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REPORT OF THE BOARD OF TRUSTEES

BOT Report 20-A-26

Subject:	Mitigating the Impact of Excessive Prior Authorization Processes; (Resolution 704-A-25, Resolve 2)
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee G

1 At the 2025 Annual Meeting, Resolution 704-A-25 was introduced by the Florida delegation.
2 The House of Delegates adopted two of the resolve statements of the resolution resulting in
3 Policy D-320.971, "Mitigating the Impact of Excessive Prior Authorization Processes", which
4 states:
5
6 1. Our AMA will actively and urgently generate a prior authorization database collecting
7 and analyzing data including metrics reflecting denial rates, care delays, impact on
8 patient care, and associated cost adversely affecting patients and physicians across major
9 health care insurers.
10 2. Our AMA will strengthen and expand the existing public awareness campaign including
11 but not limited to social media, print media, and editorials to highlight the negative
12 impacts **of** abusive and obstructive prior-authorization requirements on patient care, and
13 educate physicians AND patients on their rights and available resources.
14
15 An additional resolve statement was referred and is the subject of this report. The referred
16 resolve reads as follows:
17
18 RESOLVED, That our American Medical Association working with legal experts, determine
19 whether and to what extent it may be appropriate to initiate and/or support a class action
20 lawsuit against insurance companies based on the identified prior authorization data, and if so
21 appropriate, collaborate with patient advocacy groups to support potential lawsuits.
22
23 BACKGROUND
24
25 Prior authorization is a process used by health insurers requiring physicians to receive approval
26 from plans before certain prescribed medications, procedures, or treatments can be provided to
27 patients. While intended to control costs and ensure medical necessity, prior authorization has
28 become a significant administrative burden for physicians. Per the American Medical
29 Association ("AMA") Prior Authorization Survey conducted in 2024[i], ninety-three percent of
30 physicians report that prior authorization leads to delays in patient care, and eighty-two percent
31 say it results in patients abandoning treatment due to these barriers.[ii] Most alarmingly, more than
32 one-quarter of physicians report that such delays have resulted in serious adverse events for

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patients—including hospitalization or death.[iii] In addition, the average weekly prior authorization workload for a single physician consumes 13 hours of physician and staff time, with 89 percent of physicians saying that prior authorization increases burnout. These findings underscore the urgent need for reform to reduce administrative friction and protect patient access to timely care.

Relevant Current AMA Policy

AMA Policy H-320.939, "Prior Authorization and Utilization Management Reform," supports the overall effort to mitigate the impact of prior authorization on patient care.

AMA Policy H-320.950, "Eliminating Precertification," advocates for utilization review efforts and preauthorization request to focus on statistical outliers and physicians whose claims have shown to be statistical outliers, respectively, rather than the physician population at large.

AMA Policy D-320.974, "Insurer Accountability When Prior Authorization Harms Patients," calls for increased legal accountability of insurers via (i) private right of action for patients to sue insurers that supersedes any other contractual provision, and (ii) the prohibition of mandatory pre-dispute arbitration clauses.

DISCUSSION

The referred Resolve clause, which is the subject of this report, calls for a possible class action lawsuit against insurance companies "based on the identified prior authorization data" collected pursuant to the now adopted policy. The AMA has not yet created the prior authorization database mandated under the new policy, as funding for this project was not available until January 2026. The Advocacy Group is issuing a request for proposal (RFP) for a feasibility study to assess the logistics, costs (both initial and long term), and overall return on investment in creating such a database. The vendor selected from the RFP process would prepare a robust report to inform the AMA's future decisions on the direction of this project. Given the current status of the database, the condition precedent to implementation of the class action under the Second Resolve has not transpired, and so the AMA lacks the necessary data to evaluate the suggested lawsuit.

While the lack of the prior authorization database is a barrier to assessing potential lawsuits, disregarding that obstacle the proposed class action would be a steep uphill climb. The AMA has long been and remains a staunch advocate for physicians and that includes, where appropriate, taking necessary legal action or submitting an *amicus curiae* ("a friend of the court") non-party brief in on-going legal matters. These briefs help inform courts and judges of points of information in lawsuits involving the healthcare industry and the wider, real-world impact of legal decisions. The AMA has, for years, searched for meritorious class action lawsuits against managed care companies; however, to bring such a case remains challenging – the reasons include:

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Class Actions are Difficult to Bring

Class actions are inherently difficult to bring successfully. Rule 23 of the Federal Rule of Civil Procedure imposes multiple, demanding procedural and substantive requirements that plaintiffs must satisfy at an early stage of litigation. Proposed class representatives must establish all four prerequisites of Rule 23(a) – numerosity, commonality, typicality, and adequacy – each of which is technically complicated, closely scrutinized by courts,[iv] and often contested by defendants. These prerequisites are defined as follows:

- Numerosity: the class is so numerous that joinder of all members is impracticable.[v]
- Commonality: there are questions of law or fact common to the case.[vi]
- Typicality: the claims or defenses of the representative parties are typical of the claims or defenses of the class.[vii]
- Adequacy: the representative parties will fairly and adequately protect the interest of the class.[viii]
- Prior authorization disputes can be heavily individualized due to varied patient conditions, differing practices based on specialty, and varied insurance contracts, all of which undermine the "commonality" and "typicality" requirements for class certification.[ix]

Restrictions on Prior Authorization are Intended to Protect Patients

Restrictions on insurance companies' use of prior authorization are generally focused on protecting patients – not physicians. While physicians may incur harm because of prior authorization abuse, such harm could be considered only incidental to the harm caused to patients. Most of the prior authorization legislation enacted to date is intended to protect patients' access to care – addressing items such as response times, retrospective denial, clinical criteria, medical necessity, qualifications of reviewers, peer-to-peer review/appeals processes, and physician "gold carding" (a process where physicians with a proven track record of prior authorization approvals – often over 90 percent – are exempted from prior authorizations, and one of the few remedies that has a *direct* impact on physicians). [x] [xi] Similarly, the Centers for Medicare & Medicaid Services cited the barrier for care and disproportionate impact prior authorization may have on certain patient demographics for adopting rules requiring faster determinations and greater transparency in Medicare Advantage and Medicaid programs.[xii]

Most law and policy remedies are directed at enforcement by public officials—not at empowering physicians or their organizations to bring class actions. Physicians do not generally have a private right of action to bring a lawsuit under laws on prior authorization.[xiii] [xiv]

Other Considerations

Proving prior authorization abuse to sustain a class action suit would be difficult. An isolated case of abuse would be insufficient – a class action suit would need to rely on systematic abuse. Indirect and anecdotal evidence would be only a start. Prior authorization decisions are likely to vary, based on insurers, physicians, patients, and treatment settings. These variations can make it difficult to substantiate uniform, class-wide harm.

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Further, physician network contracts almost always include provisions that (a) require pre-dispute arbitrations and (b) prohibit consolidation of claims, of which a class action would be an extreme example. Courts have routinely upheld network contract arbitration clauses in disputes between healthcare providers and payors.[xv]

CONCLUSION

This report does not conclusively determine that the contemplated class action would be impossible – only that it would be difficult. The AMA has searched for meritorious class actions against managed care organizations, and that effort continues.

RECOMMENDATIONS

The Board of Trustees recommends the following and the remainder of the report be filed:

1. That the referred resolve clause of Resolution 704-A-25 not be adopted.
2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians.
3. That existing AMA policies H-320.939, "Prior Authorization and Utilization Management Reform", D-320.974, "Insurer Accountability When Prior Authorization Harms Patients", and H-320.950, "Eliminating Precertification" be reaffirmed.

Fiscal Note: No Significant Fiscal Impact

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[i] 2024 AMA Prior Authorization Physician Survey *located at:*https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[ii] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[iii] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[iv] Wal-Mart Stores, Inc. v. Dukes, 564 U.S. 147, 161 (2011) (holding that Rule 23(a)'s requirements "are not mere pleading standards" and must be proven with evidentiary support at certification).
[v] Fed R. Civ. P. 23(a)(1).
[vi] Fed R. Civ. P. 23(a)(2).
[vii] Fed R. Civ. P. 23(a)(3)
[viii] Fed R. Civ. P. 23(a)(4)
[ix] "Doctors Target Insurers' Prior Authorization Policies in Legislative Push," MedPage Today, March 2023 *located at*: https://www.medpagetoday.com/special-reports/features/98337.
[x] https://medcitynews.com/2025/04/gold-carding-prior-authorization/
[xi] National Association of Insurance Commissioners, Prior Authorization White Paper, December 2025 *located at*: https://content.naic.org/sites/default/files/national_meeting/PA%20white%20paper%2012.4.2025%20final.pdf
[xii] 89 Fed. Reg. 8,759-60 (Feb. 08, 2024).
[xiii] National Association of Insurance Commissioners, Prior Authorization White Paper, December 2025 *located at*: https://content.naic.org/sites/default/files/national_meeting/PA%20white%20paper%2012.4.2025%20final.pdf
[xiv] https://www.ncsl.org/health/health-insurance-how-states-are-reforming-the-prior-authorization-process

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[xv] Infectious Disease Doctors, P.A. v. Bluecross Blueshield of Texas, No. 3:13-CV-02920-L, 2015 WL 4992964 (N.D. Tex. Aug. 21, 2015). *See also.* Klay v. United Healthgroup, Inc., 376 F.3d 1092 (11th Cir. 2004).

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 22-A-26

Subject: Comprehensive AMA Policy Publication Regarding Employed Physicians

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee TBD

At the 2025 American Medical Association (AMA) Annual Meeting, the House of Delegates (HOD) adopted Policy D-225.971 "Comprehensive AMA Policy Publication Regarding Employed Physicians," which directs the AMA to "comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:

1. The changing context and expectations of different practice models;
2. Factors which have led to physicians increasingly choosing an employment practice model over independent practice;
3. The employed physician relationship with healthcare organizations, including those controlled by private equity; and
4. The evolution of collective bargaining by, and unionization of, physicians."

The policy separately directs the AMA to create a policy publication addressing various matters of relevance to employed physicians, such as employment contracting, compensation models, and maintaining professionalism and the primacy of the physician-patient relationship in an employment relationship. While that policy publication is not the subject of this informational report, this report additionally highlights various AMA resources that are responsive to the needs of employed physicians.

BACKGROUND

Practice model options

From an ownership and employment perspective, physicians have a range of practice models to choose from, each offering different levels of autonomy, financial opportunity, and administrative responsibility. At the most generalized level, these models include:

- Solo practice: Physicians have complete control and autonomy over their practice but bear all administrative duties and financial risk.

- Group practice partnership: Multiple physicians share ownership, distributing risks and workloads and providing a balance between independence and collaboration.

- Third-party-owned practice (including hospital, health system, private equity, or other corporate ownership): Physicians are employed, with reduced administrative burden but also often less autonomy.

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While the term "physician employment" most commonly refers to working for an entity owned by a third party, physicians may also be employed by group practices (sometimes on a partnership track), governmental agencies, or non-profit organizations.

Trends in practice ownership and physician employment

The AMA's Physician Practice Benchmark Survey, conducted on a biennial basis since 2012, provides insight into trends in practice ownership and physician employment and factors driving these trends. Since the early 1980s, the share of physicians with an ownership share in their practice decreased from approximately 76 percent to 53.2 percent in 2012 to just 35.4 percent in 2024. Similarly, the share of physicians who worked in a practice that was owned by a hospital, hospital system, or health system, or were directly employed by or contracted with a hospital, increased from 29 percent in 2012 to 47 percent in 2024. An additional 6.5 percent of physicians reported practicing in settings owned by private equity groups in 2024, an increase from approximately 4.5 percent in both 2020 and 2022.[1]

AMA research highlights three key factors driving physicians to sell their independent practices or seek employment relationships:[2]

- Financial pressures: Large organizations are able to negotiate higher payment rates with insurers compared to smaller, independent practices. Lower reimbursements make it more difficult for private practices to remain sustainable, while employment offers greater financial stability.

