvement in the development, implementation, and evaluation of physician profiling initiatives; (2) encourages research to develop improved data sources, methods, and feedback approaches to physician profiling initiatives; (3) opposes the use of profiling procedures that do not meet AMA principles for the credentialing or termination of physicians by managed care plans; (4) opposes physician profiling data being used for	Retain.

POLICY #	Title	Text	Recommendation
		economic credentialing purposes; (5) believes that any disclosure or release of physician profiles shall follow strict conformance to AMA policy on the use and release of physician-specific health care data (Policy 406.996); and (6) will monitor the use of profiling procedures related to physician profiling.	
H-406.994	Principles of Physician Profiling	Our AMA advocates that managed care organizations, third party payers, government entities, and others that develop physician profiles adhere to the following principles: (1) The active involvement of physician organizations and practicing physicians in all aspects of physician profiling shall be essential. (2) The methods for collecting and analyzing data and developing physician profiles shall be disclosed to relevant physician organizations and physicians under review. (3) Valid data collection and profiling methodologies, including establishment of a statistically significant sample size, shall be developed. (4) The limitations of the data sources used to develop physician profiles shall be clearly identified and acknowledged. (5) Physician profiles shall be based on valid, accurate, and objective data and used primarily for educational purposes. (6) To the greatest extent possible, physician profiling initiatives shall use standards-based norms derived from widely accepted, physician-developed practice parameters. (7) Physician profiles and any other information that have been	Retain.

POLICY #	Title	Text	Recommendation
		compiled related to physician performance shall be shared with physicians under review. (8) Comparisons among physician profiles shall adjust for patient case-mix, control for physician specialty, and distinguish between the ordering or referring physician and the physician providing the service or procedure. (9) Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed. (10) The quality and accuracy of physician profiles, data sources, and methodologies shall be evaluated regularly.	
H-406.997	Collection and Analysis of Physician-Specific Health Care Data	1. Our AMA advocates that third party payers, government entities, and others that collect and analyze physician-specific health care data adhere to the following principles: (a) The methods for collecting and analyzing physician-specific health care data shall be disclosed to physicians under review and the public. (b) Physician-specific health care data shall be valid, accurate, objective and used primarily for the education of both consumers and physicians. (c) Data elements used in the collection of physician-specific health care data, including severity adjustment factors, shall be determined by advisory committees which include actively practicing, and where relevant, specialty-specific, physicians from the region where the data are being collected. (d) Statistically valid data collection, analysis, and reporting methodologies, including establishment of a statistically significant minimum number of cases, shall be developed and appropriately implemented prior	Retain.

POLICY #	Title	Text	Recommendation
		to the release of physician-specific health care data. (e) The quality and accuracy of the physician-specific health care data shall be evaluated by conducting periodic medical record audits. 2. Our AMA believes that health care coalitions which include physicians as full voting members are an appropriate forum for undertaking health care data collection and analysis activities; in consideration of the potential for misinterpretation, violation of privacy rights, and antitrust concerns, it is recommended that charge or utilization data provided to such entities by government, third party payers, and self-insureds companies be in the form of ranges or averages and not be physician-specific.	
H-406.998	Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data	Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness; (2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;	Retain.

POLICY #	Title	Text	Recommendation
		(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data; (4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data; (5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities; (6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and (7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.	
H-435.955	Administrative and Liability Surcharges	Our AMA supports the ability of physicians to institute an "administrative surcharge" and/or a "liability surcharge."	Retain.
H-450.936	Physician Quality	Our AMA will continue to advocate for improvements in the	Rescind: The Physician Quality Reporting Initiative was replaced by

POLICY #	Title	Text	Recommendation
	Reporting Initiative Payment	Physician Quality Reporting Initiative (PQRI) including early education and outreach to physicians by the Centers for Medicare and Medicaid Services (CMS), the provision of confidential interim and final feedback reports from CMS to physicians on potential problems in their PQRI reporting, easier access to feedback reports, development of meaningful dispute resolution processes, and the provision to our AMA of the 2007 PQRI data set file.	the Merit-based Incentive Payment System (MIPS) in 2017.
H-465.986	Rural Health	1. The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well. 2. The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics, and transmit the result of such evaluation to their members. 3. The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners.	Retain; Policy H-465.989 is identically titled; recommend amending title by addition as follows: "Rural Health Clinics."
H-465.989	Rural Health	It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and	Retain.

POLICY #	Title	Text	Recommendation
		rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.	
H-70.916	Delay or Canceling of ICD-10	Our AMA supports delaying or canceling the implementation of ICD-10.	Rescind: ICD-10-CM was implemented on 10/1/15.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Regulation of Corporate Investment in the Health Care Sector

EXECUTIVE SUMMARY

Policy D-215.982, "The Corporate Practice of Medicine, Revisited" and Policy D-160.904, "The Regulation of Private Equity in the Health Care Sector" were adopted at the 2024 Annual Meeting. The former asks our American Medical Association (AMA) to revisit the concept of restrictions on the corporate practice of medicine including, but not limited to, private equities, hedge funds, and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by the 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs. The latter asks our AMA to propose appropriate guidelines for the use of private equity in health care, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

The corporate practice of medicine (CPOM) can take many forms. For example, private or public for-profit companies can purchase ownership stake in health care businesses, investment firms can partner with or acquire physician practices or hospitals, or health insurance companies can directly employ physicians.

There are risks and benefits associated with corporate investment and partnership. Corporate investment can offer a way for a practice to avoid selling to a hospital or health system, manage human resources, information technology, and other administrative tasks on behalf of the practice, offer lucrative deals for physician-owners wanting to retire or sell their practice, and help with medical liability costs. Risks include a loss of control of business decisions and/or clinical autonomy, drastic cost cutting measures, replacing physicians with non-physician practitioners, restrictive non-compete agreements, loss of liability tail coverage and retirement benefits, loss of employment, and the possibility of debt or bankruptcy for the physician-owner after the corporate investor has extracted profits and exited the partnership.

CPOM doctrine provides a legal basis for protecting the integrity of patient care in a health care environment complicated by corporate influence. Broadly, CPOM prohibitions forbid lay (i.e., non-physician) corporations from practicing medicine, owning physician practices, or otherwise employing physicians to provide medical services. While most states have CPOM restrictions in place, there is no single definition of what constitutes a valid CPOM exemption. Each state's CPOM doctrine has been shaped uniquely over the years by a combination of statutes, regulations, court decisions, attorney general opinions and actions by medical licensing boards. CPOM restrictions generally aim to avoid the commercialization of medical practice that might result when corporations own practices, to address misalignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and to ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

The Council offers a series of recommendations to strengthen guidelines for physicians considering corporate partnerships, support capital reserve and leverage standards for firms looking to acquire health care facilities, and support the enforcement of regulations and legislation pertaining to the corporate control of practices in the health care sector. These recommendations aim to ensure physician clinical autonomy and operational authority are preserved and protected.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-25

Subject: Regulation of Corporate Investment in the Health Care Sector

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy D-215.982, "The Corporate Practice of Medicine, Revisited' and Policy D-160.904, "The Regulation of Private Equity in the Health Care Sector" were adopted at the 2024 Annual Meeting. The former asks our American Medical Association (AMA) to revisit the concept of restrictions on the corporate practice of medicine including, but not limited to, private equities, hedge funds, and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by the 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs. The latter asks our AMA to propose appropriate guidelines for the use of private equity in health care, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

Of note, the Council on Ethical and Judicial Affairs (CEJA) has prepared a related report, CEJA Report 5-A-25, "Protecting Physicians Who Engage in Contracts to Deliver Health Care Services" which offers specific ethics analysis and guidance for physicians impacted by private equity's involvement in medicine.

BACKGROUND

The corporate practice of medicine (CPOM) can take many forms. For example, private or public for-profit or non-profit companies can purchase ownership stakes in health care businesses, investment firms can partner with or acquire physician practices or hospitals, or health insurance companies can directly employ physicians. Private equity firms apply several types of investment strategies. Traditional private equity firms utilize funds from leveraged buyouts to take a controlling stake in mature companies, venture capital firms invest in fledgling businesses, and growth equity firms partner with promising later-stage businesses to help them expand.

As stated in Board of Trustees Report 9-I-24, it is important for AMA policy to distinguish between corporate investment, corporate ownership, and corporate control in physician practices:

> The Board of Trustees believes that decisions made by a corporate investor on matters often characterized as operational or administrative may in some cases intrude on clinical decision-making and physician autonomy, as well as affect quality of care and patient outcomes. This is not simply in cases where the difference may be blurred, even matters that may be typically characterized as operations (coding, billing and collections, administrative, and non-clinical

> management, risk management, etc.) may themselves be implemented in ways that interfere with clinical decision-making and physician autonomy and/or expose physicians to liability.

Private equity acquisitions of health care entities increased six-fold in a decade, growing from 75 deals in 2012 to 484 deals in 2021.[1] Since 2012, private equity firms have spent approximately $1 trillion on health care transactions and between 2018 and 2023, private equity firms spent $505 billion on health care acquisitions.[2,3] The shift toward private equity investment may have been exacerbated by the COVID-19 pandemic as a solution for practices struggling financially. According to the Private Equity Stakeholder Project, it is estimated that eight percent of all private hospitals in the United States and 22 percent of for-profit hospitals are owned by private equity firms.[4]

Private equity deals range from tens to hundreds of millions of dollars and are expected to deliver 20 to 30 percent returns to investors. Key tactics include increasing prices and volume.[5] Another common investment tactic for private equity firms following acquisition includes sale-leaseback arrangements, which sell acquired facilities' land and buildings to repay investors and then charge the facility rent on assets they once owned. On average, after a private equity firm acquires a hospital, the hospital's assets decrease by 24 percent relative to hospitals not purchased by private equity.[6] Private equity firms typically purchase an established practice and acquire smaller practices to create regional brands that can exercise greater bargaining power with insurers and medical supply companies. With these acquisitions, emphasis shifts to increasing profits, often by extracting higher contracted payment rates, lowering overhead, and increasing volume and ancillary revenue streams (i.e., imaging, procedures, over the counter products).[7]

The CPOM doctrine provides a legal basis for protecting the integrity of patient care in a health care environment complicated by corporate influence. Broadly, CPOM prohibitions forbid lay (i.e., non-physician) corporations from practicing medicine, owning physician practices, or otherwise employing physicians to provide medical services. While most states have CPOM restrictions in place, there is no single definition of what constitutes the CPOM, and exemptions – such as for-profit hospitals, nonprofits, or federally qualified health centers – vary broadly. Each state's CPOM doctrine has been shaped uniquely over the years by a combination of statutes, regulations, court decisions, attorney general opinions and actions by medical licensing boards. Consequently, it is difficult to succinctly summarize the CPOM doctrine of every individual state. However, CPOM restrictions generally aim to avoid the commercialization of medical practice that might result when corporations own practices, to address any lack of alignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and to ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

Types of corporate arrangements

There are several types of corporate structuring and financing of medical practices that can occur. One of the most common is investment by private equity firms. A private equity firm pools investments and uses leveraged buyouts to purchase an ownership stake in a physician practice or hospital. The private equity firm then cuts costs and drives up profit with the goal of selling the business for a profit in three to seven years.

In a 2024 Stanford Law Review analysis, Fuse Brown and Hall point out that private equity poses three risks:

> First, private equity investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from private equity investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding,

aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by private equity companies may be subject to onerous employment terms and lose autonomy over clinical decisions.[8]

While private equity investors are often viewed as exploitative, they may not be substantially different from other entities who invest in or acquire physician practices. Private equity investment is not inherently bad but likely includes both good and bad actors as does any other investor arrangement in the health care sector, or other markets more broadly. Professional risks are not unique to corporate investment alone. Notably, however, according to a study from the Private Equity Stakeholder Project, more than 20 percent of health care bankruptcies in 2023 were private equity-backed companies. Due to the nature of the leveraged buyout strategy employed by private equity firms, debt levels on these leveraged buyouts reached a 15 year high of 7.1 times earnings in 2022. Average debt to earnings before interest, taxes, depreciation, and amortization are around three times earnings.[9]

Hedge funds are also used to invest in and acquire health care entities. A hedge fund differs from private equity in that it is an investment strategy while private equity is a source of capital. Hedge funds pool money from wealthy entities to make investments in the stock market and use different market and trading strategies to insulate investments from market volatility. In another corporate arrangement seen in recent years, corporations such as Amazon (via One Medical) and Walmart have entered directly into the health care space. In addition, health insurers have entered the market by directly employing physicians. For example, Optum, a subsidiary of UnitedHealth Group, employs about 10,000 physicians and is affiliated with another approximately 80,000 physicians. In addition to physicians, Optum employs or is affiliated with approximately 40,000 non-physician practitioners (NPPs).[10,11]

Impact on Cost

Most studies done on the effects of private equity investment conclude that these transactions have led to higher prices for patients. Recently, private equity's role in contributing to the United States' medical debt crisis has been highlighted. According to the Private Equity Stakeholder Project, private equity firms are both "creating and profiting from medical debt" by expanding into billing services and collecting payments for the health care entities they acquire.[12] Private equity owned health care entities have been increasingly outsourcing financial work to the private equity firms themselves, who have consolidated debt collecting, claims processing, and billing into an "end-to-end" service. The result is higher costs for patients, either through upcoding, higher interest rates on outstanding balances, or more aggressive bill collection practices.[13]

Impact on Patients

Evidence on corporate investor impact on quality of care is mixed. According to a 2023 *JAMA* study, hospital-acquired adverse events increased by approximately 25 percent following private equity acquisition. The rise in adverse events was impacted by an increase in the number of falls and central line associated bloodstream infections, along with a larger, but less statistically precise increase in surgical site infections. Other studies have found that private equity acquisition may improve care quality, but only under certain market and regulatory conditions.[14,15] Greater transparency is needed over private equity investment in and ownership of physician practices to help patients make informed decisions about their care. While the onus should not be put on patients to know the ownership status of a hospital or practice before receiving care, and in many cases patients may not have a choice on where they seek care, greater transparency would be beneficial for patients and communities if and when it allows for more informed decision-making.

