AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
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# PRIVATE PRACTICE PHYSICIANS SECTION
# Governing Council Report A
# Annual 2025 Meeting

## Access full text of resolutions/reports in the HOD meeting handbook.

**Recommendations key**
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

## Note: Items highlighted in blue have been recommended for reaffirmation.

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| 1 | E&B | CEJA 05 – Protecting Physicians Who Engage in Contracts to Deliver Health Care Services | The Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended by addition and deletion as follows and the remainder of this report be filed:<br><br>Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as | Delegate instructed to listen. |

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| | | | private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.<br><br>Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.<br><br>As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.<br><br>When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:<br><br>(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, or have a representative do so on their behalf to assure themselves that the arrangement:<br><br>(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended | |

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| | | | to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;<br><br>(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;<br><br>(iii) allows ensures the physician can to appropriately exercise professional judgment;<br><br>(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;<br><br>(v) is transparent and permits disclosure to patients.;<br><br>(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;<br><br>(vii) prohibits the corporate practice of medicine.<br><br>(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.<br><br>When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:<br><br>(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.<br><br>(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment. | |

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| | | | (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.<br><br>(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.<br><br>When contracted by a corporate entity involved in the delivery of health care services, physicians should:<br><br>(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms. | |
| 2 | E&B | CEJA 07 – Guidelines on Chaperones for Sensitive Exams | The Council on Ethical and Judicial Affairs recommends that alternate Opinion 1.2.4 be adopted in lieu of Opinion 1.2.4 and the remainder of the report be filed:<br><br>Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the professional boundaries of the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive exams while also empowering patients. Such efforts include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They may also include the use of chaperones regardless of the gender of the physician or patient. Having chaperones present can help protect the integrity of the patient-physician relationship. Physicians should, as always, also be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. A fair and effective policy on the use of chaperones must balance: | Delegate instructed to strongly oppose. |

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| | | | (1) respect for patient preferences and the integrity and safety of the clinical encounter; (2) protection of physicians; and (3) boundaries of the patient-physician relationship.<br><br>Physicians should:<br>(a) Provide a chaperone for all sensitive exams, with an option for patients to decline if they wish, unless the delay in obtaining a chaperone would result in significant harm to the patient. For all other types of examinations and procedures, patients must be informed that they are entitled to request a chaperone, and one should be made available when they make such a request. Physicians should honor patients' request for a chaperone, even if a patient's trusted companion is present.<br><br>(b) Provide an opportunity for private conversation with the patient without the chaperone present and minimize inquiries or history taking during a chaperoned examination or procedure.<br><br>(c) Make every effort to accommodate the preferences of the patient, consistent with the interests of patients, physicians and the maintenance of professional boundaries. If the patient and physician cannot arrive at a mutually acceptable arrangement, then the physician may facilitate transfer of care.<br><br>(d) Always use a chaperone for sensitive exams if the patient lacks the capacity to consent at the time of care, unless the delay in obtaining a chaperone would result in significant harm to the patient.<br><br>(e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision making between patient and physician.<br><br>(f) Have an authorized member of the health care team act as a chaperone. All chaperones should be provided with information and understand the responsibilities of | |

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| | | | the role. Chaperones should be made aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.<br>(Modify HOD/CEJA Policy) | |
| 2 | E&B | Res. 002 – Physician Disclosures of Relationships in Private Equity Held Organizations<br><br>(Indiana) | RESOLVED, that our American Medical Association support physician disclosure of private equity relationship(s), including employment, shareholder status, or medical directorship(s) at any accredited education function that bears continuing AMA medical education credit or approval through the Accreditation Council for Continuing Medical Education.<br><br>RESOLVED, that our AMA support physician disclosure of private equity relationship(s) for any committee member that reviews state or federal government (i.e. The Relative Value Scale Update Committee) resource allocation as it pertains to provision of medical services. | Delegate instructed to support. |
| 3 | A | Res. 109 – Medicare Advantage Plans Double Standard<br><br>(Indiana) | RESOLVED, that our American Medical Association seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor. (Directive to Take Action) | Delegate instructed to support. |
| 4 | A | Res. 114 – An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey | RESOLVED, that our American Medical Association conducts a physician survey of adequate size and scope to ascertain the impact of value-based payment models on a wide spectrum of both employed and independent physician practices, exploring its specific effects on the quality of care physicians provide (i.e., help or harm quality), patient access to care (i.e., limit Medicare patients), physician professionalism (i.e., honoring patient preferences, managing conflict of interest), and adequacy of the physician workforce (i.e., availability of primary care, burnout, early retirement) to provide legislators a better understanding and inform future AMA advocacy efforts. (Directive to Take Action) | Delegate instructed to refer for decision. |