- Access to resources: Hospitals and health systems can afford to invest in expensive medical equipment and advanced technology, often giving employed physicians better access to these resources than those in small independent practices.

- Administrative burden: The growing complexity of healthcare regulations and administrative requirements makes independent practice increasingly challenging. Employed settings provide administrative and regulatory support, alleviating some of this burden for physicians.

Members are encouraged to review the AMA's most recent Physician Practice Benchmark Survey for a comprehensive discussion of these and other practice trends.

Trends in physician unionization

While the number of physicians who are members of unions is small compared to the size of the profession, that share is growing. The AMA has estimated that between 2014 and 2019 the share of physicians who were union members increased from 5.7 percent to 7.2 percent.[3] This trend appears to be accelerating, as highlighted by a *JAMA* study analyzing trends in the number of petitions filed with the National Labor Relations Board to form unions with physician members; there were 44 such petitions filed between 2000 and 2022 – and an additional 33 filed in 2023-2024 alone.[4] The same study found that physicians are motivated to organize unions primarily due to "concerns about working conditions, physicians' autonomy, and voice in management, and the quality of patient care."[5]

Members are encouraged to review the AMA issue brief, Collective bargaining for physicians and physicians-in-training, for a comprehensive discussion of the topic. Members may also wish to review CLRPD Report 2-A-24, Scenarios on Collective Action and Physician Unions, which examined trends and factors in collective bargaining and physician unionization and implications for the AMA. Finally, see AMA ethical opinion 1.2.10, Political Action by Physicians, which addresses the ethical implications of unionization and collective bargaining.

DISCUSSION

Challenges of physician employment

Employment and practice ownership status do not change a physician's professional or ethical obligations. However, shifts in practice ownership, especially employment by third-party entities in which a physician has no ownership interest, introduce unique challenges and create complicated relationships between physicians and their employers. Notable challenges that may arise with physician employment include:

- Decreased clinical autonomy: Physicians may have less control over clinical decisions and daily operations due to complex leadership structures in larger organizations.

- Reduced influence in decision-making: Employment in larger organizations can limit opportunities for physicians to participate in high-level decisions affecting clinical practice or workplace operations.

- Alignment with organizational goals: Physicians must adapt to employer-set policies and values, which may differ from their own practice philosophies.

- Performance metrics and targets: Physicians may feel pressured to meet benchmarks set by employers, which can at times be perceived as emphasizing productivity or administrative tasks over individualized patient care.

- New administrative demands: Employment structures may simply replace the administrative demands of independent practice with a new set of administrative demands, adding to workload and impacting job satisfaction.

- Potential for burnout: These challenges can affect physician professional satisfaction and lead to burnout.[6]

Addressing the challenges of physician employment

While employment relationships often provide financial stability, access to resources, and operational advantages, they may also introduce challenges that affect satisfaction and well-being. These challenges can be reduced significantly in organizations that prioritize physician well-being. Therefore, when evaluating potential employers, physicians should look beyond compensation to consider an organization's commitment to physician well-being. Two key indicators of such commitment include:

- Has the organization conducted an AMA Organizational Biopsy®, or other biopsy assessment, to measure and take action to improve the health of the organization in areas

critical to physician well-being, such as organizational culture, practice efficiency, self-care, and retention?

- Has the organization applied for or received recognition through the AMA Joy in Medicine™ Health System Recognition Program for its efforts to combat burnout and promote a culture of wellness at the organizational level?

Weighing these factors carefully will help ensure physicians select a workplace that respects their professionalism while supporting their well-being, job satisfaction, and lasting career fulfillment. Members are encouraged to review the AMA STEPS Forward® module, What to Look for in Your First or Next Practice, to learn more.

Other AMA resources for employed physicians

The AMA offers a suite of practical tools and support to help employed physicians and health care organizations navigate challenges associated with physician employment:

- The AMA Annotated Model Physician-Group Practice Employment Agreement and the AMA Physicians' Guide to Hospital Employment Contracts provide comprehensive guidance for understanding, evaluating, and negotiating key terms and implications of physician employment contracts. Additionally, the AMA has published a six-part podcast series exploring contract negotiation.

- As a benefit of membership, AMA members receive a 20 percent discount on contract review packages and salary data from Resolve, an industry leader in physician employment contract review.

- The AMA Principles for Physician Employment, codified as AMA policy H-225.950, provide guidance to help physicians and their employers navigate unique challenges to professionalism and patient care arising from employment relationships, addressing issues such as conflicts of interest, advocacy for patients and the profession, contracting, medical staff relations, peer review, and payment agreements.

- The AMA Physician's Guide to Medical Staff Organization Bylaws is designed to assist medical staffs with drafting or amending medical staff bylaws and understanding how emerging issues in health care impact medical staff. Notably, the Guide addresses issues specific to employed physicians within the context of the medical staff, such as hearing rights for employed physicians.

- AMA STEPS Forward® is a collection of resources covering everything from time-saving strategies and preventing physician burnout to improving practice workflows, building a supportive organizational culture, and implementing digital health solutions that reduce technology-associated administrative burdens.

- The AMA Joy in Medicine® Health System Recognition Program is a prestigious AMA-granted distinction in recognition of an organization's demonstrated efforts to enhance physician well-being by resolving the root causes of work-related burnout.

- The AMA Organizational Biopsy® is an assessment tool and set of services developed by the AMA to assesses burnout levels within health care organizations to provide metrics that

can guide solutions and interventions that mitigate system-level burnout rates and improve physician well-being.

- The AMA issue brief, Collective bargaining for physicians and physicians-in-training, provides an overview of trends in physician unionization, examines the factors driving physicians to join unions, and discusses the implications of union membership for physicians and the broader healthcare system.

- The AMA Organized Medical Staff Section (OMSS) has convened an employed physician caucus to amplify the voice and issues of employed physicians in AMA policy development. Members may contact the OMSS (omss@ama-assn.org) to learn more.

The AMA is currently evaluating the most effective ways to organize its diverse and comprehensive resources for use by employed physicians and those considering employment opportunities. This curated collection ultimately will serve as the policy publication designated by Policy D-225.971, offering practical, real-time guidance for physicians as they navigate employment relationships and decisions.

CONCLUSION

The landscape of physician employment and practice ownership continues to change, with physicians increasingly employed by hospitals, health systems, and corporate-owned practices. As traditional practice ownership declines and trends toward employment and unionization increase, physicians are encountering new challenges related to clinical autonomy, professional identity, and workplace dynamics. The AMA remains committed to supporting employed physicians by providing educational resources, advocacy, and practical tools to successfully navigate these evolving environments.

RECOMMENDATION

The Board of Trustees recommends that the first directive of Policy D-225.971, Comprehensive AMA Policy Publication Regarding Employed Physicians, be rescinded as having been accomplished by this report and that the remainder of the report be filed.

REFERENCES

1. American Medical Association. Policy Research Perspectives – Physician Practice Characteristics in 2024: Private Practices Account for Less than Half of Physicians in Most Specialties. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf. Accessed March 5, 2026.
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RELEVANT AMA POLICY

D-225.971 Comprehensive AMA Policy Publication Regarding Employed Physicians

1. Our AMA will comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:
    a. The changing context and expectations of different practice models;
    b. Factors which have led to physicians increasingly choosing an employment practice model over independent practice;
    c. The employed physician relationship with healthcare organizations, including those controlled by private equity; and
    d. The evolution of collective bargaining by, and unionization of, physicians.
2. Our AMA will create a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:
    a. Employment contracting;
    b. Different compensation models;
    c. Professional accountability to, and as a member of, the medical staff; and
    d. Primacy of the doctor-patient relationship within the context of employment.
3. Our AMA will have a comprehensive policy publication regarding employed physicians available to all physicians, in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-26

Subject: Council on Medical Service Sunset Review of 2016 House Policies

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association 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 ten-year time horizon shall exist. A policy will typically sunset after ten 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; and (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.

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1 RECOMMENDATION
2
3 The Council on Medical Service recommends that the House of Delegates policies that are
4 listed in the appendix to this report be acted upon in the manner indicated and the
5 remainder of this report be filed.

APPENDIX – Recommended Actions

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-120.949	Ensuring the Safe and Appropriate Use of Compounded Medications	Our AMA will: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.	Retain. Policy is relevant.
D-155.995	Containing Catastrophic Care Costs	Our AMA will: (1) in order to ensure that quality of care is not compromised, encourage physicians and the medical profession to become more engaged in the development and implementation of cost-containment policies and strategies, particularly those directed toward high-cost patients; (2) support additional research into the characteristics of the five percent of the patient population with the highest health care costs; (3) support greater evaluation of the use of disease management, case management, pay-for-performance, and end-of-life care programs for high-cost patients, so that their cost-containment impact and projected future savings can be better assessed; and (4) continue to inform the medical profession and the general public regarding issues impacting catastrophic care costs and the complexities therein.	Retain. Policy is relevant.
D-160.924	Hospital Discharge Communications	Our AMA will develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients.	Retain. Policy is relevant.
D-160.926	A Guide to Selecting a Physician-Led Integrated System	Our AMA, in collaboration with the Integrated Physician Practice Section and appropriate partners within the House of Medicine, will accomplish the following by the 2017 Annual Meeting: 1. Develop a guide for physicians considering joining or aligning with a physician-led integrated system that addresses, but is not limited to the following: A. various models of integrated systems; B. metrics that help determine the extent to which an integrated system fulfills the definition of, and performs as, an integrated system; C. how to determine an organization's quality commitment/record; D. how to know if a particular system is the right fit;	Sunset. Directive was accomplished.