Impact on Physicians

Physicians may value investment from corporate partners because : 1) it can offer a way for the practice to avoid selling to a health system; 2) the corporate partner can manage administrative, technical, and human resources aspects of the business; 3) the corporate partner can offer financially attractive deals for physician-owners wanting to retire or exit ownership; and 4) these investors can help with medical liability costs. Some risks of partnering with corporate investors include losing control of business decisions and/or clinical autonomy; drastic cost cutting measures, including replacing physicians with NPPs; non-compete agreements which can prevent physicians from easily moving to another job; and the possibility of debt or bankruptcy for the physician-owner after the corporate investor has extracted profits from the practice and exited the partnership.[16] The use of non-compete agreements, or restrictive covenants, by larger corporations has the potential to hamper physicians' ability to leave a practice in search of another position. This is especially true of corporations that have a large geographical footprint or those that are in concentrated markets. With more limited ability to leave for another opportunity, the physician's ability to advocate for better working conditions is undermined. In these scenarios, a physician's only choice may be to move to another geographic area entirely, often uprooting themselves and their families. For employed physicians, risks could also include loss of liability tail coverage or loss of pension or retirement funds if their facility comes under private equity ownership or ultimately goes bankrupt. Physicians may also be pressured to see more patients each day or meet lofty financial targets to maximize profitability. Financial targets could include sales goals, using lower cost supplies, or encouraging patients to seek optional or cosmetic procedures that are often lucrative, but not always necessary. Additionally, high levels of debt from leveraged buyouts or sale-leaseback arrangements can burden health care practices and increase the risk of failure.[17]

While private equity and corporate investment in health care is rightfully scrutinized, it cannot be ignored that many physicians willingly choose to partner with or sell their practices to corporate investors. Owning and managing a private practice has become increasingly challenging and corporate investment offers an alternative to being employed by a hospital or health system, or leaving the practice of medicine entirely. Additionally, when physicians sell a practice to a corporate entity, the money from the sale is taxed at capital gains rates which are more favorable than income tax rates, adding to the list of incentives for pursuing these transactions. Physician-owners choosing to enter these partnerships should be aware of risks and do their best to ensure that physician autonomy in clinical and operational decision-making is sustained.

In all types of medical practice, physician autonomy is of the utmost importance. Many physicians are rightfully concerned about the loss of professional control that could arise from partnering with a corporate entity. Almost 61 percent of physicians have a negative view of private equity and less than 11 percent have a positive view, according to a 2024 study.[18] There is also emerging evidence that trainees are less likely to join a practice backed by private equity and that these practices have higher staff turnover rates. In one specific case, dermatologists drawn to private equity backed practices by high salaries quit after being pressured to significantly cut costs and meet high financial targets.[19] A February 2025 *JAMA Health Forum* article found that physician turnover also increased when private equity companies sold the practice or facility they were invested in. Physicians employed by exiting private equity firms were 16.5 percentage points less likely to continue working in that practice two years after the private equity firm exited and 10.1 percentage points more likely to go on to be employed by a facility with more than 120 practicing physicians.[20]

According to the AMA's 2022 Physician Practice Benchmark survey, 49.7 percent of physicians were employees, 44 percent were owners, and 6.4 percent were independent contractors. Between 2012 and 2022, the share of physicians who worked in practices wholly owned by physicians – private practices – dropped by 13 percentage points from 60.1 percent to 46.7 percent. In 2022, 4.5 percent of physicians

were participants in private equity ownership or investment arrangements.[21] Many physicians that have left private practice have become employed by a hospital or health system, where they feel as if they have less autonomy in clinical decision making. In 2023, 56 percent of employed physicians said what they like least about their job is decreasing autonomy, which was up from 48 percent the year prior. According to a survey from National Opinion Research Center at the University of Chicago, approximately 61 percent of employed physicians said they have moderate or no autonomy to make referrals outside of their practice or ownership system, and 47 percent said they adjust patient treatments to reduce costs based on practice policies or incentives.[22]

Another concern is changing workplace composition and replacing physicians with NPPs who can often be hired at a lower salary than physicians, resulting in savings for the practice owner. A January 2023 study examined workforce composition changes in private equity acquired practices and found that in aggregate, the clinician replacement ratio was higher for private equity acquired practices compared to those not acquired by private equity. When compared to non-private equity acquired practices, those acquired by private equity had a significant yearly increase in the number of NPPs after acquisition. While the study claimed to be preliminary in nature, it supported the hypothesis that physicians may be more frequently replaced at private equity acquired practices versus those not acquired by private equity. However, the study also conceded that regardless of ownership, there was a statistically significant increase in NPPs at all practices examined, which could be in response to physician supply shortages, payment reforms, a shift to team-based care, or other factors.[23]

Impact on Consolidation and Market Concentration

A March 2024 *Health Affairs* study looked at private equity acquired practices and market penetration between 2012-2021. This study found that private equity acquired physician sites increased from 816 across 119 metropolitan statistical areas (MSA) in 2012 to 5,779 across 307 MSAs in 2021. The result was single private equity firms having a significant market share, exceeding 30 percent in 108 MSA specialty markets and exceeding 50 percent in 50 of those markets.[24] As can be seen in Appendices A and B of this report, gastroenterology, dermatology, urology, obstetrics and gynecology, ophthalmology, and radiology have seen the highest increases in private equity investment in recent years.

When private equity firms acquire multiple providers in the same specialty within a local or regional market (also known as a "roll-up"), those firms can gain significant market power, which can lead to higher prices or lower quality, or both, due to reduced competitive pressure.[25] An example of a roll-up is U.S. Anesthesia Partners, Inc. (USAP) in Texas. USAP, backed by private equity firm Welsh Carson, systematically bought up many large anesthesiology practices in Texas to create one dominant provider with the power to increase prices. USAP and Welsh Carson further drove up prices by entering into price-setting agreements with the remaining independent anesthesiology practices as well as paying a competing anesthesiology practice to stay out of USAP market territory. The Federal Trade Commission (FTC) sued USAP and Welsh Carson and, at the time this report was written, the case was still ongoing, although Welsh Carson has been dismissed from the case.[26]

Strengthening CPOM bans to protect the independent professional judgment of physicians

States are exploring legislation to protect the independent judgment of physicians by strengthening CPOM bans, in part by setting clearer requirements that lay entities (expressly including private equity firms) may not interfere with a physician's medical decision-making or independent judgment and defining what activities constitute medical decision-making. For example, legislation proposed in Washington State in 2025 would codify that the following be included in the "professional judgment or clinical decision-making" of a physician:

> "(a) The period of time a provider may spend with a patient, including the time permitted for a health care provider to triage patients in the emergency department or evaluate admitted patients; (b) The period of time within which a health care provider must discharge a patient; (c) The clinical status of the patient, including whether the patient should be admitted to inpatient status, whether the patient should be kept in observation status, whether the patient should receive palliative care, and whether and where the patient should be referred upon discharge; (d) The diagnoses, diagnostic terminology, or codes that are entered into the medical record by the health care provider; (e) The range of clinical orders available to a health care provider, including by configuring the medical record to prohibit or significantly limit the options available to the provider; or (f) Any other action specified by rule to constitute impermissible interference or control over the clinical judgment and decision making of a health care provider related to the diagnosis and treatment of a patient."[27]

Similar legislation has been introduced in California and Vermont this year, and in 2024, California's legislature considered CA AB 3129, which would have strengthened California's already-strong corporate practice ban through similar provisions and by limiting private equity companies or hedge funds from controlling or directing a physician practice.[28,29]

Imposing limitations on the structure of Management Service Organizations (MSOs) to insulate corporate investors from clinical decisions

The structure of existing CPOM laws allow for broad workarounds that make room for corporate investors to influence the provision of health care. Every state allows for the creation of a special type of physician-owned legal entity, often known as a professional services corporation (PC), to provide medical services if the PC is entirely owned by physicians, with many states, such as Arizona, only requiring partial ownership of a PC by physicians.[30] When CPOM restrictions limiting practice ownership to physician-owned PCs ban corporate investors from employing physicians or practicing medicine, these lay entities may pursue ownership of a management services organization (MSO) to contract with the physician-owned PC. The MSO may operate the nonclinical aspects of a physician practice and conduct administrative functions, handle practice financials, or provide other clinical support services to the practice. Under these arrangements, the PC ostensibly maintains ownership.

However, existing state laws do not prevent corporate investors from exercising influence on patient care via "friendly PC" arrangements. Friendly PC or friendly physician models allow lay entities to invest in and control physician practices indirectly, generally through an MSO. Commonly, the corporate investor secures a physician(s) to work in the practice who is sympathetic ("friendly") to the investor, while the MSO is compensated to provide services necessary for practice operations. Often the "friendly physician(s)" will serve on the board of directors for or have an ownership stake in the PC, the MSO, or both. These types of arrangements may allow corporations to effectively assume control of physician practices. Major corporate investors in health care, including Oak Street Health and One Medical, leverage the friendly PC model.

Novel legislation first proposed in 2024 aims to address the friendly PC model and insulate corporate investors from clinical operations by imposing certain structural limitations on MSOs. These types of provisions, first seen in 2024 in Oregon (HB 4130), challenge the friendly PC model by prohibiting a physician from serving as a shareholder, director, officer, or employee of both a health care practice and an MSO with which the practice contracts. Essentially, they aim to prevent lay entities from circumventing CPOM bans and limit comingling between MSOs and PCs by ensuring that a physician associated with the MSO cannot also direct or own shares in the PC.[31] This year, legislation imposing structural requirements on MSOs has once again been proposed in Oregon and is being considered as a matter of first impression in both Washington and Vermont.[32] Notably, these provisions are controversial

among physicians, in part because they could disrupt existing arrangements that are ostensibly working well, and also because they might prevent physicians who have equity in an MSO from benefitting financially in the event of a sale (i.e., from receiving "roll-over equity").

Improving transparency and oversight

Legislation to increase transparency and state oversight of transactions involving corporate investors is also being considered at the state level. Corporate acquisitions of physician practices often fall under the radar because they do not meet the monetary threshold for reporting and review by federal governing agencies. This is concerning, because many strategies employed by private equity firms have anticompetitive effects that may impact cost, quality, and access to care. When implemented thoughtfully, legislation to increase oversight may allow state governing bodies to identify and mitigate transactions that may have anticompetitive effects or other harmful impacts on patient care.

A handful of state laws impose requirements that certain transactions – namely those involving corporate investors and falling under a specified threshold below the one required by the Hart-Scott-Rodino Act – be reported to the state attorneys general (AG). Indiana, for example, passed such a law in 2024, and Connecticut, Vermont, and New Mexico are among states considering such legislation in the 2025 session.[33,34] More aggressive proposals go beyond transparency and grant the state AG authority to block any transaction it deems anticompetitive or otherwise inappropriate under statute. To that end, legislation may enumerate specific characteristics that constitute "anticompetitive effects," or, importantly, may name other factors that might render a transaction unlawful, such as compromised quality of care or decreased access to care for patients. California and Massachusetts considered such legislation in 2024.[35] In 2025, a bill passed in Massachusetts that, among other things, broadened the definition of "material change transaction" to include transactions involving private equity, real estate investment trusts, and MSOs, thereby subjecting them to market impact review and potential referral to the AG for determination as to whether there is unfair competition or anti-competitive behavior.[36]

The business model employed by corporate investors in health care often allows a firm to control an acquired entity while paying only a small fraction of the total purchase price upfront. The acquired health care practice or hospital is then forced to take on debt to cover the remaining cost. When this debt load is combined with cost-cutting efforts to increase short-term profits – efforts that are often high-risk strategies given the relatively small amount of capital at stake for the private equity firm – the results can be unsustainable.[37] In recent years, this has been particularly evident in private equity's acquisition of hospitals, where private equity ownership has led to bankruptcies, service reductions, and closures that restrict patient access to care. Examples of such casualties include the 2019 bankruptcy of Hahnemann University Hospital in Pennsylvania, the bankruptcy and closure of several Steward hospitals and related physician practices over the past several years in Massachusetts, and the recent devastation of Prospect Medical hospitals in California, Connecticut, Pennsylvania, and Rhode Island.[38] These closures have also led to the loss of liability tail coverage and/or employment for many physicians.

As proposed in CA AB 3129, access to care was included as a factor that attorney general offices might consider in determining whether to approve a proposed transaction. Other proposed legislative solutions to protect patient access to care following the acquisition of a hospital or health system are multifaceted.[39] While there has not been significant activity in state legislatures, proposed federal legislation may serve as a guide for policy solutions implementable at the state level. Senator Edward Markey's (D-MA) 2024 Health Over Wealth Act is instructive: legislation could mandate an acquired system to establish escrow accounts that would cover operating and capital expenditures for a specified period of time in case of a threatened closure or service reduction; it may impose notice requirements for any service disruptions; and, in order to increase an acquiring firm's stake in the transaction and reduce the debt load taken on by the acquired system, it could require that a minimum financial investment be made by investors upfront.[40]

AMA POLICY

Board of Trustees Report 9-I-24, "Corporate Practice of Medicine Prohibition," took a strong stance on restricting CPOM arrangements. The report amended Policy H-215.981 by adding three new clauses that ask the AMA to vigorously oppose any effort to pass legislation or regulation that removes or weakens state laws prohibiting CPOM; oppose CPOM and support the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups; and create a state CPOM template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting CPOM in ways that are not detrimental to the sustainability of physician practices. In its report, the Board of Trustees recommended that AMA policy distinguish between corporate investment, corporate ownership, and corporate control in physician practices.

The Council has addressed this topic in three reports since 2013. In CMS 6-I-13 the Council discussed state CPOM doctrines and associated restrictions. Ultimately, the Council recommended the AMA maintain a balanced policy on CPOM and stated that the detrimental effects of CPOM can be mitigated by having strong policies in place to protect the independent medical judgment of physicians and patient-physician relationships. This report amended H-215.981 and reaffirmed other policies on physician employment. In CMS 11-A-19, the Council highlighted the risks and benefits of entering into corporate partnerships and noted that physician opinions vary regarding corporate investor involvement in physician practices. The report mentioned that although there has been a great deal of angst among physicians regarding private equity investment in practices, other physicians and physician groups have readily and successfully partnered with these firms. This report established Policy H-160.891, which created guidelines for physicians to consider when entering into corporate partnerships. In CMS 2-I-22, the Council provided a more detailed look at private equity investment in physician practices and shared emerging data on the impact these investments have had on physicians and patients. The report amended H-160.891 by adding two new clauses and established new Policy H-160.887.

The AMA has extensive policy on CPOM, consolidation, and related issues. Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician. Policy H-380.987 states that antitrust relief for physicians is a priority of the AMA.

Policy H-225.947 states that when physicians are seeking employment as their mode of practice they should strive for arrangements where physician clinical autonomy is preserved. Similarly, Policy D-225.977 states that the AMA will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.

Policy H-285.951 supports physicians' right to enter into whatever contractual arrangement with health care systems, plans, groups, or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, groups, and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. Additionally, this policy states that physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.

Policy H-275.937 highlights the sanctity of the patient-physician relationship by stating that the relationship between a physician and a patient is fundamental and is not to be constrained or adversely

affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship. The policy also states that some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine and this may create negative consequences for the public. Physicians must take actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. Furthermore, Policy H-225.950 states that in any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. Additionally, this policy notes that divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. Policy H-140.978 states that physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties.

Related Policy H-385.926 states that the AMA supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.), as long as physicians are charging patients fair fees and provide adequate fee information prior to the provision of services. This policy ensures physician autonomy in business decisions, but affirms that decisions, especially around pricing and fees, should be done in good conscience and be fair and transparent for patients.