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| | | (Private Practice Physicians Section | | |
| 5 | B | Res. 208 – Binding Arbitration in Health Insurance Contracts<br><br>(American Psychiatric Association) | RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians. (Directive to Take Action) | Delegate instructed to support. |
| 6 | B | Res. 220 – Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions<br><br>(New England) | RESOLVED, that our American Medical Association strongly oppose the enforcement of noncompete clauses (restrictive covenants) following any material change in practice ownership or control, including but not limited to private equity acquisitions, hospital mergers, stock acquisitions, asset sales, or reorganizations, that do not receive explicit, renewed, and informed physician consent (New HOD Policy);<br><br>RESOLVED, that our AMA advocate at both the state and federal levels for legislative and regulatory solutions that prohibit the assignment or automatic transfer of noncompete clauses in the event of ownership transitions, mergers, or acquisitions, thereby preventing such clauses from being imposed on physicians without fresh contract negotiations (Directive to Take Action);<br><br>RESOLVED, that our AMA support policies that render any noncompete clause void if the physician is dismissed by the employer or group, whether under the old or new ownership, and support amendments to state laws to that effect (New HOD Policy)<br><br>RESOLVED, that our AMA support that all physicians be provided with clear, comprehensible disclosures regarding any noncompete or assignment clauses contained in contracts, including detailed explanations of how such clauses would (or | ITEM TO BE EXTRACTED FOR SECTION DISCUSSION |

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| | | | would not) be applied in the event of a merger, acquisition, or other ownership change. (New HOD Policy) | |
| 7 | B | Res. 225 – The Private Practice Physicians in the Community<br><br>(New York) | RESOLVED, that our American Medical Association advocate for legislation, regulation or other policy mechanisms make it a priority to halt the constant yearly physician cutbacks in a climate of skyrocketing inflation and a high cost of living, in fact COLA should be built into ALL fee schedules (Directive to Take Action);<br><br>RESOLVED, that our AMA advocate to The Centers for Medicare and Medicaid Services (CMS) and Congress to decrease the need for time consuming prior authorizations, decrease the use of audits and recoupment and retrieving funds from physicians already burdened by ever increasing overhead and continual payment cutbacks. (Directive to Take Action) | Delegate instructed to reaffirm, support if extracted. |
| 8 | B | Res 227 – Payment Recoupment—Let Sanity Prevail<br><br>(Private Practice Physicians Section) | RESOLVED, that our American Medical Association advocates for legislation and regulations compliant with the Supreme Court holding in Rutledge v. PCMA (Directive to Take Action);<br><br>RESOLVED, that our AMA advocates for legislation and regulations that stipulate that if payment recovery or recoupment is due to coordination of benefit failure, the payer seeks recovery from the patient and/or the correct insurance company or primary payer responsible for the claim (Directive to Take Action);<br><br>RESOLVED, that our AMA advocates for legislation and that whenever a health plan seeks recoupment or payment recovery for overpayment or wrong payment from a physician, a detailed and comprehensive explanation for the payment recoupment/recovery must be provided (Directive to Take Action);<br><br>RESOLVED, that our AMA advocates for legislation and regulation that if the reason for claim recovery or recoupment is not due to physician error, the health plan may not seek recovery from the physician and that health plans must seek resolution from the patient on whose behalf the insurance company paid the claim and who has a contract with the | Delegate instructed to extract and strongly support – seek to keep original language. |