POLICY #	Title	Text	Recommendation
		E. what does a physician stand to gain/lose when joining such a system; and 2. The guide should also provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care.	
D-160.928	Hierarchical Condition Category Coding	Our AMA will continue to work with the Centers for Medicare and Medicaid Services to refine risk adjustment in all alternative payment models and Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change.	Retain. Policy is relevant.
D-160.945	Communication Between Hospitals and Primary Care Referring Physicians	Our AMA: (1) advocates for continued Physician Consortium for Performance Improvement? (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings; (2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety; (3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process; (4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and (5) will explore new mechanisms to facilitate and incentivize communication and tran smission of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
D-215.990	AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships	1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. 2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.	Retain. Policy is relevant.
D-220.975	The Joint Commission Transparency	1. Our AMA Commissioners to The Joint Commission will be asked to advocate for a truly open and transparent comment process for all proposed changes to TJC standards. 2. It is AMA policy that: (a) all proposed changes to TJC standards resulting from field reviews be published along with clearly stated rationale(s) for each proposed change; (b) all proposed changes to TJC standards be published along with clearly stated identities of entity(ies) external to TJC that suggested the proposed changes to TJC; (c) all proposed changes to TJC standards that are modified by TJC as a result of comments received must provide clearly stated rationale(s) for each modified proposal, to include a clear and thorough analysis of the comment or comments upon which the modification(s) was based; and (d) all proposed changes to TJC standards that are adopted as final by TJC be published along with a clear and thorough analysis of all the field review.	Retain. Policy is relevant.
D-220.976	The Relationship Between The Joint Commission and Physicians	Our AMA will: (1) communicate to The Joint Commission (TJC) the concern regarding the unintended consequences of TJC's standards, and methods of communicating those standards to physicians; (2) advocate with TJC for direct communication to physicians' organizations about standards to be	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		adopted or modified, with at least six months available for open commentary and feedback; (3) advocate that this communication be timely and that it occur in print media as well as through e-mail; (4) advocate that TJC accreditation standards be made available to any licensed physician without hindrance; (5) advocate that TJC establish a process for any physician to provide feedback about TJC programs that affect that physician's practice; and (6) require that AMA TJC Commissioners meet with the Organized Medical Staff Section Governing Council to review TJC standards no less than twice per year.	
D-220.977	The Joint Commission - Evidence-Based Recommendations	Our AMA will: (1) work with The Joint Commission (TJC) to investigate the provision of a cost analysis for each new requirement; and (2) request that TJC provide an evidence-based evaluation to justify the expenditures for the recommendations it makes.	Retain. Policy is relevant.
D-225.975	De-Linkage of Medical Staff Privileges from Hospital Employment Contracts	Our AMA will develop resources to assist physicians transitioning from employment to independent practice.	Sunset. Directive was accomplished.
D-230.988	Fiduciary Credentialing	Our AMA will: (1) continue to encourage physicians who have experienced what they believe to be inappropriate hospital de-credentialing to contact their state medical association and the Litigation Center of the AMA and the State Medical Societies; and (2) explore the feasibility of participating in legal action designed to address arbitrary and abusive economic profiling of physicians.	Retain. Policy is relevant.
D-285.974	Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations	Our AMA will continue to receive information on and monitor the issue of restrictions on referrals in all health care delivery settings.	Retain. Policy is relevant.
D-290.984	State Plan Amendments for Medicaid	Our AMA will: (1) promote mechanisms that provide the opportunity for public comment and legislative oversight prior to submission of the State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services; and (2) serve as a repository of information relating to the outcomes of SPAs in different states, disseminate such information and educate	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		physicians about the impact of proposed changes to Medicaid via SPAs.	
D-315.983	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	Our AMA will continue to monitor the economic implications of the secondary sale and use of non-identifiable, aggregate data.	Retain. Policy is relevant.
D-330.909	Study the Costs of Administrative and Regulatory Burdens	Our AMA will perform or commission an analysis of the direct and indirect costs and docu mented benefits associated with significant administrative and regulatory require ments imposed by the Centers for Medicare & Medicaid Services~~, including but not limited to face-to-face documentation requirements, the Physician Quality Reporting System, and the Meaningful Use program~~.	Retain-in-part; amend by deletion as the policy is no longer limited to the Physician Quality Reporting System or the Meaningful Use program.
D-330.928	Strategies to Strengthen the Medicare Program	Our AMA: (1) will continue to study combining Parts A and B of the Medicare Trust Funds into a single program, and report back, clearly delineating the advantages and disadvantages of this action, including the effect on graduate medical education funding and of adding a means test to Medicare Part A; and (2) encourages the Centers for Medicare and Medicaid Services to explore the use of value-based, targeted benefit design to facilitate a more efficient and meaningful cost-sharing structure that will help align incentives for patients to seek appropriate and effective care.	Retain. Policy is relevant.
D-335.987	Erroneous Guidance by Medicare Carriers and Waiver of Audit and Refund Penalties	1. Our AMA will: (a) ask the Centers for Medicare and Medicaid Services to enforce the requirement that Medicare representatives who have given verbal guidance must immediately confirm that guidance in writing, requiring Medicare carriers to (i) closely monitor carrier representatives' compliance with the rule and (ii) penalize those representatives who do not comply; and (b) urge CMS to eliminate the rule that if a physician incurs a penalty having relied on erroneous guidance from a carrier representative, that penalty cannot be waived unless the physician's initial request was in	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		writing. 2. Whether or not CMS eliminates that rule, our AMA will ask CMS to require Medicare carriers to provide central e-mail and fax units, to which physicians can send all requests for coding and billing clarifications, and from which physicians can receive all carrier responses in "real time."	
D-345.986	Accurate Mental Status Reporting	Our American Medical Association encourages interested national medical specialty societies to develop recommendations regarding mental status information that should be transmitted when patients transition care settings.	Retain. Policy is relevant.
D-380.997	Private Contracting by Medicare Patients	1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry. ~~**2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.**~~ 3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.	Retain-in-part; **rescind clause (2)**, as the Centers for Medicare & Medicaid Services has developed extensive regulatory guidelines that have eliminated the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.
D-390.974	Modes of Participation in Medicare and Their Impact on the Patient, the Physician, and the US Congress	Our AMA will: (1) continue working to identify politically viable modifications to the statutory language on private contracting that will make opting out a more reasonable choice for practicing physicians; and (2) educate physicians on the different options for participating in the Medicare program and provid e our members with the tools and information necessary to analyze the impact on their patients, their practice	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		, and the US Congress, of their choice of the three modes of relating to the Medicare program by: (a) opting out of Medicare; or (b) caring for Medicare patients in a fee-for-service relationship, making the decision to "accept assignment" on the basis of mutual needs of the patient and the physician; or (c) continuing as a "participating physician" in the Medicare program understanding that the physician is subject to the continued anticipated reductions in direct reimbursement and the ultimate inability to directly negotiate any fees on behalf of their practice. This may give Congress the wrong impression that there is no problem with continued fee reductions.	
D-390.985	Medicare Balance Billing	Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.	Retain. Policy is relevant.
D-450.953	Development of Quality Measures with Appropriate Exclusions and Review Processes	Our AMA will provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure during the National Quality Forum's (NQF) review of the measure in 2017, and ask the Centers for Medicare and Medicaid Services to redesign the measure.	Sunset. Directive was for action at the 2017 NQF meeting.
D-478.971	Electronic Health Records and Meaningful Use	Our AMA: (1) will continue to work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs; and (2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.	Retain. Policy is relevant.
D-480.970	Access and Equity in Telemedicine Payments	Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined ?shortage? areas, if that area can show a shortage of those physician specialists.	Retain. Policy is relevant.
D-60.980	Emergency Medical Services for Children (EMSC) Program	Our AMA (1) recognizes the importance of Emergency Medical Services for Children ((E MSC)); (2) advocates for full funding for the (EMSC) program in Congress; and (3) advocates for continuous passage of (EMSC) reauthorization legislation in Congress.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
D-70.957	Fixed Reimbursement to Physicians for Laboratory Services	Our AMA: (1) encourages physicians to become knowledgeable about the appropriate use of CPT modifier 26 in order to bill the professional component separately from the technical component for the interpretation of laboratory tests and clinical oversight of the laboratory; and (2) will advocate that Medicare and other third party payers provide appropriate coverage for the use of CPT modifier 26, as well as care plan oversight codes and prolonged services codes.	Retain. Policy is relevant.
D-70.958	Blended Payments	Our AMA will work with Congress to make it illegal for insurance companies to unilaterally change payments by "blending" levels.	Retain. Policy is relevant.
D-70.979	Preservation of ~~Five~~ Levels of Evaluation and Management Services	Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management ser vices should be maintained and not compressed, with appropriate payment for each level.	Retain-in-part; **edit title to remove term "Five,"** as it is no longer accurate.
H-100.950	Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers	1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system. 2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays. 3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.	Retain. Policy is relevant.
H-120.928	Pharmacy Use of Medication Discontinuation Messaging Function	Our AMA strongly encourages: (1) all software providers and those pharmaceutical dispensing organizations that create their own software to include the functionality to accept discontinuation message transmittals in their electronic prescribing software products; and (2) all dispensing pharmacies accepting medication prescriptions electronically to activate the discontinuation message transmittal functionality in their electronic prescribing support software.	Retain. Policy is relevant.
H-120.931	Access to Self-Administered Medications	1. Our AMA supports legislation that prohibits health insurance and pharmacy benefit management (PBM) companies from denying early prescription refills for solutions, ointments, gels, creams, nasal sprays, and other formulations that are difficult and/or imprecise to self-	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		administer. 2. Our AMA supports and encourages interested national medical specialty societies and other stakeholders to continue to advocate on the state level and work with health insurance and PBM companies to re-evaluate their refill policies on medications that are difficult and/or imprecise to self-administer to allow for early refills as needed.	
H-155.970	Cost-Cutting Decisions by Third Party Payers	Our AMA strongly opposes, and will take appropriate action as necessary to restrict, third party payer cost-containment strategies that jeopardize patient health and the quality of care.	Retain. Policy is relevant.
H-160.904	Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery	Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.	Retain. Policy is relevant.
H-160.908	Payment Mechanisms for Physician-Led Team-Based Health Care	1. Our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care. 2. Our AMA advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. 3. Our AMA advocates that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to: a. Volume of services provided; b. Intensity of services provided; c. Profession of the team member; d. Training and experience of the team member; and e. Quality of care provided. 4. Our AMA advocates that an effective payment system for physician-led team-based care should: a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team; b. Reflect the time, effort and intellectual capital provided by individual team members; c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		d. Be sufficient to sustain the team over the time frame that it is needed.	
H-160.937	The Promotion of Quality Telemedicine	1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians. 2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions. 3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		compromised by the use of any particular telemedicine modality. 4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education. 5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.	
H-160.966	Market Forces on Medical Practice	It is the policy of the AMA that (1) the ratcheting down of physician payment rates will not produce appreciable reductions in the rate of health care cost increase, since payment for physicians' services constitutes only about one-fifth of spending for health care; however, it may well reduce access to care as more physicians leave the area, retire, or in other ways change their practices; (2) at the same time, physician-directed peer review mechanisms must take the lead in fostering appropriate utilization of services and encouraging less hospital-intensive patterns of care where indicated; (3) the capture of a dominant or controlling share of the private health insurance market by any one payer can ultimately result in payer control of physicians' total remuneration; such control should be resisted through all legislative means available; (4) physicians must continue to initiate and publicize voluntary programs to accept assignment and/or other special arrangements for lower-income Medicare beneficiaries as a deterrent to legislation mandating assignment or banning balance billing for all Medicare enrollees regardless of economic status; and (5) it is equally incumbent on those developing state legislative and regulatory proposals to seek the advice of the health care professionals who will be affected by such proposals at the outset; without such input, the state will risk alienating those who provide the care and jeopardizing the health of its residents.	Retain. Policy is relevant.
H-165.851	Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance	Our AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance.	Reconcile with Policies H-165.828 and H-165.865.

POLICY #	Title	Text	Recommendation
H-165.887	Development of Health Care Priorities	Our AMA supports efforts to move patients in public programs into the private sector, through the implementation of vouchers or other mechanisms, thereby enabling individual patients to participate in the prioritization of their health care services; and encourages state governments that are investigating the prioritization of health care services provided under Medicaid programs to consider other potential allocation methodologies including variable levels of funding tied to relative health benefit, beneficiary income, or other factors, for such services.	Retain. Policy is relevant.
H-180.968	Third Party Payer Credentialing	It is the policy of the AMA that third party payers should not exclude non-board-certified physicians as a class from participation in their programs, without regard to individual training, experience, and current competence.	Retain. Policy is relevant.
H-185.925	Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act	1. Our AMA supports improvements to the essential health benefits benchmark plan se lection process to ensure limits and exclusions do not impede access to health care and coverage. 2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage. 3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.	Retain. Policy is relevant.
H-185.926	Reproductive Health Insurance Coverage	Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage r egardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.	Retain. Policy is relevant.
H-200.998	Tax Credit to Disadvantaged Area Medical Practices	Our AMA actively supports national and state legislation which would grant income tax credits to medical practices establishe d in disadvantaged communities and in areas of critical physician need.	Retain. Policy is relevant.