DISCUSSION

The Council has recently written several reports, and the AMA has extensive policy to guide physician relationships with CPOM. In this report, the Council aims to strengthen existing guidelines for physicians considering corporate partnerships, support capital reserve requirements for firms interested in investing in the health care sector, and support increased enforcement of existing regulations on CPOM. It is important to note that CPOM is not new, but the recent rise in corporate investment in the health care sector raises cause for concern, particularly as it relates to patient safety and physician autonomy in clinical and operational decision-making.

There are risks and benefits associated with corporate investment and partnership. Corporate investment can offer a way for a practice to avoid selling to a hospital or health system, manage human resources, information technology and other administrative tasks on behalf of the practice, offer lucrative deals for physician-owners wanting to retire or sell their practice, and help with medical liability costs. Risks to physicians include a loss of control of business decisions and/or clinical autonomy, drastic cost cutting measures, loss of employment or replacement by NPPs, restrictive non-compete agreements, loss of liability tail coverage, or increased pressure to meet lofty financial targets. For physician-owners, there is the possibility of debt or bankruptcy after the corporate investor has extracted profits and exited the partnership.

The corporate investor could also go bankrupt, as has happened most recently with Prospect Medical Holdings in January 2025, and with Steward Health and Hahnemann University Hospital in recent years. The Council discussed the importance of financial stability of private equity firms and other investors before investments are made. Because the nature of private equity investment relies heavily on investing with debt (leveraged buyouts), investments can be risky and can lead to bankruptcy if not managed properly. Anecdotally, this has led to several hospital and practice closures around the country. The *Kaiser Health News* collection "Patients for Profit: How Private Equity Hijacked Health Care" provides several examples of where this has happened in the United States and the detrimental effect it can have on patients, physicians, and communities. While an important consideration, the Council believes that it is outside the purview of the AMA to dictate specific financial requirements for corporate investors. Instead, the Council stresses the importance of due diligence on the part of physician-owners considering these partnerships to ensure that an interested corporate investor has the resources required to support a

successful business relationship. With the intent to avoid future hospital closures, the Council recommends that the AMA support capital reserve requirements and leverage standards that preserve access to care for patients by preventing the closure of health care facilities and the limiting of essential health services.

Another consideration for physicians is control over final billing and coding designations. When administrative tasks are outsourced, there is opportunity for errors or intentional upcoding by third-party companies outside of the physician's direct supervision. As it is the physician's ultimate responsibility to ensure that billing and coding are accurate for the services provided, Policy H-385.939 outlines how false claims attributed to them could result in reputational, financial, or even criminal consequences.

During deliberations on this report, the Council discussed the relationship between NPPs and private equity. Theoretically, if physicians are reluctant to enter into corporate partnerships, private equity and other corporate entities may seek to instead invest in health care practices affiliated with NPPs, such as nurse practitioners and/or physicians assistants. The Council recognizes that this could be a result of physician resistance to corporate partnerships but ultimately believes it would be out of scope for the Council to recommend policy on business models for NPPs since the AMA is an organization representing physicians and not NPPs. Informally, the Council believes that like physicians, all allied health professionals should exercise due diligence when considering partnerships with corporate entities.

It is important to enforce regulations on transparency of these transactions as well as the ownership of group practices, hospitals, and health systems, including corporate and private equity ownership and relationships. Additionally, corporate and private equity acquisitions should be reviewed for their potential to disrupt access to care and conditions should be placed to ensure physician independence, quality of care, minimization of conflicts of interest, and avoidance of excess market consolidation. It is also important to support regulations that prevent the closure of essential services, such as emergency departments or labor and delivery units, whenever possible. The importance of transparency is highlighted in Policy H-160.960, which states that patients must be informed when a corporate entity purchases a private medical facility.

Because of the intricacies involved in corporate entity transactions, the Council believes it would be difficult to unwind the mergers and acquisitions that have already taken place, both by corporate investors as well as by nonprofit entities or other types of firms (i.e., nonprofit hospitals, health systems, independent practices). However, to boost competition in already consolidated markets, current laws on CPOM need to be enforced and new businesses need to be able to enter the market. Where possible, mergers and acquisitions should be scrutinized by the appropriate parties (FTC, Department of Justice, state attorneys general, etc.) to ensure they are following antitrust laws and to determine the effect the transaction may have on the market. Pursuing transparency in ownership of health care practices, as well as transparency in pricing, could boost competition as well as allow patients to make an informed choice when it comes to the care they receive.

Given the breadth and depth of AMA policy on this topic, the Council recommends strengthening existing guidelines to promote physician due diligence and protection when considering a relationship with a corporate entity. Specifically, the Council recommends broadening policy to include other corporate structuring, not just corporate investors, including language about conflict resolution, more explicitly stating which clinical and operational decisions should remain under the direction of physicians, including considerations and protections for billing and coding responsibility, supporting physician engagement in organizational governance following a merger or acquisition, and supporting enforcement of CPOM doctrines. The Council recommends supporting capital reserve requirements for corporate entities considering investment in health care facilities in order to provide stable financing in order to preserve access to care for patients and fulfillment of contractual obligations to physicians. Finally, the

Council recommends reaffirming policy on the importance of preserving physician autonomy and clinical decision-making.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1) That our American Medical Association (AMA) amend Policy H-160.891, "Corporate Investors," by addition and deletion, including a change in title:

   CORPORATE INVESTORS AND OTHER CORPORATE ENTITIES, H-160.891

   1) Our American Medical Association encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
      a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
      b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
      c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
      d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
      e. Physicians should consider whether and how corporate ~~investor~~ partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
      f. Physicians should consider the potential impact of corporate ~~investor~~ partnerships on physician and practice employee satisfaction and future physician recruitment.
      g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate ~~investor~~ relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate partnership.
      h. Physicians should consider corporate procedures ~~investor processes~~ for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
      i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate ~~investor~~ partnerships.

j. Prior to entering into a partnership with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
    i. Determining which diagnostic tests are appropriate;
    ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
    iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
    iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
    v. Determining the content of patient medical records;
    vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
    vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
    viii. Making decisions regarding coding and billing procedures for patient care services; and
    ix. Approving the selection of medical equipment and medical supplies.

k. ~~j.~~ Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.

l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.

m. ~~k.~~ Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2) Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.

3) Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.

4) Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.

5) Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a

physician practice, hospital, or other health care organization partners. (Modify HOD Policy)

2) That our AMA amend Policy H-215.981, "Corporate Practice of Medicine," by addition:

CORPORATE PRACTICE OF MEDICINE, H-215.981

1) Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2) Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3) Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4) Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6) Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7) Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8) Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9) Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify HOD Policy)

3) That our AMA reaffirm Policy H-285.910, The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community, which provides a recommended clause to include in physician employment agreements and which states that in caring for patients physicians shall have the unfettered right to exercise independent and professional judgment and be guided by personal and professional beliefs as to what is in the best

interests of patients, the profession, and the community. Furthermore, nothing in the employment agreement shall prevent physicians from exercising their own medical judgment and employers may not retaliate against the physician in any way based on the physician's right to exercise their medical judgment. (Reaffirm HOD Policy)

4) That our AMA rescind Policy D-160.904, as it is accomplished by this report. (Rescind HOD Policy)

5) That our AMA rescind Policy D-215.982, as it is accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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Appendix A

Characteristics of private equity (PE)-acquired and non-PE-acquired practice sites for 10 physician specialties and by specialty, 2021

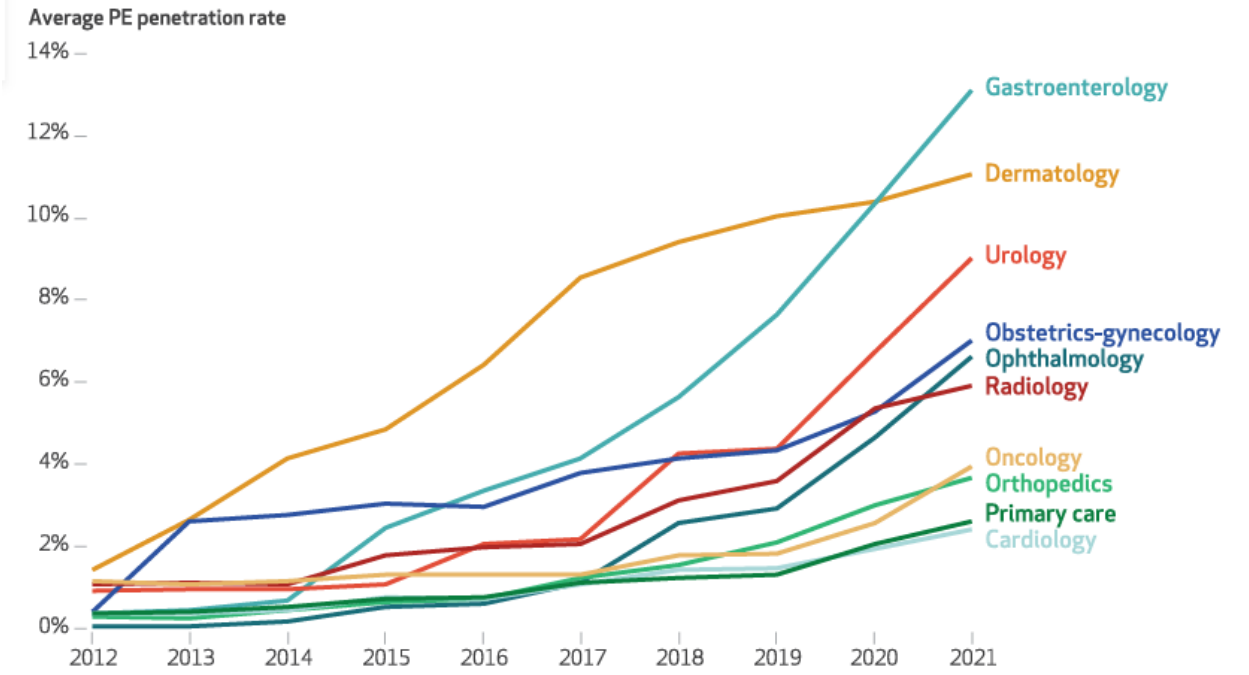
	PE-acquired practice sites (*N* = 5,779)		Non-PE-acquired practice sites (*N* = 131,552)	
Characteristics	**Number**	**Percent**	**Number**	**Percent**
No. of practice owners[a]	243	100.0	6,717	100.0
No. of physicians	14,656	100.0	328,335	100.0
No. of female physicians	5,372	36.7**	132,413	40.3
Age, years (SE)	53.3** (0.02)	—[b]	52.3 (0.09)	—[b]
Geographic region				
South	2,768	47.9	50,459	38.3
Northeast	1,157	20.0	29,212	22.2
Midwest	1,085	18.8	23,511	17.9
West	769	13.3	28,370	21.6
Specialty				
Primary care	1,440	24.9	72,412	55.1
Dermatology	827	14.3	5,818	4.4
Obstetrics-gynecology	798	13.8	10,944	8.3
Gastroenterology	697	12.1	4,468	3.4
Ophthalmology	648	11.2	8,966	6.8
Oncology	368	6.4	5,062	3.8
Urology	346	6.0	3,384	2.6
Radiology	257	4.4	4,991	3.8
Orthopedics	237	4.1	8,094	6.2
Cardiology	161	2.8	7,413	5.6

SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA. The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this exhibit are as of June 15, 2022. **NOTES** Specialties were identified at the physician level. Physicians who worked at multiple locations were counted as a fraction of physicians using full-time equivalents. If a practice included multiple specialties, counts were documented separately for each specialty, equivalent to each specialty being considered as a separate practice. We conducted a two-sample *t*-test on age and chi-square tests for the proportion of female physicians. [a]Practice owners are PE firms in the PE-acquired category and other corporate owners in the non-PE-acquired category. [b]Not applicable. $^{**}p < 0.05$

Health Affairs. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.00152

Appendix B

Trends in private equity (PE) penetration at the physician level in the US among 10 physician specialties, 2012–21



SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA (2020–21) and SK&A Office Based Physicians Database provided by IMS Health (now IQVIA) (2012–19). The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this figure are as of June 15, 2022. **NOTE** Average PE penetration rates at the physician level in each year by specialty were calculated by weighting each Metropolitan Statistical Area (MSA)-level market share by the number of full-time-equivalent physicians in that MSA by specialty, equivalent to the US penetration rate.

Health Affairs. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.00152

Council on Medical Service Report 3-A-25
Regulation of Corporate Investment in the Health Care Sector
Policy Appendix

Corporate Investors, H-160.891

1. Our American Medical Association (AMA) encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
    h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
    j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
    k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

(CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23)

Corporate Practice of Medicine, H-215.981

1. Our American Medical Association (AMA) vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.

3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
(Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified: Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19; Reaffirmed: CME Rep. 01, I-22; Modified: Res. 710, A-24, Modified: BOT Rep. 09, I-24)

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, H-285.910
Our American Medical Association endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise independent professional judgment and be guided by personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise their own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of their rights under this paragraph.
(Res. 8, A-11; Reaffirmed: CEJA Rep.1, A-21; Modified: Speakers Rep. 02, I-24)

The Regulation of Private Equity in the Health Care Sector, D-160.904
Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.
(Res. 710, A-24)

The Corporate Practice of Medicine, Revisited, D-215.982
Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing

state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.
(Res. 702, A-24)

Corporate Practice of Medicine, H-160.887
Our American Medical Association acknowledges that the corporate practice of medicine:

1. has the potential to erode the patient-physician relationship.
2. may create a conflict of interest between profit and best practices in residency and fellowship training.

(CMS Rep. 2, I-22)

Corporate Ownership of Established Private Medical Practices, H-160.960
When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.
(Res. 3, I-92; Modified by CMS Rep. 1, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 11, A-19)

Antitrust Relief as a Priority of the AMA, H-380.987
Our American Medical Association will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.
(Sub. Res. 223, A-93; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed in lieu of Res. 218, A-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: Res. 206, A-19)

Physician Employment Trends and Principles, H-225.947
1. Our American Medical Association (AMA) encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.
2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.
(CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19)

Physician Independence and Self-Governance, D-225.977

1. Our American Medical Association (AMA) will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.
2. Our AMA will promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care

systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.
(Res. 801, I-11; Modified: BOT Rep. 6, I-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

Financial Incentives Utilized in the Management of Medical Care, H-285.951
Our American Medical Association believes that the use of financial incentives in the management of medical care should be guided by the following principles:

(1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
(2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care.
(3) Financial incentives should enhance the provision of high quality, cost-effective medical care.
(4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services.
(5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients.
(6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment.
(7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care.
(8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group.
(9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care.
(10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment.
(11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract.
(12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments.
(13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality.