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| | | | insurance company or the third party responsible for the payment involved in claim recovery or recoupment (Directive to Take Action);<br><br>RESOLVED, that our AMA report back at the 2026 Annual Meeting on the progress of the implementation of this resolution (Directive to Take Action). | |
| 9 | B | Res 230 – Advocating to Expand Private Insurance Coverage of Anti-Obesity Medications<br><br>(Endocrine Society) | RESOLVED, that our American Medical Association amend policy H-440.801, Advocacy Against Obesity-Related Bias by Insurance Providers, by addition to read as follows:<br><br>1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:<br>a. Revise their policies to ensure that bariatric surgery is covered for patients who meet the appropriate medical criteria.<br>b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.<br>c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.<br>d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.<br>e. Eliminate coverage exclusions for the pharmacologic treatment of obesity.<br>f. Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change or requiring "step therapy".<br>g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.<br>h. Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.<br>2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. (Modify Current HOD Policy) | Delegate instructed to strongly support. |

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| 10 | F | CLRPD 01 – International Medical Graduates Section Five-Year Review | The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action) | Delegate instructed to strongly support. |
| 11 | F | CLRPD 02 – Organized Medical Staff Section Five-Year Review | The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action) | Delegate instructed to strongly support. |
| 12 | G | CMS 04 – Requiring Payment for Physician Signatures | 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:<br><br>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)<br><br>2. That our AMA amend Policy D-320.978 by deletion as follows:<br>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.<br>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.<br>3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.<br>~~4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:~~<br>~~a. the prior authorization process.~~<br>~~b. appeals or denials of services (visits, tests, procedures, medications, devices, and~~ | Delegate instructed to strongly support. |

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| | | | ~~claims), whether pre- or post-service denials.~~ (Modify HOD Policy) | |
| 13 | G | CMS 07 – Impact of Patient Non-Adherence on Quality Scores | The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:<br><br>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)<br><br>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)<br><br>3. That our AMA support additional research to understand the intricacies of non-adherence and potential models/strategies to improve adherence. (New HOD Policy)<br><br>4. That our AMA amend Policy D-450.958, "Pain Medicine," by addition and deletion, including a change in title:<br><br>PAIN MEDICINE AND PATIENT ADHERENCE IN QUALITY CARE ASSESSMENT, D-450.958<br>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) 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) | Delegate instructed to support. |

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| | | | 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)<br><br>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)<br><br>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)<br><br>8. Rescind Policy D-450.950, as having been completed with this report. (Rescind HOD Policy) | |
| 14 | G | Res. 704 – Mitigating the Impact of Excessive Prior Authorization Processes<br><br>(Florida) | 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<br><br>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<br><br>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 | Delegate instructed to listen – pay attention to the fiscal note. |

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| | | | 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) | |
| 15 | G | Res. 706 – Increasing Transparency Surrounding Medicare Advantage Plans<br><br>(Illinois) | 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) | Delegate instructed to support. |
| 16 | G | Res 708 – Advocating Against Prior Authorization for in-Person Visits with Physicians<br><br>(Mississippi) | 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) | Delegate instructed to support. |
| 17 | G | Res. 714 – Root Cause Analysis of the Causes of the Decline of Private Medical Practice<br><br>(Private Practice Physicians Section) | 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:<br>1) The declining inflation-adjusted Medicare rates<br>2) Stark laws, which allow hospitals, but not private physicians, to self-refer<br>3) The development of insurance plans that had no out-of-network benefits<br>4) The permitted consolidation of insurers and hospitals<br>5) Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees<br>6) Increased government influence by insurers and hospitals and decreased influence by doctors<br>(Directive to Take Action) | Delegate instructed to strongly support. |

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## Governing Council Report A
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| 18 | G | Res. 715 – Grace Period for Timely Filing Due to Technology Failures Regardless of Cause<br><br>(Private Practice Physicians Section) | 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) | Delegate instructed to strongly support. |
| 19 | G | Res. 716 – Minimum Payer Communication Quality Standards<br><br>(Private Practice Physicians Section) | 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) | Delegate instructed to strongly support. |
| 20 | G | Res. 717 – Promoting Medication Continuity and Reducing Prior Authorization Burdens<br><br>(Young Physicians Section) | 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<br><br>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) | Delegate instructed to strongly support. |

**END**