POLICY #	**Title**	**Text**	**Recommendation**
H-215.966	Evaluating Advertising	1. AMA policy is that organizations conferring titles/awards/rankings on hospitals should adopt the following criteria: a. Significant physician involvement in selection of criteria and methodology. b. Significant physician involvement in screening potential award winners. c. Significant physician involvement in on-site hospital review (if part of the ranking/title/award process). d. Significant physician involvement in the judging process and final selection of award winners. e. Evidenced based performance measures for selection. f. Public transparency and substantive information regarding all aspects including the leadership involved in the criteria, methodology, selection process. g. Disclosure of any conflicts of interest	Retain. Policy is relevant.
H-215.975	Uniform Standards for Not-For-Profit and For-Profit Hospitals	The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.	Retain. Policy is relevant.
H-220.938	The Joint Commission Adherence to its Own Standards	The AMA Board of Trustees directs its Commissioners to The Joint Commissi on (TJC) to strongly advocate that TJC: (1) consistently enforce its standards regarding unilateral amendment of medical staff bylaws; (2) continue to cite hospitals for unilateral amendment of medical staff bylaws, rules and regulations, which may lead to loss of accreditation if the violation is not rectified within a specified time frame; and (3) cite hospitals for including provisions in their corporate bylaws that allow for the unilateral amendment of medical staff bylaws, rules and regulations, when state statutes do not require the governing body of the hospital to have such authority.	Retain. Policy is relevant.
H-220.975	Medical Staff Comment on The Joint Commission "Field Review of Proposed Standards"	Our AMA believes that all "Field Review of Proposed Standards" that are sent to hospitals should be sent simultaneously to the medical staff of said hospital, with their comments to be returned directly to The Joint Commission for its consideration.	Retain. Policy is relevant.
H-220.976	Bylaws Approval Time Limit	The AMA supports including a standard in The Joint Commission Accreditation Manual for Hospitals requiring that initial medical staff bylaws and subsequent amendments be approved or disapproved by the hospital	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		governing body within a reasonable period of time specified in the medical staff bylaws and, if the governing body fails to act within the time specified, the proposed changes should be deemed adopted.	
H-220.978	Hospital Medical Staff Representation on the Hospital Governing Body	The AMA supports amending The Joint Commission Leadership Standard LD.01.03.01 to provide for representation at all meetings of the governing body, with vote by one or more medical staff members nominated and elected by the medical staff, consistent with applicable state law.	Retain. Policy is relevant.
H-225.943	Mixed Medical Staffs	Our AMA affirms its unyielding support for the principle that the members of the organized medical staff must work collectively to improve patient care and outcomes, regardless of the employment status or practice setting of each individual member, and through its Organized Medical Staff Section and other appropriate channels, will provide guidance to medical staffs, including but not limited to effective medical staff leadership strategies and relevant updates to the *AMA Physician's Guide to Medical Staff Organization Bylaws*, that facilitate representation of and encourage participation in medical staff activities by community-based and independent physicians.	Retain. Policy is relevant.
H-225.944	Medical Staff Engagement at Critical Access Hospitals	Our AMA encourages all MD/DO(s) on staff at Critical Access Hospitals to contribute to the quality and safety of care provided in those organizations by participating in medical staff activities, including but not limited to credentialing and privileging activities.	Retain. Policy is relevant.
H-225.949	Medical Staff and Hospital Engagement of Community Physicians	1. Our AMA encourages medical staffs to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital ("community physicians"). 2. Our AMA encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities, which may include but need not be limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.	Retain. Policy is relevant.
H-225.984	Hospital Corporate Bylaws	The AMA encourages hospital medical executive committees to: (1) regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices; (2) request that their hospital board of trustees/directors notify them of any proposed or	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		impending changes in the hospital/corporate bylaws; and (3) advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws, rules and regulations.	
H-225.986	Physician Economic Incentive Program	The AMA: (1) opposes physician economic incentives that conflict with patients' welfare; and (2) believe the physician must remain the patient's advocate in the patient's relationship with the hospital.	Retain. Policy is relevant.
H-230.963	Limitations of Membership on Multiple Hospital Medical Staffs	Our AMA: (1) supports the principle that a hospital may not limit a physician's participation or medical staff privileges at the hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; (2) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; and (3) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician (or a partner, associate or employee of the physician) having a financial relationship with another hospital/health system.	Retain. Policy is relevant.
H-230.984	Peer Review of the Performance of Hospital Medical Staff Physicians	The AMA (1) encourages state and local medical associations to establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review; and (2) supports working with the AHA and other appropriate organizations to devise methods to encourage the development of such programs.	Retain. Policy is relevant.
H-230.997	Recertification and Hospital or Health Plan Network Privileges	(1) The fact that a board-certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold hospital privileges or health plan network status from a physician. (2) Modification or withholding of hospital privileges or health plan network status shall be purely on the basis of assessment of performance.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-235.968	Physician Review of Medical Staff Activities	The AMA recommends that hospital medical staffs have a policy that would allow minutes of medical staff committees, except minutes concerning peer review or corrective action information, be made available for review by medical staff members in the medical staff office; and recommends that the medical executive committee approve all reports, policies and recommendations from medical staff clinical departments and committees and have a process to distribute significant changes to the members of the medical staff.	Retain. Policy is relevant.
H-235.970	Conflict of Interest Issues and Medical Staff Leaders	Our AMA encourages medical staffs to adopt and incorporate into their bylaws medical staff conflict of interest policies that reflect the following principles: 1. Disclosure of potential conflicts. Candidates for election or appointment to medical staff leadership positions should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or relationships of which they are reasonably aware, including employment or contractual relationships, which could foreseeably result in a conflict of interest with their acting on behalf of the medical staff. Elected or appointed medical staff leaders should disclose potential conflicts in writing to the medical staff whenever they arise. 2. Management of conflicts. When conflicts of interest exist, elected or appointed medical staff leaders should, as appropriate, recuse themselves from the deliberative process and/or abstain from voting on the matter to which the conflict relates. The medical staff should establish a process for disqualification from the deliberative process and/or from voting on the matter at hand for any elected or appointed medical staff leader with an identified conflict who fails to disclose the interest or who fails to recuse himself or herself from the deliberative process and/or from voting on the matter to which the conflict relates, as appropriate.	Retain. Policy is relevant.
H-235.985	Medical Executive Committee Composition	The AMA's policy states that the medical staff shall govern itself by the bylaws, rules and regulations which define the Medical Staff Executive Committee, whose members are selected in accordance with criteria and standards established by the medical staff, consistent with applicable state law.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-260.964	Reimbursement for Clinical Lab Work	Our AMA supports the concept that a professional fee should be paid directly to the appropriate physician for clinical laboratory work, regardless of payer source.	Retain. Policy is relevant.
H-260.998	Laboratory Services Contracted by a Physician	Our AMA believes that: (1) laboratories should bill and collect from patients or third-party payers for laboratory services; (2) attending physicians are entitled to fair compensation for professional services rendered; and (3) bills for laboratory services performed by attending physicians should show the location where services were rendered and a description of such services.	Retain. Policy is relevant.
H-280.951	Quality of Care and Staffing in Nursing Homes	Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff.	Retain. Policy is relevant.
H-280.953	Physicians Visits Under Medicare Skilled Nursing Facility Prospective Payment System	Our AMA will: (1) work with the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) to ensure that physician visits to nursing homes and skilled nursing facilities be based on the physician's determination of appropriate care for each patient; (2) work with CMS to ensure that its Medicare carriers implement these policies in a uniform way; and (3) advocate that physician assessments necessary to comply with both the prospective payment system (PPS) as well as TJC requirements be recognized and reimbursed.	Retain. Policy is relevant.
H-285.941	Managed Care Consensus Bill	The AMA continues to support the enactment of comprehensive legislation that addresses the wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physician involvement in health plan medical policies.	Retain. Policy is relevant.
H-285.950	Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services	The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services. (1) All managed care plans shall disclose to their	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities. (2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness. (3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided. (4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided. (5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition. (6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility.	
H-285.967	Distribution of Premiums Collected by Managed Care Companies	The AMA develop and support appropriate legislation to require managed care plans to publish, on an annual basis, relevant operating and financial information.	Retain. Policy is relevant.
H-285.971	Population Based Practices in Managed Care Systems	The AMA recommends to all managed care plans that they: (1) develop population based programs for prevention, health risk assessments, and health's status improvement; (2) adopt a process to measure clinical quality provided to patients and demonstrate how quality in their system	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		of care is improving; (3) develop programs which assure that communicable and environmentally induced health problems are followed up by physicians within the plan in cooperation with competent health department personnel; and (4) manage these programs in concert with established standards of preventive medicine and public health.	
H-285.983	Organized Medical Staffs in Medical Delivery Systems	The AMA supports expanding the concept of physician governance of medical delivery systems by recommending that: (1) Medical delivery systems establish self-governing medical staffs similar, if not identical, to those in hospitals; (2) The principles of self-governance should include, but not be limited to: (a) the development of medical staff bylaws which cannot be unilaterally changed by the governing board of a medical delivery system; (b) physician election of representatives to the governing board and other appropriate committees of medical delivery systems including credentialing, privileging, quality assurance and utilization review committees; (c) due process protections for physicians credentialed by a medical delivery system; and (d) full indemnification by medical delivery systems of physicians who, in good faith, serve as members of credentialing, quality assurance and utilization review committees of medical delivery systems; and (3) Policy of the AMA is that the establishment of guidelines, review of decisions, and the adjudication of patient care quality issues in managed care plans must be performed by participating practicing physicians.	Retain. Policy is relevant.
H-290.973	Medicaid Citizenship Documentation	Our AMA strongly advocates that a state Medicaid agency's record of payment for the birth of an individual in a US hospital is satisfactory documentary evidence of both identity and citizenship.	Retain. Policy is relevant.
H-315.972	HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing	1. Our AMA encourages physicians who have entered or who are considering entering a business associate agreement (BAA) to undertake careful due diligence regarding the business associate and to consider with legal counsel the inclusion of contractual provisions such as: a. strong confidentiality clauses; b. required steps to mitigate any harmful effects of wrongful use or disclosure of protected health information (PHI); c. assurance that, upon the contract's termination, all PHI is returned to the covered entity, and no copies are retained by the business associate, except as required for legal or audit purposes; d. indemnification of the covered entity against	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		any losses caused by a business associate; e. the business associate's procurement of specified types of liability insurance which may either protect the covered entity or enable the business associate to meet its indemnity; f. posting a surety bond (a.k.a. performance bond) to ensure faithful performance of the BAA by the business associate; or g. physicians should take care that the original contract should contain provisions addressing the costs involved with the return and maintenance of the PHI at or after the end of the contract term. 2. Our AMA supports legislation and/or regulation requiring all third parties who receive and maintain clinical information from a clinician to make those data available to the clinician in usable form at the end of the business relationship.	
H-320.941	Eliminate Fail First Policy in Addiction Treatment	Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.	Retain. Policy is relevant.
H-320.943	Medicare and Insurance Takeback Procedures	Our AMA: (1) will advocate to ensure that when a patient hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take back amount be only the difference between the cost of the admission and the cost of necessary observation for that patient stay; and (2) will advocate to ensure that, for any care provided to hospital patients who have Medicare, managed Medicare, or commercial insurance, hospitals have the option to rebill denied inpatient claims as outpatient claims, when a physician using clinical judgment makes a prospective decision to admit a patient who is later not found to meet admission criteria.	Retain. Policy is relevant.
H-320.987	Second Opinions When Required by Carrier	The AMA believes that second opinions for medical or surgical services and procedures are best provided by physicians who have the training, experience or skills which provide the necessary information base to assess the need for or advisability of a specific medical or surgical intervention.	Retain. Policy is relevant.
H-320.989	Third Party Utilization Review Programs	Our American Medical Association recommends that hospital medical staffs, prior to approving the written plan for utilization review, ensure the inclusion of provisions that require the hospital to seek formal review and recommendations from the medical staff concerning "any qualified outside organization" that is going to contract with the hospital to perform review activities specified in the plan, prior to entering into the contract.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-320.990	Standardization of Mandatory Second Surgical Opinion Programs	The AMA urges third party payers who require second opinions to inform their subscribers so that they understand the requirements of such programs.	Retain. Policy is relevant.
H-320.991	Hospital Preadmission Review/Certification	The AMA believes that the following principle should be applied in evaluating any preadmission review program, so as to minimize any detrimental impacts on quality or accessibility of care: There should be direct and continuing communications to physicians and insured~~s~~ **patients** regarding prior authorization requirements.	Retain-in-part; amend by deletion and addition to make the policy consistent with language used in other AMA policies.
H-330.879	Providers and the Annual Wellness Visit	1. Our AMA supports that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care. 2. Our AMA supports that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care. 3. Our AMA supports that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months. 4. Our AMA encourages CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care.	Retain. Policy is relevant.
H-330.880	Virtual Supervision of "Incident to" Services	1. Our AMA supports pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision if they are developed with specialty society input and abide by the following principles: A. The physician billing "incident to" must fulfill other requirements of direct supervision of "incident to" services, including first seeing the patient and initiating the course of treatment, and providing subsequent services at a rate that shows active participation in and management of the course of treatment. B. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. C. Non-physician practitioners and employees providing "incident to" services must follow existing requirements for the provision of	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		"incident to" services, including abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. D. The delivery of "incident to" services must be consistent with state scope of practice laws. E. Virtual supervision of "incident to" services must require the supervising physician to be connected through real-time audio and video technology with the room in which the "incident to" service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service. F. Virtual supervision of "incident to" services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. G. Physicians providing virtual supervision of "incident to" services should visit the sites in person where patients receive procedures from non-physician practitioners or employees. H. Physicians providing virtual supervision of "incident to" services must establish protocols for arranging for emergency services, including having an agreement with a physician at the site at which "incident to" services are provided, to ensure the provision of immediate assistance. I. Patients receiving "incident to" services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit. J. Patients receiving "incident to" services that are virtually supervised must have a choice of provider, as is required for all medical services. 2. Our AMA encourages national medical specialty societies to develop best practices and protocols for virtual supervision of "incident to" services, including specifying which services and procedures would not qualify for this practice.	
H-330.899	Medicare Pharmaceutical Benefit	Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit: (1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures. (2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		and those with catastrophic costs. (3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions. (4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible. (5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible behavior. (6) Any pharmaceutical benefit should be designed to prevent adverse selection. (7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions. (8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians. (9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies. (10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage.	
H-330.934	Sharing Demographic Medicare Data with Other Public Entities by CMS	The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved.	Retain. Policy is relevant.
H-330.937	Local Medical Policy of Medical Payers	AMA policy states that when payers apply local medical policies to physicians in remote areas from where the local medical policy was originally developed, this local medical policy must be widely disseminated to the physicians in those areas along with ~~**printed**~~ explanations to the practitioners involved.	Retain-in-part; amend by deletion as printing is no longer the standard and if maintained, it becomes the expectation.
H-340.913	Peer Review by Actively Practicing Physicians	The AMA continues to urge CMS to assure that under the Medicare review process only actively practicing physicians in the same specialty and similar practice settings be allowed to perform Medicare reviews.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-345.980	Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services	Our American Medical Association advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health a nd substance use disorder services to our citizens.	Retain. Policy is relevant.
H-375.964	IOM Report on QIO Program	Our AMA opposes the removal of medical review responsibilities from the QIO scope of work and further opposes conversion of contracts to national or regional contractors.	Retain. Policy is relevant.
H-385.909	The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services	Our AMA will: (1) engage in efforts to convince the Centers for Medicare & Medicaid Services to abstain from inappropriate bundling in situations in which functional and aesthetic considerations should be considered separately; and (2) actively oppose further regulations that would interfere with the rights of patients, providers, and facilitie s to privately contract for non-covered services.	Retain. Policy is relevant.
H-385.910	Physician Communications and Care Coordination During Patient Hospitalization	Our AMA will continue to advocate that third party payers establish separate physician payments for interprofessional consultative services related to the care of hospitalized patients.	Retain. Policy is relevant.
H-385.924	Support for State Medical Association Economic Research, Development and Planning	The AMA urges state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice. The AMA continues to assist state associations in collecting such data and to act as a clearinghouse for data so gathered. The AMA encourages state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.	Retain. Policy is relevant.
H-385.991	Balance Billing	Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.	Retain. Policy is relevant.
H-390.836	Support for Seamless Physician Continuity of Care	Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-390.839	Requiring Secondary and Supplemental Insurers to Medicare to Follow Medicare Payments	Our AMA will support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer.	Retain. Policy is relevant.
H-390.854	Freedom of Choice	(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.	Retain. Policy is relevant.
H-390.977	Reimbursement for Diagnostic Studies Identified as Surgical Procedures	(1) The AMA supports the concept of separate payment by private and public payers for the services of physicians who perform diagnostic procedures separately and apart from surgical therapy. (2) The AMA supports the concept of one inclusive fee or payment to a physician by private and public payers for diagnostic surgical procedures performed in conjunction with and as a part of surgical therapy and encourages payers to utilize for payment purposes a coding system which can recognize the greater complexity or extent of the service which may be rendered. (3) The AMA urges physicians billing third parties to ensure that all services provided are completely described or coded on the appropriate claim form(s).	Retain. Policy is relevant.
H-405.993	Median Physician Income	The AMA encourages all who prepare reports on physician income to include not simply "mean" (average) data, but also "median" data and quartile distributions, which are far more representative of actual physician income profiles and are better reflections of medical care costs.	Retain. Policy is relevant.
H-406.999	Goal of Health Care Data Collection	The AMA (1) continues to advocate that health care data collected by government and third-party payers be used for education of both consumers and providers; and (2) believes that government, third party payers and self-insured companies should make physician-specific utilization information **<u>from carefully selected studies</u>** available to medical societies.	Retain-in-part; amend by addition to fulfill the intent of Board Report W-A-92, the origin of this policy.
H-410.970	Use of Practice Parameters	Our AMA: (1) urges organizations that have developed practice parameters to recognize that practice parameters are educational tools, not mechanisms to determine reimbursement or credentialing, to assist physicians in clinical decision making and are not replacements for	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		clinical decision making. Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients; (2) encourages physicians to be cost conscious and to exercise discretion, consistent with good medical care, when implementing practice parameters; and (3) encourages physician organizations developing practice parameters to include appropriate explanatory disclaimers to ensure that practice parameters are used in a manner that is consistent with AMA policy.	
H-410.997	Practice Parameters and Review Criteria	Our AMA believes that variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues.	Retain. Policy is relevant.
H-450.929	CMS Emergency Department Patient Experience of Care Survey (EDPEC)	Our AMA will monitor the development of ~~**the**~~ Centers for Medicare and Medicaid Services' ~~**E**~~**e**mergency ~~**D**~~**d**epartment ~~**P**~~**p**atient ~~**E**~~**e**xperience of ~~**C**~~**c**are ~~**(EDPEC)**~~ ~~**S**~~**s**urvey**s** and advocate for fair and reliable reporting that accurately reflects the quality of care provided by physicians and/or hospitals.	Retain-in-part; amend by deletion and addition to reflect the fact that while the initial CMS EDPEC survey has been completed, subsequent surveys are ongoing.
H-450.930	Developing Measures for Good Access to Care	1. Our AMA will collaborate with the appropriate organizations to support specialty-designed measures of access to care that ensure physicians have the measures they need to be successful under the Medicare Access and Chip Reauthorization Act (MACRA). 2. Our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to use specialty society-developed access to care measures for the Clinical Practice Improvement incentives rather than CMS-generated measures of access.	Retain. Policy is relevant.
H-450.937	Medical Care Outside the United States	1. Our AMA advocates that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to the following principles:	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		A. Medical care outside of the US must be voluntary. B. Financial incentives to travel outside the US for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. C. Patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care). D. Prior to travel, local follow-up care should be coordinated and financing should be arranged to ensure continuity of care when patients return from medical care outside the US. E. Coverage for travel outside the US for medical care must include the costs of necessary follow-up care upon return to the US. F. Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the US for medical care. G. Access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the US. H. The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines. I. Patients choosing to travel outside the US for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities. 2. Our AMA supports efforts that allow for the reporting and tracking of quality and safety issues associated with medical procedures performed abroad.	
H-450.941	Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks	1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947.	Retain-in-part; **rescind clause (4)**, as time frame for reporting directive has passed. Additionally, in 2018 the AMA published a thorough guide, including model contract language, titled: Evaluating Pay-for-Performance Contracts.