(CMS Rep. 3, I-96; Reaffirmed by CMS Rep. 15, A-98; Reaffirmation: A-99; Reaffirmed: CMS Rep. 12, I-99; Reaffirmation: A-00; Reaffirmation: A-01; Reaffirmed in lieu of Resolution 901, I-05; Modified: BOT Rep. 38, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: CMS Rep. 11, A-19)

American Medical Association Principles for Physician Employment, H-225.950

1. **Addressing Conflicts of Interest**
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
    d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
        i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
        ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
    e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. **Advocacy for Patients and the Profession**
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. **Contracting**
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance

plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. **Hospital Medical Staff Relations**
   a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
   b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
   c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
   d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. **Peer Review and Performance Evaluations**
   a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
   b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
   c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
   d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
   e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
   f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the

medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis.
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

(BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-25

Subject: Requiring Payment for Physician Signatures (Resolution 108-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

At the 2024 Annual Meeting, the House of Delegates referred Resolution 108, which was sponsored by the Mississippi State Medical Association, and asked the American Medical Association (AMA) to advocate that insurance companies be required to pay a physician for any required physician signature and/or peer-to-peer review which is requested or required outside of a patient visit.

BACKGROUND

Physician signatures are an integral part of health care delivered by a physician, as they serve as an identifier as to who provided services, verify care, assign legal responsibility, and demonstrate that services have been accurately documented to allow eligibility for payment.[1,2,3] Ensuring program integrity, signatures verify that the services provided were accurately and thoroughly documented and reviewed.[4] Physician signatures also assure patient safety by serving to identify which physician is responsible for the patient's care and attesting that they have carefully reviewed the patient's medical information.[5] Further, most health care regulations require signatures on medical records to verify the legitimacy of services provided and proper payment. The state of Illinois, for example, requires that, "all physician's orders and plans of treatment shall have the authentication of the physician…" as "authentication means an original written signature or an electronic signature system that allows for the verification of a signer's credentials."[6]

Physician signatures are required throughout the entire course of treatment for a patient, including prescriptions, medical orders, progress notes, discharge summaries, referrals, evaluations, re-evaluations, surgical reports, pathology reports, diagnosis/treatment plans, and claim forms.[7,8,9] For a prior authorization (PA), a physician's signature is typically required to authenticate the medical necessity of the requested treatment, meaning they must personally sign the document to indicate their approval and agreement with the information provided, usually including their full name and credentials.[10,11]

A peer-to-peer medical review is a dialogue between a treating physician, usually by telephone, and a medical director from a health insurance company, where the physician is required to explain the medical necessity of a treatment or procedure for a patient.[12] Typically, it is a discussion between medical peers to clarify a patient's case when coverage is disputed and occurs by request after a payer denies coverage for services. Denials are usually made for medical orders, services, and inpatient status but can occur for medications or medical devices.[13] While the process can be tedious and frustrating, in some circumstances, it can be expeditious when it gives the treating physician the opportunity to speak with another physician.[14] However, it can be less effective when

the health plan reviewer is a physician from another specialty or subspecialty, knows little about the disease or treatment in determination, or may not be licensed in the same state.[15] Further, the process approaches futility when the assigned reviewer is not a physician.[16]

REPORTING PHYSICIAN SIGNATURES AND PEER-TO-PEER REVIEW

CPT Assistant, a digital monthly newsletter which serves as a companion to the *Current Procedural Terminology* (CPT®) code set, published an October 2024 article providing coding guidance for PA-related activities within evaluation and management (E/M) services.[17] The article describes how PA-related work of providing signatures can be reported with CPT code 99080 (*Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form*).[18] Code 99080 can be appropriately reported when a physician spends time solely on completing special reports or signing forms independent of PA-related work performed on the date of an E/M encounter, excluding time spent on the telephone or in other conversations.[19]

The article also describes how the PA-related work of peer-to-peer review can be captured in the CPT code set. When selecting a code based on total time, physicians or other qualified health care professionals may include both face-to-face and non-face-to-face time, including time spent on PA-related work, on the same date of the encounter.[20] Alternatively, if E/M reporting is based on medical decision making (MDM), the review can be accounted for in the MDM Risk Element by incorporating social drivers of health and elevating to moderate complexity. For peer-to-peer reviews that occur on a different day than the E/M encounter, a separate code for prolonged physician services can be reported.[21] A summary of the codes referenced in the article can be found in Appendix A.[22]

AMA POLICY

Policy D-320.978 advocates for the fair reimbursement of established and future CPT codes for administrative burdens. Policy D-320.993 supports the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of health plan documentation requirements. Policy D-330.919 tasks the AMA to re-engage with the Centers for Medicare & Medicaid Services to re-evaluate Medicare signature requirements. Policy H-155.976 directs the AMA to seek comprehensive reforms to reduce administrative inefficiencies, address the need to reduce administrative costs and burdens, and minimize the administrative burdens imposed on physicians Policy H-225.965 supports that, unless otherwise required by law or regulation, a single signature may document the validity of entries in the medical record. In addition, it is important to note that Policy H-70.919 delineates that the CPT Editorial Panel is the body charged with developing new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers independent of the AMA. Therefore, the AMA cannot direct the activities of the CPT Editorial Panel, including the identification of potential gaps in the nomenclature surrounding the reporting of physician signatures and peer-to-peer review.

DISCUSSION

Resolution 108-A-24 asked the AMA to advocate for payment for physician signatures and/or peer-to-peer review requested or required outside of a patient visit. The Council understands the burden associated with required physician signatures and peer-to-peer reviews before, during, and after the treatment of a patient. However, we also believe that physician signatures are necessary to identify who provided services, ensure integrity, verify PA treatment necessity, assign legal responsibility, satisfy federal and state requirements, and demonstrate that services have been accurately

documented to allow eligibility for payment. Similarly, peer-to-peer reviews may allow a treating physician the chance to communicate the necessity of treatment as well as insight into new procedures or drugs not previously considered. Therefore, the Council recognizes that its recommendations must take each position into consideration.

Additionally, the Council's recommendations must not infringe on PA reform advocacy, which is a priority for the AMA. We are skeptical that the burden of physician signatures is confined to the PA process, as physician signatures are required throughout the entirety of a patient's treatment. Therefore, the Council recommends broadening policy to recognize this issue.

Recently, *CPT Assistant* provided coding guidance for PA-related activities, delineating how services such as signing forms may be appropriately reported with CPT codes. The Council believes that this guidance outlines infrastructure sufficient for the appropriate reporting of such services, thereby allowing eligibility for payment.

While Policy D-320.978 advocates for fair payment of established and future CPT codes for administrative burdens related to PA, the Council recommends underscoring this existing policy by creating a new, standalone policy, expanding it to include advocacy for fair payment of "all administrative tasks." The Council believes this fulfills the resolution's request, embeds seamlessly within existing policy, and provides an impactful solution.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-24 and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for fair payment of CPT codes that accurately describe the myriad of administrative tasks performed by physicians, which can include the prior authorization process, appeals, or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. (New HOD Policy)

2. That our AMA amend Policy D-320.978 by deletion as follows:

    1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
    2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
    3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
    ~~4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:~~
        ~~a. the prior authorization process.~~
        ~~b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.~~ (Modify HOD Policy)

Fiscal Note: Minimal - less than $1,000.

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[16] *Supra* Note 11.
[17] CPT® Assistant. Special Edition: October Update. Reporting Prior Authorization – Related Activities Within E/M Services (99203, 99204, 99205, 99213, 99214, 99215, 99358, 99452, 99080). https://www.ama-assn.org/system/files/cpt-assistant-oct2024-prior-auth.pdf.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

Council on Medical Service Report 4-A-25
Requiring Payment for Physician Signatures
Policy Appendix

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association (AMA) will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

(Res. 701, A-22)

Insurance Coverage Appeals D-320.993

Our AMA will:
(1) continue to support the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of the health plan documentation requirements, such as the appeal process;
(2) continue to advocate to ensure that physicians receive prompt, fair payment from health plans through educational products, seminars and advocacy efforts;
(3) continue to encourage health plans to implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately;
(4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes;
(5) remain an active participant in the standards development activities of several standards development organizations and data content committees; and
(6) continue in its leadership role in the National Uniform Claims Committee and its work with the standards development organizations.
(BOT Rep. 23, A-06 Modified: CMS Rep. 01, A-16 Reaffirmation: I-17)

Reduction of Burdensome CMS Signature Compliance Requirements D-330-919

Our AMA will re-engage the Centers for Medicare & Medicaid Services to re-evaluate Medicare signature requirements.
(Res. 813, I-10 Reaffirmed: Res. 708, A-18)

Administrative Costs and Access to Health Care H-155.976

Our American Medical Association supports accurate calculations of the administrative costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA:

(1) to begin immediately to seek comprehensive reforms to reduce the administrative inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce administrative costs and burdens;
(2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the administrative burdens they impose on physicians and hospitals;
(3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available;
(4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and
(5) that this information be conveyed to the American public through appropriate mechanisms.
(Res. 202, A-90 CMS Rep. A, A-90 Reaffirmed: BOT Rep. 40, I-93 CMS Rep. 12, A-95 Appended: Res. 715, I-02 Reaffirmation A-07 Reaffirmed in lieu of Res. 828, I-08 Reaffirmation I-11 Reaffirmation: A-17)

Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965
The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.
(BOT Rep. 58, A-96 Reaffirmed: CLRPD Rep. 2, A-06 Modified: CMS Rep. 01, A-16 Reaffirmation: I-18)

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.
(BOT Rep. 4, A-06 Reaffirmation A-07 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmation A-11 Reaffirmation I-14 Reaffirmed: CMS Rep. 4, I-15 Reaffirmation A-16 Reaffirmed in lieu of: Res. 117, A-16 Reaffirmed in lieu of: Res. 121, A-17 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 816, I-19)

APPENDIX A

Reporting Prior Authorization Activities Provided as Part of Evaluation and Management Services

- 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

- 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

- 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour. Code 99359 can be used for each additional half hour.

- 99452 - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional.

- 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Impact of Patient Non-adherence on Quality Scores
(Reference Committee G)

EXECUTIVE SUMMARY

Policy D-450.950 was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized and identify equitable and actionable solutions. This report discusses quality of care metrics, measuring patient adherence, the role of coding in value-based care (VBC), patient adherence models, and includes several policy recommendations.

As quality metrics assess the effectiveness of health care processes, outcomes, patient perceptions, and organizational structures or systems to meet assigned goals, they have increasingly been tied to payment in VBC. Poor patient adherence to physician recommendations obscures quality metrics and results in poor outcome measures. Many factors outside of the control of a physician impact the adherence of a patient to physician recommendations. Patient adherence can be measured in three ways: objective, subjective, and biomedical strategies.

In 2003, the World Health Organization (WHO) released a report which provided a critical review of potential solutions to improve adherence, including the WHO Multidimensional Adherence Model, which considers extrinsic factors impacting a patient. There are several additional adherence models that may provide a roadmap to improve patient adherence. While there is no "gold" standard to improve adherence, there may be opportunities based on a combination of methods enhancing patient self-regulation or self-management.

The Council on Medical Service recommends new policy supporting the removal of outcome scores that are unfairly tied to patient non-adherence and the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. The Council also recommends additional research on the intricacies of non-adherence and potential models to improve adherence.

Additionally, the Council recommends amending Policy D-450.958 to capture that patient non-adherence to physician recommendations should not be evaluated in the Hospital Consumer Assessment of Healthcare Providers and Systems and Clinician and Group Consumer Assessment of Healthcare Providers and Systems surveys nor should physician compensation, employment retention or promotion, faculty retention or promotion, or provider network participation be linked to patient non-adherence. Furthermore, the Council recommends reaffirming Policies H-450.947 and H-450.966 to illustrate the AMA's principles and guidelines for pay-for-performance payment systems as well as the principles to consider when assessing quality and performance measures. Lastly, the Council recommends reaffirming Policy H-390.837 to emphasize the AMA's position regarding the Medicare Access and CHIP Reauthorization Act system.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-25

Subject: Impact of Patient Non-adherence on Quality Scores

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy D-450.950 was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized and identify equitable and actionable solutions. This report discusses quality of care metrics, measuring patient adherence, the role of coding in value-based care (VBC), patient adherence models, and includes several policy recommendations.

BACKGROUND

The National Academy of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] Quality metrics assess the effectiveness of health care processes, outcomes, patient perceptions, and organizational structures or systems to meet assigned goals, such as safe, efficient, patient-centered, equitable, and timely care.[2] Increasingly, these quality measures are being linked to payment to ensure quality health care. For Medicare and Medicaid beneficiaries, the Centers for Medicare & Medicaid Services (CMS) uses measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting. Private payers are also increasingly measuring the performance of physicians, with the intent to provide financial incentives to improve health care delivery and establish transparency programs to allow comparison among physicians. While more than half of health care payments are still fee-for-service, CMS continues to expand its value-based payment and alternative payment model programs.[3] In 2022, CMS launched its National Quality Strategy which, "aims to promote the highest quality outcomes and safest care for all individuals" and instills a person-centered approach to the broader goal of quality by focusing on the overall care trajectory across the continuum of care. Further, the approach seeks to reduce provider burden, advance equity, aid in the transition from manual to digital reporting, and clarify comparison between quality and VBC programs.

Broadly speaking, quality can be measured in three ways: structure, process, and outcome.[4] Structural measures focus on the attributes of a setting in which the care is received. Some examples of structural measures include whether the health care organization uses electronic medical records, the number or proportion of board-certified physicians, or the ratio of providers to patients.[5] Process measures assess the interaction between the physician and patient and include the percentage of people receiving preventive services (such as mammograms or immunizations) or the percentage of people with diabetes who have their blood sugar evaluated and controlled.[6] Lastly, outcome measures address morbidity or quality of life. Examples of outcome measures include the percentage of patients who die because of surgery (surgical mortality rates) or the rate of surgical

complications or hospital-acquired infections.[7] Some other examples of measurable care include: patients' reports on the care and service they receive from the hospital (process, structure, or outcome), provision of care instructions upon hospital discharge for certain conditions (process), percentage of patients receiving recommended hospital care for specific conditions such as heart attack (process), pneumonia care (process), and prevention of surgical infection (outcome), rates at which patients fall and incur injury during a hospital stay (outcome), and number of beds and the types of services available (structure).[8]

Unique challenges have arisen during the transition to VBC. For instance, the distinct values, perspectives, and self-interests of health care stakeholders have made it difficult to clarify what should be assessed. Beyond this, the considerable variety of quality measures has caused confusion as they do not share a common theme. Further, the increased requirement to report quality measures (quantity or complexity) leads to increased reporting burden. While the Medicare Merit-based Incentive Payment System (MIPS) is well intentioned, the reporting requirements are burdensome to physician practices and often appear to be irrelevant. MIPS is not unique in that the nature of having to report any quality measures creates a burden. It may be presumed that improving care is ancillary to "checking a box." Further, despite the current efforts to prioritize effective and relevant metrics to determine quality care, the problems within the current framework remain. According to the Commonwealth Fund, many primary care physicians have decided not to participate in value-based models based on "imperfect performance measures," as they believe that quality suffers because of these measures.[9] Indeed, commercial insurers often use the same, or similar, quality measures as CMS to adjust physician payment.

Beyond poor outcome scores, a physician can feel the negative impacts of VBC in a myriad of ways. For instance, there is financial risk associated with changing the payment structure. If the physician, or practice, does not meet targets or costs exceed what is expected, this can be a significant deterrent to VBC.[10] The financial risk can be especially pronounced if the practice does not have the infrastructure or resources to manage the consequences. Beyond this, data interoperability brought forth by fragmented health care data systems makes it difficult to obtain a complete understanding of the patient and their outcomes, which is critical for VBC.[11] Additionally, the administrative burden associated with VBC can be onerous, a transition to VBC may require a workflow redesign, and lack of technology and resources may impede the ability of the physician or practice to participate in VBC.[12]

Ideally, VBC would improve the quality of care and patient experience while decreasing health care costs. However, it is unclear whether that is the case. In some studies, there is evidence demonstrating its benefits.[13] Other studies contradict those sentiments.[14,15] Patient non-adherence to medication protocol, for instance, continues to be a significant issue.[16] One recent estimate revealed that morbidity and mortality associated with non-optimized prescription drug regimens, with non-adherence playing a significant role, cost $528.4 billion per year on average in the United States (U.S.).[17] Beyond this, health care costs have continued to rise during the transition to VBC. The cost of disease progression, readmissions, wasted resources, labor burden, and insurance costs represent three to ten percent of total health care costs in the U.S.[18] Indeed, one meta-analysis showed that all-cause non-adherence costs ranged from $5,271 to $52,341 per person.[19]

Poor patient adherence can obscure a prescribed treatment's effectiveness, or whether it results in avoidable hospitalization, increased mortality, and/or increased health care costs. Physicians may change the regimen with the belief that the health care provided is not improving the patient's outcome, thereby unintentionally negatively impacting a patient, and further complicating the cost or complexity of the health care provided. In addition, a physician may receive a poor-quality score despite providing evidence-based care.[20] However, if a physician provides care that focuses on the

patient's experience (e.g., choosing a lower cost alternative treatment at the patient's request) and the patient fails to improve, the physician is deemed to have provided poor quality care. For diabetes patients, for example, an individual may have a remarkably high blood sugar level when they begin seeing their physician. Over time, the blood sugar level may improve significantly due to the provision of evidence-based care, but the physician's care will be rated as poor quality if it does not meet a certain threshold.[21] Alternatively, if a patient cannot afford medication and the physician provides alternative mechanisms that are cost-effective but do not significantly improve blood sugar levels, the care is considered "poor quality."

Similarly, a physician may have a low MIPS score despite providing evidence-based care. One study suggests that MIPS score was inconsistently associated with performance on process and outcome measures as the MIPS program may be ineffective at measuring and incentivizing quality improvement among U.S. physicians.[22] Further, it was found that physicians caring for medically complex and socially vulnerable patients were more likely to receive low MIPS scores, even when they delivered relatively high-quality care.[23] In another study, it was proposed that safety-net hospitals are more likely to serve patients with higher risk factors and thus have worse performance measures, on average.[24] Hospital-based value-based payment programs may unintentionally increase financial penalties for social safety-net hospitals. Therefore, some VBC payment systems may be ineffective at evaluating and providing payment for quality of care in certain circumstances.

Furthermore, to understand the limitations of quality measures, it is important to consider disparities, structural racism, and discrimination. In 2003, the Institute of Medicine published the report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which provided specific recommendations to reduce disparities by improving financing, allocation of care, communication, and community-based care.[25] The report outlined that racial and ethnic disparities are consistent across a range of illnesses and health care services. Racial and ethnic disparities remain even after adjustment for socioeconomic differences and other health care access related factors.[26] Moreover, while disparities based on race or ethnicity are pervasive, it is important to note that other forms of discrimination impact the health of a patient. For instance, sex, gender, sexual orientation, disability, and socioeconomic status can impede effective health care and create disparate outcomes. Further, while discrimination, bias, and disparities are prevalent in health care, they are also ubiquitous throughout society. Outcome measures evaluate physicians by the outcome of the patient, but many factors outside the physician's control, yet affect a patient's access. In some circumstances, a physician may help by creating alternative options for payment, testing, or treatment. However, many social drivers of health (SDOH) are beyond the control of a physician.

MEASURING PATIENT ADHERENCE

Patient adherence emphasizes the patient's active involvement and decision-making process in following treatment recommendations, suggesting that the patient understands, agrees with, and takes responsibility for their health behaviors. As VBC relies on outcome-based measures, patient adherence becomes a critical factor for tying physician payment to measurement since measures assume patient adherence with prescribed treatments. Unfortunately, patient adherence is contingent on many factors outside the control of a physician. Further, tying physician payment to measures that focus on patient adherence may improperly penalize physicians who are otherwise providing quality care.

The World Health Organization (WHO) defines adherence as "the extent to which a person's behavior – taking medication, following a diet, and/or executing lifestyle changes, corresponds

with agreed recommendations from a health care provider."[27] Measuring adherence involves objective, subjective, and biomedical strategies. Subjective strategies can include questionnaires, diaries, and interviews. Objective strategies can include counting remaining dosages, table counts, patterns of missed dosages, treatment attendance, or electronic monitoring devices which record the time and date when a medication container was opened. Biochemical measures usually involve the detection of a metabolite or marker in bodily fluids. There are drawbacks to each of the methods. For instance, subjective ratings may lead to overestimates of adherence and underestimates of non-adherence. Objective strategies, such as electronic monitoring devices or the use of pharmacy databases may be expensive and time consuming. Biochemical measures might not account for variability in areas such as drug-drug interactions, drug-food interactions, and individual pharmacokinetics of the drug. The most accurate approach may include a combination of all three.

Patient adherence research has focused on the determinants of non-adherence, extent of non-adherence, and strategies to improve adherence. Failure to address the patient's perspective in adherence research has led to a lack of progress in research as well as the lack of understanding physicians' prescribing practices. Furthermore, individual bias, or prejudice, is a key factor when understanding non-adherence. Physician bias, for instance, may impact care. A physician may unintentionally associate the patient's attributes with the care they receive because of ignorance of social or cultural norms.[28] Additionally, physicians, like others in our society, are affected by stereotypes.[29] These impediments to good health care outcomes, and effective care, may make it difficult for a patient to follow physician recommendations.

Furthermore, patient non-adherence to screening tests and vaccinations continues to be a significant impediment to quality metrics. Despite the importance of chronic disease screening, underutilization persists. Even though there is a preponderance of data explicating the usefulness of vaccines, there continues to be concern about their side effects. Parents may be hesitant to vaccinate their children due to concerns about long-term side effects, a lack of trust in medical authorities, and doubt about the benefits of vaccines.[30] Globally, while there was an improvement in vaccination rates in 2022 as compared to 2021, they still remain below 2019 rates.[31] In screening for lung cancer, patient adherence was found to be lower for high-risk individuals – people who smoke, those who are not white, or individuals older than 65.[32] Therefore, it was suggested that interventions to promote adherence should prioritize current smokers and smokers from minority populations.[33] While lung cancer screening is underutilized by minority populations, cancer screening, in general, continues to be underutilized for all populations despite its benefits to reduce morbidity and mortality.[34] Further, adherence to recommended blood-based screening is underutilized, which is troubling as it is an option for early detection and management of cancers or other chronic diseases.[35]

However, some key themes within studies give credence to ways to improve adherence. Physician recommendations significantly improve cancer screening rates among most populations.[36] While physician recommendations are necessary to improve adherence, they are not the only consideration, as the quality and content of the patient/parent-physician discussion also play key roles in the level of adherence since they foster shared decision making.[37] Limited success is also seen with vaccine counseling, as it continues to be the most significant way to improve vaccination rates, especially when coupled with technology such as sending text message reminders and allowing patients to make vaccine reservations.[38]

THE ROLE OF CODING IN VALUE-BASED CARE

As mentioned previously, SDOH factors outside of the control of a physician may impact health care outcomes. Some of these factors may be captured in the *Current Procedural Terminology* (CPT®) nomenclature, particularly with Category II codes.[39] Category II CPT codes are optional, supplemental codes used for performance measurement and intended to facilitate data collection about quality of care by reporting certain services and/or test results that support performance measures.[40] In addition to performance measure codes, performance measure modifiers are used to account for reporting measure exceptions due to the inability to meet the denominator action of the measure for medical, patient, or system reasons.[41]

Research has been compiled toward understanding how the CPT code set can help physicians adapt to VBC arrangements. Recently, the AMA developed an issue brief in conjunction with Manatt Health Strategies, "Accelerating the Adoption of Value-Based Care with the CPT Code Set," which outlines how the CPT code set supports current VBC arrangements and opportunities for continued evolution.[42] The issue brief synthesizes the feedback received from 34 organizations representing VBC provider organizations, health plans, integrated delivery systems, VBC enablement organizations, and health technology organizations, identifying three areas where codes are successfully enabling VBC adoption.[43] Interviewees suggested a variety of opportunities for the CPT code set to support accelerated adoption of VBC models, such as, "considering how CPT might address new types of health care services being delivered, such as how to best account for the delivery of services cognizant of patients' SDOH factors."[44] However, it is important to note that revision or expansion of the CPT code set must be done independent of the AMA HOD, as Policy H-70.919 attests that the CPT Editorial Panel maintains autonomy in the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements, and modifiers.

There are limitations associated with Category II CPT codes, namely that CMS has replaced most Category II CPT codes with Healthcare Common Procedure Coding System (HCPCS) Level II codes. HCPCS Level II codes identify professional services and temporary procedures (G codes) as well as medical services (M codes) and can be used to report services such as the administration of a vaccine, ultrasound, or mammogram.[45] Furthermore, HCPCS Level II codes are used in the MIPS Value Pathways program to identify specific subsets of measures and activities to meet MIPS reporting requirements.[46] While HCPCS Level II codes were initially developed for Medicare claims, many private payers have adopted them. HCPCS Level II codes were selected as part of the Health Insurance Portability & Accountability Act (HIPAA) standard procedural code set for describing services, health care equipment, or supplies not represented in CPT.[47] One of the advantages of HCPCS Level II codes is that they allow for more specificity than CPT codes. For example, HCPCS Level II codes can identify durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies (like surgical bandaging or splints/casts).[48] While HCPCS Level II codes provide a standardized system for reporting across different payers, they have some drawbacks, as well. The complexity of the HCPCS Level II coding nomenclature necessitates specialized knowledge and can present obstacles for health care systems.[49] Additionally, selecting an incorrect code may lead to improper payment or a denial of claims which can result in recoupment or actions against the physician. Furthermore, the code set is updated throughout the year, which can make it difficult to stay up to date on the coding infrastructure.

WORLD HEALTH ORGANIZATION MULTIDIMENSIONAL ADHERENCE MODEL (WHO-MAM)

In 2003, the WHO released, "Adherence to Long Term Therapies: Evidence for Action," which provided a critical review of what is known about and potential solutions to improve adherence.[50]

The report was developed as a result of the WHO Adherence to Long-term Therapies Project, a global initiative launched in 2001 by the Noncommunicable Diseases and Mental Health Cluster of the WHO. The tenets include:[51]

- Poor adherence to treatment of chronic diseases is a worldwide problem of striking magnitude.
- The impact of poor adherence grows as the burden of chronic disease grows worldwide.
- The consequences of poor adherence to long-term therapies are poor health outcomes and increased health care costs.
- Improving adherence also enhances patients' safety.
- Adherence is an important modifier of health system effectiveness.
- Increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.
- Health systems must evolve to meet new challenges.
- Patients need to be supported, not blamed.
- Adherence is simultaneously influenced by several factors.
- Patient-tailored interventions are required.
- Adherence is a dynamic process that needs to be followed up.
- Health professionals need to be trained in adherence.
- Family, community, and patients' organizations: a key factor for success in improving adherence.
- A multidisciplinary approach towards adherence is needed.

In addition, the report introduced five dimensions of adherence. The multidimensional interplay between these factors determines adherence to treatment. As the report mentions, "the common belief that patients are solely responsible for taking their treatment is misleading and most often reflects a misunderstanding of how other factors affect people's behavior and capacity to adhere to their treatment." However, the model may provide a solution to equitably promote adherence to physician recommendations. The dimensions of adherence include:[52]

A. Social and economic factors – negative impacts can include poor socioeconomic status, poverty, illiteracy, low level of education, unemployment, lack of effective social support networks, unstable living conditions, long distance from treatment center, high cost of transport, high cost of medication, changing environmental situations, culture and lay beliefs about illness and treatment, and family dysfunction.
B. Health care team and system-related factors – negative impacts can include poorly developed health services with inadequate or non-existent payment by health insurance plans, poor medication distribution systems, lack of knowledge and training for health care providers on managing chronic diseases, overworked health care providers, lack of incentives and feedback on performance, short consultations, weak capacity of the system to educate patients and provide follow-up, inability to establish community support and self-management capacity, lack of knowledge on adherence and of effective interventions for improving it.
C. Condition-related factors – condition-related factors represent illness-related demands faced by the patient.
D. Therapy-related factors – the most notable therapy-related factors are the complexity of the medical regimen, duration of treatment, previous treatment failures, frequent changes in treatment, the immediacy of beneficial effects, side-effects, and the availability of medical support to deal with them.
E. Patient-related factors – patient-related factors represent the resources, knowledge, attitudes, beliefs, perceptions, and expectations of the patient.

ADDITIONAL ADHERENCE MODELS

Besides WHO-MAM, there are other models to consider that could provide a roadmap to equitably improve adherence, such as:

- Medication Adherence Model (MAM):[53] This option was developed to address medication adherence in patients with hypertension. Its three core concepts are: a) purposeful action; b) patterned behavior; and c) feedback. Patients' initiating and sustaining medication adherence are dependent on the deliberate decision to take medications based on perceived need, effectiveness, and safety (Purposeful Action). Then they establish medication-taking patterns through access, routines, and remembering (Patterned Behavior). Individuals use information, prompts, or events (Feedback) during the appraisal process to evaluate health treatment that, in return, influences individuals' levels of Purposeful Action and Patterned Behavior.

- Hierarchical Model for Medication Adherence (HMMA):[54] The HMMA was developed in consideration of Maslow's hierarchy of needs. In this model, an individual acquires certain skills/beliefs/behaviors at lower levels to achieve the higher level of medication adherence behavior. At the base level, every individual should have adequate health literacy. Once the patient understands their disease and treatment, the beliefs component comes into play. The next phase in the model is an individual's belief in their medicines. The final stage of the hierarchical model is self-efficacy.

- Transtheoretical Model (TTM):[55] The TTM is a theory of change that a common set of change processes can be replicated across behaviors and situations. TTM posits that health behavior change involves progress through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. The stages are transtheoretical and integrate principles of change from across a variety of theories. Each stage brings an individual closer to behavioral changes.

- Three Factor Heuristic Model:[56] The model comprises three important clinical actions: (1) insuring that patients have the right information and know how to adhere – including listening to patients' concerns, encouraging their participation and partnership in decision-making, building trust and empathy, and enhancing recall; (2) helping patients believe in their treatment and become motivated to commit to it - that is, addressing the cognitive, social, cultural normative and contextual factors that affect patients' beliefs, attitudes and motivation; and (3) assisting patients to overcome practical barriers to treatment adherence and develop a workable strategy for long-term disease management - including assessing and enhancing patients' social support, identifying and treating their depression and helping patients overcome cost-related treatment barriers.