POLICY #	Title	Text	Recommendation
		2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. 3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties. ~~**4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should shall clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives.**~~ 5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries. 6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care. 7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation.	
H-450.943	Effects of Pay-for-Performance on Minority Health Disparities	Our American Medical Association urges that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs.	Retain. Policy is relevant.
H-450.999	Practice Evaluation	(1) Our AMA urges state and local medical societies to consider developing public	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		information programs to inform consumers about existing quality assurance activities. (2) Our AMA encourages increased use of office or hospital outpatient facilities, and use of these facilities for diagnostic testing prior to hospitalization whenever medically feasible, and where quality of service can be assured.	
H-460.896	Stem Cell Tourism	Our AMA (a) encourages the study of appropriate guidance for physicians to use when advising patients who seek to engage in stem cell tourism and how to guide them in risk assessment, (b) encourages further research on stem cell tourism, and (c) urges physicians to educate themselves on these issues.	Retain. Policy is relevant.
H-475.991	Postoperative Care - Responsibility and Reimbursement	Our AMA: (1) continues to support repeal of the federal law which allows reimbursement to optometrists for the unsupervised/independent provision of postoperative care; and (2) reaffirms its position that physicians performing surgery have an ethical and professional responsibility to continue the care of their individual patients through the post-surgical recovery and healing period, or to arrange coordination of such care, especially in those situations where there is a reasonable expectation that another physician will provide postoperative surgical care.	Retain. Policy is relevant.
H-475.996	Revision of AMA Surgical Screening Criteria	The AMA (1) urges national medical specialty societies to review all criteria sets in use within the QIO program to determine whether sections applicable to the practice of their members are in need of revision and, if they are, to develop recommendations for change; (2) encourages state medical societies to organize specialty specific liaison activities between specialty groups and their respective QIOs in order to address particular issues that may arise concerning the development or application of criteria; and (3) supports continued efforts to collect information on screening criteria sets and to evaluate the process by which they are being applied.	Retain. Policy is relevant.
H-480.953	Interoperability of Medical Devices	Our AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
		optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.	
H-480.968	Telemedicine	The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.	Retain. Policy is relevant.
H-70.914	Opposing Coverage Decisions Based Solely on ICD-10 Code Specificity	Our AMA opposes limitations in coverage for medical services based solely on diagnostic code specificity.	Retain. Policy is relevant.
H-70.918	Medicare Evaluation and Management Medical Decision Making Guidelines	It is AMA policy that: (1) all Medicare contractors disclose any Medical Decision Making tool or ~~**score sheet**~~ **algorithm** used in audits; (2) all Medicare contractors have a **clearly defined** process to resolve conflicts of interpretation on Medical Decision Making ~~tools and/or score sheets~~ between practicing physicians and contractor clinical auditors; and (3) any Medical Decision Making tool or ~~**score sheet**~~ **algorithm** must be based on the ~~**factors for arriving at complexity, as defined in**~~ **instructions for Medical Decision Making as** outlined in CPT Guidelines that accompany the CPT ~~**Book**~~ **Code Set**.	Retain-in-part; amend by deletion and addition to update this policy to align with current CPT guidelines.
H-70.958	Medicare ICD-10 Coding Requirements	Our AMA will: (1) request that the Centers for Medicare & Medicaid Services ensure that its Medicare carriers fully understand and implement the distinction between coding to the "highest level of specificity" within a code category, and that coding for the condition(s) to the "highest degree of certainty" for that visit. For this purpose, symptoms, signs, abnormal test results or other reason for the visit are appropriate and acceptable diagnoses; and (2) will use all appropriate vehicles to communicate to physicians the correct method to report ICD-10-CM codes to describe diagnoses and other reasons for the physician-patient encounter.	Retain. Policy is relevant.