- Health Belief Model (HBM):[57] HBM allows physicians, and other health care professionals, access and assess the patient's behavior by breaking down their beliefs. Following the HBM, a health care provider should: verify the patient's understanding of the potential consequences of their disease; make sure the patient knows that they are susceptible to those consequences, and that they have a degree of control over the outcome; assess the patient's understanding of the benefits of the treatment to ensure they fully understand those benefits; and make sure that the patient has a realistic understanding of side effects to ensure that if side effects manifest, they do not undermine the perceived value of the behavior change.

- Theory of Planned Behavior (TPB):[58] TPB suggests that people will at least form the intention to conduct a given behavior if all three of the domains – beliefs about a behavior, the perception of a subjective norm, and the perception of control – come together. TPB adds an important social element because people are social and have strong reactions to behaviors that are perceived to affect social standing. To apply the TPB, health care providers should consider the following suggestions: ask the patient how difficult they think it will be to carry out suggestions and follow the prescription, ask the patient what they think might lead to failure, inquire about the degree to which the people close to the patient will either help or hinder behavior changes, and discuss the patient's perception of what other people or society in general might feel about the condition or treatment behaviors.

While there is an array of options to help assuage non-adherence, it is important to highlight that no one option is the "gold-standard." Indeed, none of the options boast a wide array of studies to verify legitimacy. Therefore, more research should be compiled to evaluate the most effective models.

IMPROVING PATIENT ADHERENCE

There may be opportunities to help improve patient adherence in an equitable way. According to the WHO report, some innovative interventions can target the patient, physician, and the health care system as outlined below. For example, the AMA Improving Health Outcomes (IHO) Group supports physicians, care teams and the patients they serve to prevent cardiovascular disease. IHO found that a lack of blood pressure measurement protocol contributes to variation and inaccurate measurements. As a result, patients with uncontrolled hypertension are sub-optimally treated, which frequently leads to non-adherence of medications and treatment plans. In response, IHO created the MAP (Measure Accurately, Act Rapidly, and Partner with Patients) Framework to address the systemwide problem.[59]

While the WHO report did not identify a single intervention as most effective, promising methods include a combination of the following strategies:[60]

- Patient Education
- Behavioral Skills
- Self-Rewards
- Social Support
- Telephone Follow-up

Further, it was found that the most effective interventions directed at patients aim to enhance self-regulation or self-management capabilities, such as:[61]

- Self-Monitoring
- Goal Setting
- Stimulus Control
- Behavioral Contracting
- Commitment Enhancement
- Creating Social Support
- Relapse Prevention
- Corrective Feedback

However, as the WHO's report outlines, "even the most efficacious patient-focused interventions have no substantial effects on adherence behavior over the long term." Therefore, further study is required to understand viable options to improve adherence behavior long-term.

AMA POLICY

Policy H-450.947 outlines Principles for Pay-for-Performance and Guidelines for Pay-for-Performance, which support the formation, implementation, and assessment of fair and ethical Pay-for-Performance programs. Further, the principles and guidelines reinforce the importance of a patient-centered approach and evidence-based performance measures.

Policy H-450.966 supports the need for the AMA, national medical specialty societies, state medical associations, and physicians to actively participate in the development, implementation, and assessment of quality and performance measures. Policy H-410.960 encourages physicians to support the development and usage of quality improvement standards and indicators for measurement of quality practice.

Policy H-390.837 encourages CMS to simplify MIPS, advocates for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the Medicare Access and CHIP Reauthorization Act (MACRA) system, and urges CMS to study whether the MACRA system disincentives physicians to provide care to sicker Medicare patients. In addition, there are several policies that are more specific about the removal of measures or metrics within quality scores. Policy D-450.955 supports asking CMS to remove pain scores from quality metrics that impact payment from nursing facilities, while Policy D-450.958 advocates that CMS remove pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems and Clinician and Group Consumer Assessment of Healthcare Providers and Systems and encourages health care systems not to link physician compensation and attainment to patient pain scores.

DISCUSSION

While the Council recognizes the importance of performance measures and values their contribution to VBC, many require patient adherence which is not always controlled by the physician. In addition, the Council believes that physicians have a significant role to play in the development, assessment, and implementation of quality measures.

Quality metrics are specific, quantifiable measures used to evaluate the quality of care provided to patients. The metrics assess various aspects of health care delivery, including patient outcomes, safety, efficiency, and patient satisfaction. While these metrics are important in the evaluation of the care provided, unique challenges have been identified. For instance, quality metrics may not account for the progression of a patient. While a patient may get significantly better, they may not meet a certain threshold indicating so-called "good" care. Further, patient adherence may be a significant issue. A patient may not take medication because of social stigma or cultural differences. Beyond this, quality metrics do not consider the systemic issues that impede quality of care. Structural racism is a significant factor in the health care outcomes of patients, as is discrimination in other forms – such as disability, sex, gender, and socioeconomic status. Therefore, the Council supports the modification of quality measures and removal of outcome scores that are unfairly tied to patient non-adherence. Further, the Council recommends amending Policy D-450.958, to remove patient outcomes and patient non-adherence to treatment from the HCAHPS and to remove patient outcomes and adherence to treatment from the evaluation of physician compensation, retention, promotion, and provider network participation. The Council

recommends reaffirming Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance to highlight best practices when developing VBC.

Significant problems continue to exist with MIPS, leading the Council to believe that the unique challenges of MIPS are an organic extension of the issues related to VBC. As such, the Council recommends reaffirming Policy H-390.837, which encourages CMS to improve MIPS to a simplified quality and payment system. Furthermore, the Council believes that physicians must have a significant role in the assessment of quality and performance measures. Therefore, the Council recommends reaffirming Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA, national medical specialty societies, and state medical associations to be involved in the assessment, as well as the development and implementation of quality measures.

The importance of patient adherence in VBC cannot be overstated. VBC relies on outcome measures which are determined by the ability of the patient to adhere to prescribed treatments. However, patient adherence is contingent on many factors outside a physician's control. Research on patient adherence is lacking, specifically a patient's perspective, which has led to a lack of knowledge about how to address long-term adherence. Therefore, the Council recommends that additional research be conducted to understand patient non-adherence, and potential models or strategies to improve adherence. Furthermore, many models have been developed to address patient adherence and holistically improve health care outcomes. The most notable is the WHO-MAM, which was introduced in 2003, providing a critical review of what is known about and potential solutions to equitably improve adherence. Fourteen tenets captured the findings of the report, and five dimensions of adherence were outlined to diagram the multidimensional interplay that determines adherence. Therefore, the Council recommends support for these types of models to provide guidance to improve patient adherence.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the removal of physician outcome scores that are unfairly tied to patient non-adherence. (New HOD Policy)

2. That our AMA support the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. (New HOD Policy)

3. That our AMA support additional research to understand the intricacies of non-adherence and potential models/strategies to improve adherence. (New HOD Policy)

4. That our AMA amend Policy D-450.958, "Pain Medicine," by addition and deletion, including a change in title:

   PAIN MEDICINE AND PATIENT ADHERENCE IN QUALITY CARE ASSESSMENT, D-450.958
   Our AMA: (1) ~~continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2)~~ continues to advocate that the Centers for Medicare & Medicaid Services ~~CMS~~ not incorporate items linked to pain scores and adherence

to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems ~~CAHPS~~ Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys; and (2) ~~(3)~~ encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. (Revise HOD Policy)

5. That our AMA reaffirm Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA and state medical societies to be involved in the assessment, as well as the development and implementation, of quality measures. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-390.837, which encourages the Centers for Medicare & Medicaid Services (CMS) to revise the Merit-Based Incentive Payment System to a simplified quality and payment system, asks the AMA to advocate for appropriate scoring adjustments for physicians treating high risk beneficiaries in the Medicare Access and CHIP Reauthorization Act (MACRA) program, and urges CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients. (Reaffirm HOD Policy)

8. Rescind Policy D-450.950, as having been completed with this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 7-A-25
Impact of Patient Non-adherence on Quality Scores
Policy Appendix

Quality Management H-450.966

1. Our AMA continues to advocate for quality management provisions that are consistent with AMA policy.
2. Our AMA seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures.
3. Our AMA continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures.
4. Our AMA emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts.
5. Our AMA urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures.
6. Our AMA advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:
    a. Standards and measures shall have demonstrated validity and reliability.
    b. Standards and measures shall reflect current professional knowledge and available medical technologies.
    c. Standards and measures shall be linked to health outcomes and/or access to care.
    d. Standards and measures shall be representative of the range of health care services commonly provided by those being measured.
    e. Standards and measures shall be representative of episodes of care, as well as team-based care.
    f. Standards and measures shall account for the range of settings and practitioners involved in health care delivery.
    g. Standards and measures shall recognize the informational needs of patients and physicians.
    h. Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.
    i. Standards and measures shall recognize the importance and implications of patient choice and preference.
    j. Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.
    k. Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

BOT Rep. 35, A-94 Reaffirmed: CMS Rep. 10, I-95 Reaffirmed: CMS Rep. 7, A-05 Modified: CMS Rep. 6, A-13 Reaffirmed in lieu of Res. 714, A-14 Reaffirmed in lieu of Res. 814, I-14 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmed in lieu of

Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed: CMS Rep. 02, I-17 Reaffirmation: A-22

Quality Patient Care Measures H-410.960
Our American Medical Association encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice.
Res. 811, I-02 Reaffirmed: CSAPH Rep. 1, A-12 Reaffirmed: CSAPH Rep. 1, A-22

Pay-for-Performance Principles and Guidelines H-450-947
The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:
1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.
Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

BOT Rep. 5, A-05 Reaffirmation A-06 Reaffirmed: Res. 210, A-06 Reaffirmed in lieu of Res. 215, A-06 Reaffirmed in lieu of Res. 226, A-06 Reaffirmation I-06 Reaffirmation A-07 Reaffirmation A-09 Reaffirmed: BOT Rep. 18, A-09 Reaffirmed in lieu of Res. 808, I-10 Modified: BOT Rep. 8, I-11 Reaffirmed: Sub. Res. 226, I-13 Appended: BOT Rep. 1, I-14 Reaffirmed in lieu of Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmation I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmation: A-18 Reaffirmation: A-22

MACRA and the Independent Practice of Medicine H-390.837

1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.

3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Alt. Res. 206, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Remove Pain Scores from Quality Metrics D-450.955
Our AMA will work with the Centers for Medicare and Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five-star rating system for nursing facilities.
Res. 236, A-16

Pain Medicine D-450.958
Our AMA: (1) continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2) continues to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and (3) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.
BOT Rep. 5, I-15

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.
BOT Rep. 4, A-06 Reaffirmation A-07 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmation A-11 Reaffirmation I-14 Reaffirmed: CMS Rep. 4, I-15 Reaffirmation A-16 Reaffirmed in lieu of: Res. 117, A-16 Reaffirmed in lieu of: Res. 121, A-17 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 816, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-25)

Introduced by: American Association of Clinical Urologists

Subject: Electronic Health Records Contract Termination

Referred to: Reference Committee G

Whereas, Electronic Health Records (EHR) are an integral part of medical practices; and

Whereas, implementation of an EHR requires significant time and analysis prior to purchase; and

Whereas, the financial burden of the investment for hardware, software, and training is substantial; and

Whereas, the ongoing maintenance costs for hardware, software and continuous training are also significant; and

Whereas, abruptly changing EHR vendors places the practice at risk of not meeting government mandates such as the Merit-Based Incentive Payment System (MIPS); and

Whereas, an EHR vendor recently provided 30-day notice of termination to a group of physician practices without cause; therefore be it

RESOLVED, that our American Medical Association adopt as policy that Electronic Health Record (EHR) vendors provide physician practices with a minimum180-day notification of contract termination without cause (New HOD Policy); and be it further

RESOLVED, that our AMA petition the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) to mandate that EHR vendors provide a minimum 180-day notification of contract termination without cause to physician practices. (Directive To Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/15/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-25)

Introduced by: The American Academy of Family Physicians

Subject: Strengthening Health Plan Accountability for Physician Satisfaction

Referred to: Reference Committee G

Whereas, there is no accrediting body that publicly reports metrics to quantify physician satisfaction with health insurance plans (e.g., comprehensive data exchange and feedback mechanisms, utilization management criteria, payment policies, claims denials, or customer service); and

Whereas, the current lack of standardized metrics for physician satisfaction with health insurance plans creates a gap in understanding and addressing the administrative burdens faced by physicians[1,2.]; and

Whereas, the integration of physician satisfaction metrics into health plan evaluations can provide valuable insights into the effectiveness of health insurance plans and their impact on healthcare delivery[2]; and

Whereas, the American Medical Association recognizes the importance of physician satisfaction as a critical component of healthcare quality and advocates for measures that enhance transparency and efficiency in health plan operations[1]; and

Whereas, the National Committee for Quality Assurance (NCQA) has the potential to play a pivotal role in advancing healthcare transparency by incorporating physician satisfaction metrics into its health plan measurement framework; therefore be it

RESOLVED, that our American Medical Association advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive physician satisfaction metrics (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive physician satisfaction metrics. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/2025

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RELEVANT AMA POLICY

National Committee for Quality Assurance H-450.962
Our AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality, and cost policies.

Physician Satisfaction D-405.985
Our AMA will study current tools and develop metrics to measure physician professional satisfaction.

Health Plan "Report Cards" H-450.961
1. Our American Medical Association supports the development and appropriate use of health plan performance standards.

Insurance Coverage Appeals D-320.993
Our AMA... (4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes.

Prior Authorization and Utilization Management Reform H-320.939
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Prior Authorization Relief in Medicare Advantage Plans H-320.938
Our American Medical Association supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans: c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-25)

Introduced by: American Association of Gynecologic Laparoscopists, American College of Obstetricians and Gynecologists

Subject: Appropriate Use of Data from Surgical Practices

Referred to: Reference Committee G

Whereas, the advancement of technology in surgical practices, especially robotics, has significantly increased the amount of data that can be captured and analyzed, including metrics such as case duration, instrument usage, camera movement, and surgeon economy of motion[1]; and

Whereas, these data provide valuable insights and identifies areas for improvement that can help surgeons and trainees refine their surgical techniques, as well as offer opportunities for surgical innovation- thereby potentially improving patient safety and outcomes[2]; and

Whereas, no current guidelines exist that protect those same data, when accessed by hospital administrators, from being used to compare surgeons, construct productivity benchmarks, establish rigid surgical targets (e.g., goal case times, instrument cost limits), and create incentive/penalty systems based on these targets; and

Whereas, such practices can deter surgeons from involving trainees in surgical procedures, as trainees typically take more time and have less refined movements, potentially impacting their education and development[3-4]; and

Whereas, surgical procedures vary greatly in terms of complexity, and thus, the time taken, costs, and instruments used can differ significantly from one case to another[5]; and

Whereas, a surgeon's choices during a particular operation are influenced by innumerable factors, including the patient’s risk factors, history, and anatomy, as well as the surgeon’s prior experience, the types of equipment available, operating room availability, the quality and mix of operating room staff and assistants, and the operating room schedule[6]; and

Whereas, comparing individual surgeries or surgeons based on rigid metrics fails to account for the nuances and complexities inherent in different surgical cases[7]; and

Whereas, there is evidence that suggests the involvement of physicians in hospital decision-making is associated with lower-cost and higher-quality care, therefore hospitals benefit from the involvement of physicians in the decision-making process regarding the use of clinical data to ensure they are interpreted and used appropriately[6]; and

Whereas, surgical data have the potential to enhance patient safety and surgical education, but could also be used for punitive measures, emphasizing the importance of context in interpreting surgical metrics; and

Whereas, clear guidelines and robust studies are needed to ensure the appropriate and ethical use of surgical data; therefore be it

RESOLVED, that our American Medical Association advocate for policies that ensure data collected from surgical practices are used primarily to support surgical education, quality improvement, and patient safety, with appropriate protections to prevent misuse (New HOD Policy); and be it further

RESOLVED, that our AMA support physician leadership and involvement in the collection, interpretation, and application of surgical data to ensure that its use respects clinical complexity, preserves professional judgment, and accounts for patient-specific factors, surgical variability, and the nuances of individual operative decision-making (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of surgical data by hospital administrators or other stakeholders to create rigid productivity benchmarks, comparative performance metrics, or incentive/penalty systems that fail to account for the educational value of training environments, differences in case complexity, or surgeon-specific clinical contexts. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/17/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-25)

Introduced by: Florida, New York, Maryland, Mississippi, Tennessee, Pennsylvania, West Virginia

Subject: Mitigating the Impact of Excessive Prior Authorization Processes

Referred to: Reference Committee G

Whereas, excessive prior authorization requirements by insurance companies increasingly hinder timely patient access to necessary medical care; and

Whereas, these processes often lead to significant delays, outright denials, and increased administrative burdens on physicians without demonstrable benefit to patient care, quality, or outcomes; and

Whereas, the current prior-authorization structure imposes substantial financial and operational burden on physicians, undermines patient trust, and jeopardizes patient safety; and

Whereas, prior-authorization is performed by individuals who lack the skills, knowledge and training of the requesting residency-trained, specialist physician; and

Whereas, there is the need to comprehensively understand the impact of these practices on both patients and physicians to facilitate meaningful reform; therefore be it

RESOLVED, that our American Medical Association actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers (Directive to Take Action); and be it further

RESOLVED, that our AMA working with legal experts, determine whether and to what extent it may be appropriate to initiate and/or support a class action lawsuit against insurance companies based on the identified prior authorization data, and, if so appropriate, collaborate with patient advocacy groups to support potential lawsuits (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 4/21/25

RELEVANT AMA POLICY

Click D-320.974 Insurer Accountability When Prior Authorization Harms Patients
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care. [Res. 711, A-24]

H-320.939 Prior Authorization and Utilization Management Reform
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. [CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19 Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21 Reaffirmation: A-22]

D-478.958 Prior Authorization-Patient Autonomy
Our American Medical Association will advocate that patients and physicians should be given access to an electronic prior authorization system by their health plans with the ability to monitor the electronic prior authorization process in any model legislation and as a basis for advocacy for prior authorization reforms. [Res. 731, A-22]

D-320.978 Fair Reimbursement for Administrative Burdens
1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
a. the prior authorization process.
b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. [Res. 701, A-22]

D-320.976 Prior Authorization Costs, AMA Update to CMS
Our American Medical Association will continue to conduct research on the costs associated with prior authorization by utilizing our AMA and other data sources. [Res. 720, A-23]

D-320.979 Processing Prior Authorization Decisions
Our American Medical Association will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. [Res. 712, I-20 Reaffirmation: A-22] or tap here to enter text.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-25)

Introduced by: Georgia

Subject: Elimination of Transaction Fees for Electronic Healthcare Payments

Referred to: Reference Committee G

Whereas, fees associated with electronic transactions for healthcare services are a costly and unnecessary burden on patients and healthcare providers; and

Whereas, the Affordable Care Act requires that health plans give providers the option of being paid electronically to improve efficiency and save money; and

Whereas, in 2017, the Centers for Medicare & Medicaid Services (CMS) issued guidance that prohibited insurers and their payment processing vendors from "engaging in unfair business practices that do not support an efficient healthcare system," according to the Medical Group Management Association (MGMA)[1], though that guidance was later removed from the CMS website; and

Whereas, the Medical Group Management Association (MGMA) asserts that 75% of practices' annual revenue is paid electronically[2]; and

Whereas, addressing the burden of electronic transaction fees is especially crucial for the healthcare field as reimbursement rates continue to fall; and

Whereas, bipartisan legislation was introduced to the U.S. House of Representatives in 2023 to address the predatory electronic fund transfers (EFTs) fee process[3]; and

Whereas, our American Medical Association worked closely with the sponsors in drafting this legislation, the No Fees for EFTs Act (H.R. 6487 2023); and

Whereas, H.R. 6487 did not have any movement in the House of Representatives after its introduction; therefore be it

RESOLVED, that our American Medical Association continue to advocate to the United States Congress to eliminate transaction fees for electronic payments for healthcare. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

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2. https://www.ama-assn.org/practice-management/claims-processing/house-bill-makes-it-clear-no-fees-health-plan-efts
3. H.R. 6487—No Fees for EFTs Act (118th Congress, 2023-2024): https://www.congress.gov/bill/118th-congress/house-bill/6487

RELEVANT AMA POLICY

Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:
    a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.
    b. CMS enforcement activities related to this issue.
    c. Physician access to a timely no fee EFT option as an alternative to VCCs.

Res. 819, I-23

CMS Administrative Requirements D-190.970

1. Our American Medical Association will forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA).
2. Our AMA will forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees.
3. Our AMA will communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans.
4. Our AMA will through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Res. 229, I-21Reaffirmation: A-22

Virtual Credit Card Payments H-190.955

1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.

2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.

3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Sub. Res. 704, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-25)

Introduced by: Illinois

Subject: Increasing Transparency Surrounding Medicare Advantage Plans

Referred to: Reference Committee G

Whereas, enrollment in Medicare Advantage (MA) plans has increased from 19% to 54% of all Medicare beneficiaries since 2007, with projections estimating this will increase to 64% by 2034 (1); and

Whereas, Medicare Advantage plans are able to negotiate provider networks, require referrals and prior authorizations, and impose out-of-pocket costs to constituents (2); and

Whereas, the lack of transparency surrounding Medicare Advantage plans recently led the National Association of Insurance Commissioners (NAIC) to submit a Request for Information to the Centers for Medicare & Medicaid Services (CMS) asking for increased reporting of various parameters including rates of prior authorization requirements, frequency of claim denials, network adequacy, and out-of-pocket costs to constituents of MA plans (3); and

Whereas, lack of transparency contributes to longstanding difficulties in holding CMS accountable for reclaiming overpayments made to those private insurance companies administering MA, leading to millions of lost tax dollars annually (4); and

Whereas, there is evidence to suggest that Medicare Advantage policies differ significantly from traditional Medicare in multiple areas including prior authorization, claims denials, network adequacy, and marketing practices; and

Whereas, traditional Medicare requires prior authorizations only in rare circumstances (5); and

Whereas, one cross-sectional study found that five major MA providers (encompassing 62% market share collectively) required prior authorizations for 17% to 33% of all healthcare spending, and that there was little agreement (less than 30%) between these five MA providers regarding which medical interventions warranted prior authorization, suggesting inconsistent criteria defining low-value care and suboptimal prior authorization policy (6); and

Whereas, prior authorization requirements place substantial administrative burdens on medical practices, disrupt workflow, and lead to costly delays and denials of necessary medical care, prompting the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) to report adverse impacts on beneficiary care due to delayed and denied prior authorization requests that nonetheless met Medicare coverage criteria (7); and

Whereas, CMS has identified the heightened prior authorization and administrative burden in MA plans compared to traditional Medicare as a significant source of provider burnout,

compelling providers to allocate resources to navigate varied authorization requirements across payers, which diverts time and resources from direct patient care (8); and

Whereas, Medicare Advantage plans deny more claims than traditional Medicare, with a 15% increasing rate of denials between 2014-2019, during which time one-third of MA beneficiaries experienced at least one denial each year among which 34% did not meet denial criteria under traditional Medicare guidelines (9); and

Whereas, Medicare Advantage plans restrict patient choice of hospitals and doctors through narrow networks that often do not meet network adequacy standards set by the CMS (10); and

Whereas, Medicare Advantage plans engage in deceptive marketing that appears as official correspondence from Medicare or government documents, as well as targeted marketing to individuals with cognitive impairment, prompting the Majority Staff of the U.S. Senate Committee on Finance to call for the CMS and Congress to regulate MA marketing materials (11); and

Whereas, Medicare Advantage plan marketing often leads seniors to believe they are receiving comprehensive benefits, only for them to later discover that certain services, providers, or coverage terms do not meet their initial expectations or needs (12); and

Whereas, professional societies including the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP) the American Academy of Neurology (AAN), the American College of Rheumatology (ACR), the American Optometric Association (AOA), the American Hospital Association (AHA), the American Psychiatric Association (APA), the American Dental Association (ADA), the American Speech-Language-Hearing Association (ASHA), the American Society of Nephrology (ASN), the American Academy of Audiology (AAA), and the American Association of Hip and Knee Surgeons (AAHKS) have raised concerns and/or supported increased transparency regarding MA plans (13-24); therefore be it

RESOLVED, that our American Medical Association support policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, provider contracts, and provider networks. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVEANT AMA POLICY

Medicare Advantage Policies H-285.913

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;

2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and

3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Medicare Advantage Policies H-330.878
1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Prevent Medicare Advantage Plans from Limiting Care D-285.959
Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

Medicare Advantage Plans H-330.867
1. Our American Medical Association encourages that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.
2. Our AMA will provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-25)

Introduced by: Mississippi

Subject: Simplifying Correspondence from Health Insurers

Referred to: Reference Committee G

Whereas, multiple studies show the tremendous financial and human resource burden imposed upon physician practices by health insurance companies; and

Whereas, multiple polls and studies have shown that the unnecessary administrative burdens of medicine imposed upon physician practices by health insurance companies is a major factor in physician burnout; and

Whereas, there is a longstanding, widely-acknowledged physician shortage that is worsened by unreasonable and unnecessary administrative burdens imposed by health insurance companies upon physician practices; and

Whereas, the administrative burden of medicine is known to delay and deny necessary care to patients, often resulting in worsened outcomes; and

Whereas, non-standardized communication contributes to administrative burden by requiring physicians and their staff to read each correspondence to determine its purpose and reread it completely to find specific information each time the issue is dealt with; and

Whereas, standardized communication from health insurers will increase the efficiency of physician offices, and decrease administrative costs as well as physician burnout; therefore be it

RESOLVED, that the American Medical Association advocate for the regulation and standardization of correspondence from health insurers for the goal of simplifying the message, making it more readable, more quickly processed, and more efficiently reviewed. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-25)

Introduced by: Mississippi

Subject: Advocating Against Prior Authorization for In-Person Visits with Physicians

Referred to: Reference Committee G

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is, for most Americans currently, necessary to access standard of care treatment and prevention for acute and chronic diseases; and

Whereas, some health insurers offer plans that require various processes of approval of an in-person healthcare visit with a physician; and

Whereas, many problems cannot be treated properly over the phone – even with visual capabilities; and

Whereas, in lieu of in-person visits with the patient's physician, some insurers require the patient to receive care by non-physician providers who do not know the patient prior to the patient's healthcare complaint and are not the patient's first choice to meet their healthcare needs; and

Whereas, this practice necessarily causes a delay in evaluation and treatment for the patient; and

Whereas, this practice increases the barriers and costs to care and unnecessarily complicates the healthcare system for patients who likely already have difficulty navigating the system effectively; and

Whereas, these cost-controlling measures by health insurers are unethical, unnecessary, and benefit only the health insurer; therefore be it

RESOLVED, that our American Medical Association advocate against health insurance plan policies that require prior authorization for in-person visits with a physician. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-25)

Introduced by: New York

Subject: Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients

Referred to: Reference Committee G

Whereas, patients who are in pain are discharged from Hospitals and Ambulatory surgery centers deserve timely access to coverage for pain medication prescribed by their treating physician and/or other providers; and

Whereas, some Health Insurers create barriers to timely access to post discharge pain medications by requiring preauthorization or certain well established FDA approved medications even when cost effective generic versions exist, because of the perceived potential for addiction or abuse e.g. oxycodone or MS Contin or for financial reasons; and

Whereas, there is often little time to obtain preauthorization before the last dose of the prescribed medication given predischarge has worn off – resulting in patients who can't afford to pay cash for these medications suffering an unnecessary escalation in their pain – which may result in costly ER visits or readmission for pain control -further overburdening the strained ER /hospital systems in NY state; therefore be it

RESOLVED, that our American Medical Association shall advocate for legislation and/or regulation prohibiting ERISA and Medicare Advantage plans from requiring preauthorization for prescribed opioid pain medicine for post-surgery and post-hospital discharged patients for an initial 7-day supply. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-25)

Introduced by: New York

Subject: Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible

Referred to: Reference Committee G

Whereas, the insurance industry has created these outrageous entities called Pharmacy Benefit Managers (PBM) under the guise of prescription cost reduction; and

Whereas, many pharmacies have coupon codes and online websites that offer lower prices than the PBM; and

Whereas, these lower prices are then not applied to the patient's deductible and out of pocket maximum as it ultimately does not go through the patient's insurance, even though the PBM should have provided the lowest possible price; and

Whereas, many states have passed laws that prohibit so-called "co-pay" accumulators imposed by health plans and PBMs but these laws often do not apply to drug discount card program; therefore; therefore be it

RESOLVED, that our American Medical Association advocate for legislation or other appropriate mans to ensure that all payment made by patients for prescription medications outside of their insurance coverage (such as pharmaceutical discount programs) count towards that patient's annual deductible and out of pocket maximum. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-25)

Introduced by: Oklahoma

Subject: Study of Practice Models for Physicians Working Across State Lines

Referred to: Reference Committee G

Whereas, physicians working with private procedure/surgical centers are increasingly entering the Oklahoma healthcare landscape, often performing procedures within the state without maintaining a local practice; and

Whereas, licensed physicians who primarily practice out of state may not provide continuity of care, potentially leaving patients without necessary follow-up, access to additional laboratory testing, or sufficient documentation when complications arise; and

Whereas, hospitals and their on-call healthcare providers may be left covering those complications without coverage agreements or appropriate access to records, increasing the risk of adverse outcomes; and