POLICY #	Title	Text	Recommendation
H-70.960	Documentation Requirements for Physician Care Plan Oversight	The AMA will (1) continue to work with CMS so that CPT codes 99375 and 99376, for Care Plan Oversight, are recognized for payment to all physicians; (2) the AMA CPT Editorial Panel will consider revising the Care Plan Oversight codes to more accurately reflect medical practice; (3) will work with CMS to develop documentation requirements that are more consistent with standard medical practice and are not time based; and (4) the CPT Editorial Panel will continue to monitor CMS's implementation of documentation requirements.	Sunset; policy obsolete with advent of the Chronic Care Management (99490, 99491; 99437, 99439) and Complex Chronic Care Management (99487, 99489) CPT codes.
H-75.984	Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement	1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee. 2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.	Retain. Policy is relevant.
H-85.957	Encouraging Standardized Advance Directives Forms Within States	Our AMA encourages each state society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.	Retain. Policy is relevant.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-26

Subject: Expanding Medicare Coverage of Medical Nutrition Therapy

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

Resolution 116, "Medicare Coverage of Registered Dietician and Certified Nutrition Support Specialist Visits Beyond Type 2 Diabetes and Renal Disease," was introduced by the Senior Physicians Section at the 2025 Annual Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) support legislation for Medicare coverage for registered dietitian or certified nutrition support specialist visits referred by physicians for conditions such as obesity, pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome, small intestinal bacterial overgrowth, gout, and allergies, recognizing that other significant chronic conditions can also benefit from tailored dietary interventions; and be it further;
>
> RESOLVED, that our AMA specify that payment for registered dietician or certified nutrition support specialist services should be made separately from Medicare physician services (i.e. outside the Medicare physician fee schedule) to avoid having a negative impact on the conversion factor that would impact payment for all physician services.

This report discusses the Medicare Physician Fee Schedule (MPFS), provides a summary of medical nutrition therapy (MNT) Medicare coverage, and includes several policy recommendations.

BACKGROUND

Since 1992, Medicare payment for physicians' services has been valued through the MPFS.[1] Payment rates are based on resources required to furnish services, which are assigned relative value units (RVUs) under the Resource-Based Relative Value Scale (RBRVS) considering three types of inputs: clinician work, practice expense, and professional liability insurance.[2] Annual updates to the MPFS include statutorily-required updates to the conversion factor under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[3]

Under current law, the projected cost of all changes to the MPFS must be budget neutral and may not raise or lower total Medicare spending by more than $20 million per year.[4] Thus, the evaluated change of RVUs or the introduction of new services are accompanied by offsets to the fees for other services.[5,6] The budget neutrality requirement is a provision of the Social Security Act which dates to the founding of the RBRVS legislation and has not been updated since passage. The Centers for Medicare & Medicaid Services administers the statute's budget neutrality requirement with a percentage adjustment.[7] The actual payment rate for each service is determined by multiplying its value under the RBRVS by a conversion factor.[8] Budget neutrality adjustments are accomplished by raising or lowering that conversion factor. If new services or higher payments are

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added to the MPFS, an offsetting cut (a negative adjustment) must be made to other service payments to keep total spending balanced.[9] Beginning in 2026, there will be two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs.[10] QPs are those that meet thresholds for participation in an Advanced APM – features that ensure accountability for quality and cost of care.[11]

MEDICAL NUTRITION THERAPY

Medical nutrition therapy (MNT) is a form of treatment that utilizes nutrition education and behavioral counseling to prevent or manage a medical condition.[12] A Registered Dietitian Nutritionist (RDN), credentialed by the Commission on Dietetic Registration (CDR), collaborates with an individual and, in some cases, members of their medical team to identify health needs and personal goals. RDNs must hold at least a master's degree, complete an Accreditation Council for Education in Nutrition and Dietetics accredited program with specific coursework, and finish 1,000 hours of supervised practice in health care facilities, community agencies, or food service corporations. Additionally, an RDN must pass a national registration exam administered by the CDR. Further, many states require licensure to practice and ongoing professional development to maintain credentialling. The RDN can act as part of a medical team, in various practice settings, such as hospitals, physician offices, private practice and other health care facilities. An RDN can build a nutrition plan that maximizes micro- and macronutrient intake while optimizing health status.[13,14,15,16] MNT typically has four steps: nutrition assessment, nutrition diagnosis, plan, and monitoring and evaluation.[17] The tailored personalized nutrition plan includes: 1) dietary changes, 2) education, 3) supplements, and 4) advanced nutrition support which includes, in severe cases, tube feeding (enteral) or intravenous nutrition (parenteral). MNT also comes in two types – standard MNT and diabetic self-management training – which may be offered either alone or together. For patients with diabetes, MNT is usually most effective when the practitioner delivers both types together.

MNT can provide significant benefits by offering personalized nutrition plans to improve chronic disease management (e.g., diabetes, heart disease, obesity, kidney disease, cancer), reduce symptoms, lower health risks, improve lab markers (e.g., blood sugar, lipids, blood pressure), boost energy, support weight management, and decrease overall health care costs by reducing hospitalization and medications.[18] MNT can also nourish a patient's body when the digestive system is not working effectively or efficiently. MNT can help a patient learn ways to build physical activity into their daily routine, take an active role in their health care, and overcome barriers to nutritious eating. Twenty-five systematic reviews published between 2017 and 2024 indicate that MNT is likely effective in improving a range of health outcomes in adults with pre-diabetes, type 1 diabetes, type 2 diabetes, obesity, pre-hypertension, hypertension, dyslipidemia, chronic kidney disease, head and neck cancer, and chronic obstructive pulmonary disease compared with no MNT or standard care.[19]

Current systematic reviews demonstrate that MNT interventions provided by RDNs may be clinically effective for adults with overweight or obesity, malnutrition , and chronic obstructive pulmonary disease.[20] Additionally, in a pooled analysis, MNT interventions lowered low-density lipoprotein cholesterol, total C, triglycerides, fasting blood glucose, hemoglobin A1c, and body mass index (BMI) compared to a control group.[21] Cost effectiveness and economic savings of MNT for dyslipidemia showed improved quality-adjusted life years and cost savings from reduced medication use.[22] It was concluded that multiple MNT sessions by an RDN are clinically effective and cost beneficial in patients with dyslipidemia and cardiometabolic risk factors.[23]

While there are benefits to MNT, there are also potential disadvantages. For instance, MNT is a time burden with high drop-out rates for patients engaging in therapy.[24] Relatedly, while telehealth has grown in use overall, face-to-face visits tend to be the most widely used mode of service for MNT and can pose a burden for patients, RDNs, and clinical operations.[25] Furthermore, though nurses, community health workers, and primary care physicians can play a significant role in the nutritional counseling of patients, it is not always the case that they are involved. In many states, MNT can be provided without the supervision or order (prescription) of a physician, making it difficult for patients to receive integrated care.

There are also broader concerns about access to effective, safe, and integrated MNT. Currently, there is only consistent insurance coverage for nutrition care for adults with type 2 diabetes and chronic kidney disease in outpatient settings.[26] Though evidence indicates that MNT can improve outcomes, practitioners may hesitate to refer clients due to high out-of-pocket costs. The lack of coverage for MNT may be a detriment to clients with lower incomes who may have more health issues, but who are less likely to be able to afford nutrition care.[27] Shortages of health care workers, including RDNs, are also a widespread concern, particularly in areas that are rural or lack sufficient resources.[28] Additionally, a lack of appropriate coverage for services may lead hospitals to have too few RDNs on staff, leading to more patients being served per RDN and less effective care as a result.

MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY

Medicare covers MNT for patients who meet certain eligibility criteria, such as those with diabetes, kidney disease, and post-36 months after a kidney transplant.[29] Services included are nutrition assessments, therapy, counseling, and follow-up visits.[30] Medicare does not provide coverage for MNT for patients with pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome, small intestinal bacterial overgrowth, gout, and allergies. However, Medicare provides coverage for medically necessary diagnosis and treatment, which can include physician visits, diagnostic tests, screenings, prescription medications, and procedures for each of the outlined conditions. While Medicare does not cover MNT for patients with obesity, it does cover obesity screenings and behavioral counseling for those with a BMI of thirty or greater.[31] Medicare covers behavioral therapy if a primary care physician or other primary care practitioner provides the counseling in a primary care setting, where personalized prevention plans can be coordinated with other care. Intensive Behavioral Therapy (IBT) is a structured counseling program, primarily for obesity, that uses behavioral techniques (e.g., cognitive behavioral therapy, goal setting, dietary advice) with a health care provider (e.g., physician, dietitian, therapist) to promote lasting weight loss through diet, exercise, and mindset changes.[32] IBT focuses on changing habits and thoughts around food and activity, offering support and strategies for healthier lifestyles.[33] Studies surrounding IBT have been shown to be effective in inducing a 10 percent weight loss, which is sufficient to significantly improve health. While weight loss maintenance was shown to be difficult for most participants, long-term outcomes have the potential to be improved through various methods, including prolonging contact between patients and providers or combining lifestyle modification with pharmacotherapy.[34]

As previously discussed, the projected cost of all changes to the MPFS must be budget neutral and may not raise or lower total Medicare spending by more than $20 million per year. Therefore, additional coverage of MNT for patients with the conditions listed above would necessitate offsets to the fees for other services. Furthermore, paying for additional coverage for Medicare beneficiaries outside the MPFS may not be advisable as it could create access challenges for Medicare beneficiaries, disrupt coordination in team-based and value-based care models, and introduce uncertainty around payment authorization, valuation, and operational implementation.

Finally, paying for these services outside of the MPFS could set a precedent affecting other non-physician providers currently paid through the MPFS.

AMA ADVOCACY & RESOURCES

In statements to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health & Retirement Security, and the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, the AMA expressed support for expanded coverage and access to intensive behavioral and nutritional interventions including MNT. In these statements, the AMA urged Congress to expand Medicare coverage for MNT to include additional diet-related health conditions beyond diabetes and renal disease. In a 2021 letter to the Centers for Medicare & Medicaid Services on the 2022 MPFS rule, the AMA commented on the importance of requiring registered dieticians and nutritional professionals to report back to the physician at the onset of the therapy and periodically during the course of treatment.

AMA POLICY

Policy D-440-954 broadly outlines the role that the AMA will take in the study, prevention, and treatment of obesity, which includes increasing public insurance of and payment for the full spectrum evidence-based adult and pediatric obesity treatment, working with national medical specialty societies and state medical associations to address out-of-date restrictions prohibiting physicians from treating obesity, and advocating for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

Policy H-150.953 urges physicians and managed care organizations and other third-party payers to recognize obesity as a complex disorder and all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

Policy H-390.849 states that the AMA will advocate for the development and adoption of physician payment reforms that adhere to its outlined principles, opposes bundling of payments in ways that limit medically necessary care, and supports payment methodologies that redistribute Medicare payments among providers based on outcomes. Additionally, Policy H-390.849 highlights that the AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

Policy H-385.905 supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.

Policy H-400.972 broadly outlines the AMA policy on and recommended principles guiding Medicare physician payment reform.

Policy H-160.906 defines the role that physicians should have within team-based health care as well as guidelines and a model in the development of physician-led team-based health care.