Whereas, there is growing national concern regarding the impact of licensed physicians who primarily practice out of state without appropriate backup agreements, including its effects on patient safety, physician autonomy, healthcare costs, and overall quality of care; and

Whereas, a comprehensive study of the effects of licensed physicians who primarily practice out of state without appropriate backup agreements, physicians practice requirements, rates, and other concerns, is necessary to assess the potential impact on Oklahoma patients and our medical community; therefore be it

RESOLVED, that our American Medical Association undertake a thorough review of the practice models for physicians relying on transfer agreements between corporate healthcare entities, rather than physician-to-physician backup agreements for back up coverage, their rates of expected and unexpected complications, the impact of this model on local patients and on local physician medical liability costs (Directive to Take Action); and be it further

RESOLVED, that our AMA should collect and analyze data regarding patient outcomes, complications, and continuity of care issues associated with licensed physicians who primarily practice out of state without appropriate backup agreements (Directive to Take Action); and be it further

RESOLVED, that our AMA's study should include an extensive review of the impact this practice model has on physicians thrust into cross coverage without adequate handoff or fore-knowledge of the patient, impact on physician malpractice costs, patient safety, and physician well-being in our country. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/17/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Billings and Collections Transparency

Referred to: Reference Committee G

Whereas, most corporate-employed physicians are denied access to what is billed and collected in their name[1]; and

Whereas, a lack of transparency regarding what is billed and collected in a physician's name can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing medicine[2]; and

Whereas, the physician is obligated to see this information to ensure honest billings and can be held individually liable for up-coding and fraud; and

Whereas, without this information the physician risks being a party to fee-splitting whereby a physician gives up a portion of their professional fee above fair market value in return for the right to see patients (received referrals) in their practice setting; and

Whereas, our American Medical Association policy H-190.971 states, "all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information" (reaffirmed 2019); and

Whereas, denial of this information can be detrimental to physicians in regards to unwitting participation in fee-splitting and up-coding as well as to the public if they are subject to excessive charges; and

Whereas, employed physicians routinely lack access to this information, and upon requesting it, are threatened with retaliation, termination or are "taken off the schedule"; and

Whereas, the billing entity is supposed to be answerable to the individual physician; and

Whereas, the reputation of a physician can be affected if inflated bills for services are sent to the patient; therefore be it

RESOLVED, that our American Medical Association amend policy H-225.950, Principles for Physician Employment, to include a new section to read as follows:

6. Payment Agreements

a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about

the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary. (Modify Current HOD Policy);

and be it further

RESOLVED, that our AMA will educate physicians as to the importance of billing transparency and advocate for employed physicians to have full access to itemized statements of billing and remittances for medical services they provide (Directive to Take Action).

Fiscal Note: Resolved 1 – Modest, between $1,000 - $5,000
Resolved 2 – Moderate, between $5,000 - $10,000

Received: 2/28/25

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2. Hudes, B. The core problem behind physician burnout: loss of independence. KevinMD.com 22 Jul 2023. https://www.kevinmd.com/2023/07/the-core-problem-behind-physician-burnout-loss-of-independence.html

RELEVANT AMA POLICY

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their

employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

d. A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
    i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions.
    ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c. When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the

care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
    a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
    b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
    c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
    d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
    i. The agreement is for the provision of services on an exclusive basis.
    ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
    iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
    a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
    b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to

any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.
Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 5, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmed: A-22; Reaffirmed: BOT Rep. 29, A-12

Physicians' Right to Receive Billing and Remittance Information H-190.971
AMA policy is that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information.
Citation: Sub. Res. 711, I-97; Reaffirmed: I-04; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Aiding Members of Medical Staffs

Referred to: Reference Committee G

Whereas, a goal of our American Medical Association is to support the sustainability of medical practice; and

Whereas, for many years, the medical staff organization and bylaws were compacts honored by hospitals, but with the advent of corporate systems of healthcare there is more intrusion of hospital administration into the practice of medicine in the hospital, sometimes disregarding the boundaries between administration and the professional medical staff responsibilities; and

Whereas, where there is no legal protection of the status of the medical staff and its bylaws, individual physicians may be subject to adverse institutional actions without firm recourse; and

Whereas, some of the adverse actions have, in some instances:

- Taken the medical staff's bank account;
- Tried to oust duly elected medical staff officers and replace them with administration appointees;
- Unilaterally imposed a "code of conduct;"
- Adopted a conflict-of-interest policy without medical staff consent or input;
- Unilaterally amended medical staff bylaws;
- Bypassed the medical staff credentialing process;
- Refused to turn over charts for regular department peer review;
- A host of other violations of medical staff prerogatives[1]; and

Whereas, individual physicians may be at risk of administrative harm regardless of being a member of the medical staff[2]; and

Whereas, there are institutional as well as individual recourses that may apply to a physician threatened by administration with adverse action, which include having an independent lawyer who is an expert in medical staff and a physician advocate separate from hospital counsel, incorporation of the medical staff as a separate entity, and "engagement of state and national medical societies to lobby for stronger laws assuring medical staff independence"[3]; and

Whereas, our AMA has model legislation concerning legal definitions to protect the autonomy of the medical staff[4]; and

Whereas, "Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization… The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty. The right to full due process before the medical staff or health care

organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments"[5]; and

Whereas, in the last decade progress has been made in validating the independence of the medical staff, but the acceptance in law is not universal through the states nor universally defined[6-10]; and

Whereas, actions available to defend oneself against unfair actions may be a prohibitive barrier to success[11]; therefore be it

RESOLVED, that our American Medical Association establish and promote a well-defined procedure with access to resources to guide physicians on how to challenge adverse institutional actions or policies to practice medicine (Directive to Take Action).

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 2/28/2025

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RELEVANT AMA POLICY

Physician and Medical Staff Member Bill of Rights H-225.942

Our American Medical Association adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.

   b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

   c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

   d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

   e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

   f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

   a. The right to be self-governed, which includes but is not limited to

      i. initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations,

      ii. selecting and removing medical staff leaders,

      iii. controlling the use of medical staff funds,

      iv. being advised by independent legal counsel, and

      v. establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

   b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

g. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

g. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21; Reaffirmed: A-22

Principles for Strengthening the Physician-Hospital Relationship H-225.957
The following twelve principles are our American Medical Association policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws:

    1. The qualifications for holding office.

    2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.

    3. The qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.
Citation: Res. 828, I-07; Rea ffirmed in lieu of: Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmed: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 204, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Root Cause Analysis of the Causes of the Decline of Private Medical Practice

Referred to: Reference Committee G

Whereas, the percent of physicians who are working in a private practice in the United States has dramatically declined in the past 50 years; and

Whereas, many physicians who were in private practice and ultimately went out of business and took an employed job did so against their wishes; and

Whereas, a greater ability to work independently would be critical for the ability of employed physicians to negotiate an acceptable contract for their services; and

Whereas, there are certain likely key factors to this decline in the ability of medical professionals to work independently and understanding such factors would be critical in any effort to reverse such processes; and

Whereas, such root causes likely include at least the following factors:

1) The declining inflation-adjusted Medicare rates
2) Stark laws, which allow hospitals, but not private physicians, to self-refer
3) The development of insurance plans that had no out-of-network benefits
4) The permitted consolidation of insurers and hospitals
5) Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees
6) Increased government influence by insurers and hospitals and decreased influence by doctors; and

Whereas, there may be other factors as well; therefore be it

RESOLVED, that our American Medical Association study and report back on the root cause of the decline in private practice to include consideration of at least the following factors:

1) The declining inflation-adjusted Medicare rates
2) Stark laws, which allow hospitals, but not private physicians, to self-refer
3) The development of insurance plans that had no out-of-network benefits
4) The permitted consolidation of insurers and hospitals
5) Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees
6) Increased government influence by insurers and hospitals and decreased influence by doctors

(Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-25)

Introduced by: Private Practice Physician Section

Subject: Grace Period for Timely Filing Due to Technology Failures Regardless of Cause

Referred to: Reference Committee G

Whereas, there is a lag period between when a claim is submitted and when it is acted upon for many payers despite timely filing laws in many states; and

Whereas, for months after the Change Healthcare cyber-event, claims were not being acted upon by payers using this clearinghouse; and

Whereas, some insurers, even those that are subsidiaries of United Healthcare, did not create a grace period for timely filing despite the Change Healthcare cyber-event; and

Whereas, having an all-payer extended grace period would assist practices destabilized by the Change Healthcare cyber-event and would strengthen the healthcare economy by aiding medical practices still weakened by the Covid pandemic to recover financially from the cyber-event; therefore be it

RESOLVED, that our American Medical Association advocate for a two-year grace period from the date of a claims processing failure, allowing payers to resolve claims before denying them based on a “timely filing limit”. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

RELEVANT AMA POLICY

Ransomware and Electronic Health Records D-478.960

1. Our American Medical Association acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients.
2. Our AMA will:
    a. advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law;
    b. encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion;
    c. advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection; and
    d. seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation.

Citation: Res. 210, A-21; Reaffirmed: Res. 241, A-24

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
    i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.

iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.

d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

i. Regulatory approval status.

ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.

iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.

iv. Intended population and intended practice setting.

v. Clear description of any limitations or risks for use, including possible disparate impact.

vi. Description of how impacted populations were engaged during the AI lifecycle.

vii. Detailed information regarding data used to train the model:

1. Data provenance.
2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:

1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:

1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
        iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
        v. Data privacy.
        vi. Cybersecurity.
        vii. Physician liability associated with the use of generative AI tools.
    c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
    d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
    e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
    b. User Education:
        i. Users should be provided with training specifically on generative AI. Education should address:
            1. Legal, ethical, and equity considerations.
            2. Risks such as data breaches and re-identification.
            3. Potential pitfalls of inputting sensitive and personal data.
            4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems

a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 1, I-24

Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977
Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.
Citation: Res. 221, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Minimum Payer Communication Quality Standards

Referred to: Reference Committee G

Whereas, the entire healthcare community is affected by insurance company business structures that shield them from complaints, requests, questions or directly addressing client and contractor needs; and

Whereas, some government payer websites do not have a telephone number or email address published. Many would consider these to be the most basic of customer service standards. Some physicians are only able to resolve payer issues by working through their congressional office; and

Whereas, even if a telephone number is published, some phone tree messaging never leads to a human being able to comprehend and address the clinician's problem; and

Whereas, even if a telephone number is published, some payer hold times are beyond any industry standard; therefore be it

RESOLVED, that our American Medical Association advocate for payer minimum quality standards to include immediate access to a live representative during business hours. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.939
Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on

   a. clinical validation.
   b. alignment with clinical decision-making that is familiar to physicians.
   c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
   a. be informed by real world workflow and human-centered design principles.
   b. enable physicians to prepare for and transition to new care delivery models.
   c. support effective communication and engagement between patients, physicians, and the health care team.
   d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
   e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
   a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
   b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
   a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
   b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
   c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
   a. Identify areas of medical practice where AI systems would advance the quadruple aim.
   b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
   c. Outline new professional roles and capacities required to aid and guide health care AI systems.
   d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmed: A-22

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
   a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.

b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]
f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician’s consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
        iv. Intended population and intended practice setting.
        v. Clear description of any limitations or risks for use, including possible disparate impact.
        vi. Description of how impacted populations were engaged during the AI lifecycle.
        vii. Detailed information regarding data used to train the model:
            1. Data provenance.
            2. Data size and completeness.
            3. Data timeframes.
            4. Data diversity.
            5. Data labeling accuracy.
        viii. Validation Data/Information and evidence of:
            1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
            2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
            3. Algorithmic validation.
            4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
            5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
            6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
            7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
        ix. Data Use Policy:
            1. Privacy.
            2. Security.
            3. Special considerations for protected populations or groups put at increased risk.
        x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
        xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
    b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this

information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
        iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
        v. Data privacy.
        vi. Cybersecurity.
        vii. Physician liability associated with the use of generative AI tools.
    c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
    d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
    e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use.

Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b. User Education:

i. Users should be provided with training specifically on generative AI. Education should address:

1. Legal, ethical, and equity considerations.
2. Risks such as data breaches and re-identification.
3. Potential pitfalls of inputting sensitive and personal data.
4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor

criteria), and disclosed to both patients and their physician in a way that is easy to understand.

b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 1, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-25)

Introduced by:	Young Physicians Section
Subject:	Promoting Medication Continuity and Reducing Prior Authorization Burdens
Referred to:	Reference Committee G

Whereas, patients who have lost their primary care physician or experienced gaps in health insurance coverage face increased prior authorization burdens, often leading to disruptions in their medication regimens, which can result in adverse health outcomes and increased healthcare costs[1,2]; and

Whereas, research shows that patients who experience disruptions in health insurance coverage are significantly less likely to receive preventive services, more likely to forgo needed care due to cost, and have higher rates of medication non-adherence, with those experiencing longer coverage disruptions facing even worse outcomes in care access, receipt, and affordability[3]; and

Whereas, uninsured individuals with limited access to affordable care and medications often resort to emergency departments and urgent care facilities for manageable conditions, leading to preventable utilization of these high-cost services and straining healthcare resources[1]; and

Whereas, the process of re-obtaining prior authorizations for previously approved medications can be time-consuming and burdensome for both patients and physicians, potentially delaying necessary treatment; and

Whereas, early career physicians, who typically change employers within two years[4] of completing their training, are at higher risk of experiencing personal gaps in health insurance coverage and medication access and

Whereas, prior authorization requirements impose substantial administrative burdens on physicians, diverting time away from direct patient care, increasing practice costs, significantly contributing to physician burnout, and undermining the financial stability of physician practices already struggling with declining Medicare reimbursements[5]; and

Whereas, research shows that disruptions in health insurance coverage continue to negatively impact access to care for more than a year after coverage is regained, suggesting that improving healthcare access requires not only helping uninsured individuals gain coverage, but also strengthening coverage continuity for those who are already insured[6]; and

Whereas, streamlining the prior authorization process for previously approved medications could significantly reduce administrative burdens on physicians, strengthen coverage continuity for those re-insured, and improve patient care; therefore be it

RESOLVED, that our American Medical Association advocates for federal and state legislation that minimizes the impact of prior authorization requirements and payer-specific formulary tiering policies for medications during transitions or lapses in insurance coverage (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with relevant stakeholders to develop and promote best practices for implementing medication continuity policies across different insurance plans and healthcare systems. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/21/2025

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RELEVANT AMA POLICY

Economics of Prescription Medication Prior Authorization H-120.916
Our American Medical Association supports working with payers and interested parties to ensure that prior authorization denial letters include at a minimum:

a. a detailed explanation of the denial reasoning;
b. a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial; and
c. what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication.
[CMS Rep. 06, A-24]

Insurer Accountability When Prior Authorization Harms Patients D-320.974
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.

2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.
   [Res. 711, A-24]

Prior Authorization and Utilization Management Reform H-320.939

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

[CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22]

Opposition to Prescription Prior Approval D-125.992

Our American Medical Association will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.
[Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmation: A-22]