DISCUSSION

The Council acknowledges the value of visits with and treatment from an RDN, especially for patients who are aging or those who have chronic health conditions. At the same time, the Council

understands the scope of practice concerns surrounding MNT and the central role that physicians must play in such treatments. Accordingly, the Council supports the use of MNT – delivered by a RDN, as defined in §1861(v)(2) of the Social Security Act and credentialed by the CDR and in ongoing collaboration with the patient's physician. Furthermore, while the Council supports expanded coverage for these services, it should be accompanied by physician oversight of care teams consistent with Policy H-160.906, which defines the role that physicians have within team-based health care and provides guidelines and a model in the development of physician-led team-based health care.

On balance, and consistent with previous AMA statements and advocacy efforts, the Council supports expansion of Medicare coverage and access to intensive behavioral and nutritional interventions including medical nutrition therapy for diet-related health conditions exempted from budget neutrality. The Council recognizes that expansion of nutritional services impacts the MFPS but believes the value of this therapy warrants its inclusion. At the same time, the Council acknowledges the negative impacts of budget neutrality on payment and encourages reform of the MFPS to eliminate this effect. As outlined in the AMA Medicare Basics Series, the threshold required by budget neutrality unfairly restricts payment for physicians as well as access to care for patients. Therefore, the Council recommends reaffirming Policy H-385.905, which supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replacing or supplement budget neutrality in the Merit-based Incentive Payment System (MIPS) with incentive payments, or implementing positive annual payment updates. We also acknowledge that broader reform of the MPFS is important and, as such, recommend reaffirming Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 116-A-25 and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognize the benefits and support the use of medical nutrition therapy (MNT) – delivered by a Registered Dietitian Nutritionist, as defined in §1861(v)(2) of the Social Security Act and credentialed by the Commission on Dietetic Registration and in ongoing support with the patient's physician – for the purpose of managing and treating chronic health conditions for which there is evidence of efficacy. (New HOD Policy)
2. That our AMA support the expansion of Medicare coverage and exemption from budget neutrality for evidence-based intensive behavioral and nutritional interventions, including medical nutrition therapy(MNT). (New HOD Policy)
3. That our AMA reaffirm Policy H-160.906, which defines the role that physicians should have within team-based health care as well as guidelines and a model in the development of physician-led team-based health care. (Reaffirm HOD Policy).
4. That our AMA reaffirm Policy H-385.905, which supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in Merit-based Incentive Payment System with incentive payments, or implements positive annual physician payment updates. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 4-A-26
Expanding Medicare Access to Medical Nutrition Therapy (MNT)
Policy Appendix

Obesity as a Major Public Health Problem H-150.953

1. Our American Medical Association (AMA) will urge physicians as well as managed care organizations and other third-party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.
2. Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs.
3. Our AMA will urge federal support of research to determine:
    a. the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
    b. the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
    c. effective interventions to prevent obesity in children and adults; and
    d. the effectiveness of weight loss counseling by physicians.
4. Our AMA will encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight.
5. Our AMA will urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity.
6. Our AMA will urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain.
7. Our AMA will encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients.
8. Our AMA will urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
9. Our AMA will urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

(CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19; Appended: Res. 806, I-23)

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.

  c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
  d. Not require budget neutrality within Medicare Part B.
  e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
  f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
  g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
  h. Use adequate risk adjustment methodologies.
  i. Incorporate incentives large enough to merit additional investments by physicians.
  j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
  k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
  l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
  m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

(CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22; Modified: CMS Rep. 04, A-23; Reaffirmed: Res. 214, A-23; Reaffirmation: A-23; Reaffirmed in lieu of: Res. 225, A-25; Reaffirmed: Res. 226, A-25)

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our American Medical Association supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.

(BOT Rep. 13, I-20; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 220, I-24)

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating

Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a ”shadow” Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

(Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 802, I-24)

Addressing Adult and Pediatric Obesity D-440.954

1. Our American Medical Association will:
    a. Assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
    b. Encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
    c. Continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will:
    a. work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment.
    b. work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
    - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
    - Advocacy efforts at the state and federal level to impact the disease obesity.
    - Health disparities, stigma and bias affecting people with obesity.

  - Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
  - Increasing obesity rates in children, adolescents and adults.
  - Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5 above.

(BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22)

Models / Guidelines for Medical Health Care Teams H-160.906

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:
a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.

Teamwork:
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of

treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

(CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-26

Subject: Study of Practice Models for Physicians Performing Procedures Across State Lines

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

Resolution 711, "Study of Practice Models for Physicians Working Across State Lines," was introduced by the Oklahoma delegation at the 2025 Annual Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) undertake a thorough review of the practice models for physicians relying on transfer agreements between corporate health care entities, rather than physician-to-physician backup agreements for backup coverage, their rates of expected and unexpected complications, the impact of this model on local patients and on local physician medical liability costs; 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; 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.

This report focuses on physicians traveling out of state or to another area distant from their home practice, performing a procedure in an ambulatory surgical center (ASC) or office-based laboratory (OBL) and subsequently leaving the area or state. The report recommends the adoption of a new set of related policy principles.

BACKGROUND

An itinerant surgeon travels to a distant site from their home practice, performs surgery, and departs after completing the procedure, often leaving the postoperative care of the patient to another physician or member of the care team. Many believe that in order for this practice to be ethical, a surgeon must perform appropriate preoperative assessments and postoperative follow-up care or delegate this care to a physician familiar with the patient and trained in the same specialty as the surgeon performing the procedure. It should be noted that patients in rural settings can benefit from services provided by itinerant surgeons, granting them access to specialists they would otherwise have to travel long distances to see. Recent data from peer reviewed sources was not available on the impact of itinerant surgeons on patient outcomes or physician liability and/or malpractice. Studies on surgical workforce in the United States almost always omitted the effect of

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itinerant surgeons. In cases where itinerant surgery was taken into account, data on the impact of this arrangement was inconclusive.

ASCs are regulated health care facilities providing outpatient surgical care for patients who do not require an overnight stay, including preventive and diagnostic treatments. ASC procedures are often paid at rates 35-50 percent lower than those for comparable procedures performed at hospital outpatient departments and thus may be considered more cost efficient.[1] Examples of procedures performed at ASCs include hemodialysis thrombectomy, arteriovenous fistula creation, iliac artery intervention, venous stents, ports, and pacemaker and defibrillator installations. OBLs are similar non-hospital outpatient facilities, typically offering less complex procedures, including endovascular procedures, diagnostic health catheterization, and peripheral angiograms and/or interventions.

ASCs account for over 60 percent of outpatient procedural care and represent a $30 billion market.[2] In recent years, ASCs have become an attractive target for private equity investment. The shift to outpatient surgical procedures presents lucrative opportunities for investors without having to directly acquire a hospital facility. Empirical evidence on quality of care in ASCs after private equity acquisition is still limited and relies on a small number of studies, which to date have not found significant changes in short-term quality metrics though they do show substantial changes in charges and payer mix.[3] A recent study found that private equity-owned ASCs do not increase surgical volume but do raise prices significantly – charging nearly 50 percent more per case within 4-5 years.[4]

RELEVANT POLICY

Policy H-475.984 establishes Core Principles on Office-Based Surgery. Most relevant to this report is Core Principle #4, which states that physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital or maintains an emergency transfer agreement with a nearby hospital.

The AMA Code of Ethics discusses related issues in Opinions 2.3.6, Surgical Co-Management, 1.1.3, Patient Rights, and 11.2.3, Contracts to Deliver Health Care Services. Opinion 2.3.6 states that physicians engaging in the practice of surgical co-management should do so following all ethical and legal guidelines, working with the patient to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner, and obtaining patient consent for the surgical co-management arrangement. This consent should include the disclosure of significant aspects of the arrangement, such as qualifications of clinicians, services each clinician will provide, and billing arrangements. Opinion 1.1.3 states that patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals. Further, the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care. Finally, Opinion 11.2.3 states that prior to entering into contracts to deliver health care services, physicians should consider the proposed contract to assure themselves that the terms do not create conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.

The American College of Surgeons (ACS) has its own policy and ethics statements regarding itinerant surgeons and surgical co-management.[6] Other surgical specialty societies such as the American Academy of Ophthalmology, American Society of Plastic Surgeons, and American Academy of Otolaryngology-Head and Neck Surgery also have policies or statements that outline

situations where itinerant surgery may be permissible. While these vary, they all generally indicate that the ultimate responsibility for arranging an appropriate level of continuity of care falls upon the operating surgeon.[7,8,9]

DISCUSSION

The lack of available data on patient outcomes and physician liability and/or malpractice makes it difficult to accurately gauge the impact of itinerant surgeons and their work at ASCs across state lines. One can surmise that there may be negative impacts on patients who need follow-up care or burdens on physicians who may be required to provide that care, but there are no data to indicate that is the case.

There are varying opinions on the ethics of itinerant surgery. Despite some criticisms, it may be the most appropriate way to provide specialty surgical care in rural areas or other places with a shortage of specialty surgeons. Ethics statements from the AMA and ACS state that surgeons who perform elective surgery at a practice that is distant from their home have a professional obligation to also perform preoperative assessments and postoperative follow-up care. There is leeway, however, if perioperative care is designated to another physician who is equivalently qualified to continue caring for the patient, as long this arrangement is agreed to ahead of the procedure by all parties, including the patient.

While the original resolution mentioned corporate entities, the recommendations made by the Council are not specific to ownership type (e.g., private equity, physician-owned) as there is no evidence to date that ownership of an ASC has an impact on itinerant surgeon arrangements or outcomes for patients. When compared to non-private equity-owned ASCs, those owned by private equity did not have statistically significant differences in the probability of a patient having an unplanned hospital visit (i.e., complications during or post-surgery).[5]

The principles outlined in the recommendations below can be applied generally and highlight important considerations for those considering the practice of itinerant surgery. Of utmost importance is continuity of care for the patient and having both backup and transfer agreements in place with local physicians who are able to provide the necessary follow-up care, both in case of emergencies and to ensure proper healing and recovery. Itinerant surgery may not be appropriate in all cases, but the Council believes that it may be acceptable in certain circumstances, specifically providing planned specialty surgical care to areas of shortage. The Council concurs with the ethical standards reviewed and agrees that in cases where itinerant surgery is the best option, physicians should follow appropriate guidelines and ethical and legal standards.

As written, the original resolve clauses have challenges to their feasibility but raise an important concern. Additionally, recent data could not be found to quantify the impact of the concerns raised in the original resolution. However, the Council believes there is a gap in AMA policy regarding the practice of itinerant surgeons and thus presents a set of guidelines for physicians performing procedures across state lines, specifically at ASCs and OBLs, to address the issues raised in Resolution 711-A-25.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 711-A-25 and the remainder of the report be filed.

1. That our American Medical Association (AMA) supports the following principles for physicians employed by ambulatory surgical centers (ASC) or office-based laboratories (OBL) who may travel from their primary practice location to provide patient care:
    a. A transfer agreement with a physician or physician group licensed in the patient's state should be arranged to address in-person care needs that may arise from a patient receiving care from a physician who primarily practices out of state or out of the immediate area or from a physician with no admitting privileges to the local hospital.
    b. A referral system with a local physician, physician practice, or other facility for appropriate treatment should be established if a patient's conditions or symptoms are beyond the scope of services provided by the ASC or OBL.
    c. Transfer agreements and backup plans should be coordinated between physicians.
        i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician that would be among those receiving the patient must give explicit consent to the agreement to provide follow-up care.
        ii. When patient transfer is required, a direct hand off of the patient and patient records should be completed.
        iii. Transfer and referral agreements should be evidence-based and risk-based to balance access to care and patient safety.
    d. Protocols for ensuring continuity of care with physicians in the local community should be established.
    e. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.
    f. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements.

    (New HOD Policy)

2. That our AMA reaffirm Policy H-475.984, which lists Core Principles for Office-Based Surgery Regulations, with a focus on Core Principle #4 which states that physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospitals or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or to maintain an emergency transfer agreement with a nearby hospital. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 6-A-26
Study of Practice Models for Physicians Working Across State Lines
Policy Appendix

Office-Based Surgery Regulation, H-475.984
Our American Medical Association supports the following Core Principles on Office-Based Surgery:

Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia).

Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system).

Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.

Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. (Med. Licensure Discipline. 2002; 88:-160-174).

Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. https://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf).

Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is

generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.
(BOT Action in response to referred for decision BOT Rep. 23, A-03; Modified: CMS Rep. 4, A-13; Modified: CCB/CLRPD Rep. 1, A-23)

E-2.3.6 Surgical Co Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

AMA Principles of Medical Ethics: I,II,IV,V,VI
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

E-1.1.3 Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
(e) To have the physician and other staff respect the patient's privacy and confidentiality.
(f) To obtain copies or summaries of their medical records.
(g) To obtain a second opinion.
(h) To be advised of any conflicts of interest their physician may have in respect to their care.
(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I,IV,V,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

E-11.2.3 Contracts to Deliver Health Care Services
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 that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions 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 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.

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 and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

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 some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
- (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
- (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;
- (iii) ensures the physician can appropriately exercise professional judgment;
- (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
- (v) is transparent and permits disclosure to patients;
- (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
- (vii) prohibits the corporate practice of medicine.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:
(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.
(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.
(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.
(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of health care services, physicians should:
(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.

AMA Principles of Medical Ethics: I,II,III,V,VI,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Private Insurance Coverage of Anti-Obesity Medications

EXECUTIVE SUMMARY

Resolution 230-A-25, "Advocating to Expand Private Insurance Coverage of Anti-Obesity Medications," was introduced by the Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, and American College of Physicians. The resolution asked that existing Policy H-440.801 be amended. Subclauses 1f and 1h were adopted while Subclauses 1e and 1g were referred. These referred subclauses ask the following:

> RESOLVED, that our American Medical Association (AMA) amend policy H-440.801, Advocacy Against Obesity-Related Bias by Insurance Providers, by addition to read as follows:
> 1. Our AMA will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
>   e. Eliminate coverage exclusions for the pharmacologic treatment of obesity.
>   g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.

This report discusses the persistence of obesity, the marketplace and coverage of anti-obesity medications (AOMs), guidelines for the treatment of obesity, and includes several policy recommendations. Obesity is a chronic, progressive disease and a global public health challenge. While seven medications are currently approved for weight loss, the next generation of AOMs will enter the market within the next few years and are considered more effective with fewer side effects. Despite an increasing body of evidence to suggest that AOMs are effective treatments, coverage for obesity remains limited. The World Health Organization and Institute for Clinical and Economic Review recently released reports providing guidance on the use of glucagon-like peptide-1 (GLP-1) medications, strategies to guide market action, policy solutions, and federal policy interventions to improve access. Furthermore, the regulatory environment has been dynamic, with GLP-1s included in the Trump Administration's priority to lower prescription drug prices.

The Council on Medical Service recommends new policy supporting potential innovative payment arrangements and pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management. The Council also recommends the long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability. Furthermore, the Council recommends equitable access to comprehensive disease management, health promotion, and prevention interventions targeting the general population and those who are at elevated risk for obesity. Additionally, the Council recommends reaffirming Policy H-110.997 and Policy H-110.959 to emphasize the AMA's support for affordable access to prescription drugs. The Council also recommends reaffirming Policy H-110.987 to highlight the AMA's support to ensure that drug prices are affordable to patients and Policy D-330.954 and Policy D-110.987 to underscore the AMA's support and recognition for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS and efforts to increase pharmacy benefit manager transparency and regulation. Lastly, the Council recommends reaffirming Policy H-150.953 to highlight the AMA's recognition of obesity as a complex health disorder.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-26

Subject: Private Insurance Coverage of Anti-Obesity Medications

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

Resolution 230-A-25, "Advocating to Expand Private Insurance Coverage of Anti-Obesity Medications," was introduced by the Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, and American College of Physicians. The resolution asked that existing Policy H-440.801 be amended. Subclauses 1f and 1h were adopted, while Subclauses 1e and 1g were referred. These referred subclauses ask the following:

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>   g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.

This report discusses the persistence of obesity, the emerging marketplace and coverage of anti-obesity medications (AOMs), guidelines for the treatment of obesity, and includes several policy recommendations.

BACKGROUND

Defined by the World Health Organization (WHO) as a chronic, progressive, and relapsing disease, obesity is a global public health challenge affecting more than one billion people worldwide and contributing to millions in preventable deaths each year. In the United States (U.S.), the prevalence of obesity among adults increased from 34.7 million (19.3 percent) in 1990 to 107 million (42.5 percent) in 2022.[1,2] Adults with severe obesity accounted for 9.2 percent (over twenty-two million by total population) in 2020.[3] By 2035, an estimated 46.9 percent of the adult population (126 million) will be categorized as obese.[4] The percentage of U.S. children and adolescents affected by obesity has more than tripled from 1965 (5 percent) to 2018 (19 percent).[5] Obesity is costly to the U.S. health care system, with an estimated $172 billion annually attributed in medical costs, representing 5 to 7 percent of all health care expenditures.[6] Despite obesity being a significant chronic disease for all populations, prevalence varies by race and ethnicity. In 2022, non-Hispanic Black females were estimated to have the highest prevalence of obesity, at 56.9 percent followed by Hispanic females at 49.4 percent.[7] The increasing prevalence of obesity also varied by race and ethnicity. For instance, obesity has risen least for non-Hispanic Black males, with an increase in prevalence from 22.0 percent in 1990 to 40.4 percent in 2022.[8] Additionally, there are state-level differences, with prevalence highest in Midwestern and Southern states and variance by age, with

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obesity prevalence highest among middle-aged adults and large increases in the youngest adult ages, especially for females.[9]

While the WHO defines obesity as having a body mass index (BMI) of 30.0 or higher in adults, the Lancet Commission recently announced a new definition that moves beyond BMI to classify it as a chronic disease.[10] Obesity is associated with and can result in an increased risk of comorbidities such as hypertension, diabetes, hypercholesterolemia, coronary heart disease, gallbladder disease, osteoarthritis, certain cancers, and liver disease. Severe obesity, defined as having a BMI of 40 or higher, can shorten life expectancy by up to 14 years, similar to smoking.[11] Moderately obese and severely obese individuals are estimated to have 14 to 25 percent more visits to their physicians, respectively, with visits to primary physicians to be 38 percent higher for those who are obese.[12]

Previously, obesity was thought to be an imbalance between energy intake and expenditure. However, recent research has suggested that genetic, physiological, and behavioral factors play a significant role.[13] Variations in genes that affect metabolic processes, appetite regulation, body fat distribution, and environmental factors such as geography, food and physical activity environment, and socioeconomic status are consequential in the development of obesity.[14] While traditional strategies focused on individual behavior have been insufficient, prevention efforts targeting obesity-related noncommunicable diseases have never been more important. For instance, prevention efforts can include the promotion of healthy eating, active lifestyles, and early intervention to reduce risks of diabetes, heart disease, and cancer. People with obesity continue to face social stigma with weight bias and discrimination persisting as significant factors in understanding the impact of and providing treatment through pharmacological methods.[15] Additionally, weight bias has led to delays in diagnosis and treatment and contributes to poorer health outcomes leading to a profound effect on all aspects of patients' lives and those of their families.[16]

Multiple public health interventions, such as school nutrition and exercise programs, taxes on unhealthy foods, and health system requirements for nutritional counseling programs[17] have had limited success, requiring health care to evolve to meet the needs of the population more adequately. Currently, comprehensive care for obesity includes nutrition therapy, physical therapy, behavioral counseling, and pharmacotherapy.[18] There are multiple methods for treating obesity including lifestyle modifications (e.g., diet, physical activity, and behavioral modifications), medications, and bariatric surgery, usually in combination.[19]

ANTI-OBESITY MEDICATIONS

Initially developed for the treatment of type-2 diabetes, GLP-1 receptor agonist and glucose-dependent insulinotropic polypeptides (GIP)/GLP-1 dual agonist therapies have emerged as potential AOMs. By targeting mechanisms that reduce appetite and enhance satiety along with other physiological effects, GLP-1 medications provide a complementary treatment to traditional behavioral interventions and important innovations to address obesity.[20] Additionally, clinical benefits associated with GLP-1 therapies have demonstrated improvements for major cardiovascular events, heart failure with preserved ejection fraction, diabetes prevention, systolic blood pressure and low-density lipoprotein cholesterol, obstructive sleep apnea, peripheral artery disease, kidney disease, metabolic dysfunction-associated steatohepatitis, and neurodegenerative diseases.[21] Similar results can be seen for patients with diabetes: improved glycemic control, significant weight loss, cardiovascular risk reduction, renal and liver production, a reduced need for other medications, lowered blood pressure, and improved cholesterol profiles.[22] The pleiotropic effects are beneficial for patients with multiple chronic conditions, especially for older patients, because it can help reduce polypharmacy and increase adherence to pharmacological treatments.[23]

There has also been emerging evidence to suggest their utility in treating neurodegenerative diseases, reducing stroke risk, liver disease, and substance use disorders.[24] However, there are potential unintended consequences through the long-term use of GLP-1 medications. For instance, there is emerging clinical and paraclinical evidence that suggests that the agents may contribute to a reduction in skeletal muscle mass, potentially exacerbating or precipitating sarcopenic obesity, particularly in older or frail individuals with limited muscular reserves.[25] Therefore, the preservation of muscular health through nutritional support, exercise, and pharmacological therapies are important supplementary treatments, especially for older patients.

At the time this report was written, there were seven medications approved for weight loss by the Food & Drug Administration (FDA), with varying effectiveness and occurrences of side effects. Earlier generations of obesity medications had lower degrees of effectiveness with higher incidences of side effects. Appendix A highlights the FDA approved GLP-1 medications for the treatment of obesity. There may be potential benefits to prescribing and administering earlier generations of AOMs.[26] For instance, access to second generation AOMs remains limited because of restricted insurance coverage and high out-of-pocket costs. While Wegovy® and Zepbound® are listed at $16,188 and $12,720 per year, respectively, Qsymia and Contrave are $1,465 and $2,095, respectively.[27] Additionally, significant shortages of GLP-1 medications can make it difficult to prescribe the second generation of AOMs and further inhibit access for certain patients. Furthermore, some patients may be nonresponders to semaglutide (or tirzepatide) or have difficulty tolerating GLP-1 based medications.[28] Some patients may require multiple medications in addition to semaglutide or tirzepatide to achieve significant weight loss or second generation AOMs might be too powerful and result in too much weight loss, loss of lean muscle mass, and concern of increased frailty.[29]

The next generation of AOMs are set to enter the market within the next several years–with 40 manufacturers in the process of developing GLP-1 drugs and 16 AOMs expected to be approved from 2026 to 2029–and are considered more effective with fewer side effects.[30] Similarly, non-GLP-1 medications are part of this emerging market and include melanocortin-4 receptor agonists, amylin analogs, and mitochondrial uncouplers.[31] Non-GLP-1 medications can be appealing for patients who do not respond to GLP-1s or have specific metabolic needs. Some of these new medications provide an oral alternative targeting similar pathways without requiring injections, thereby improving accessibility and patient adherence. Further, the dosing schedule for some of these new medicines is easily adherable. The emergence of these medications, their efficacy, favorable effects on metabolism and obesity-related complications, and recognition of obesity as a chronic health condition, has led to a rapid expansion in their use. GLP-1-based prescriptions among people without diabetes have risen by 700 percent between 2019 to 2023.[32] Pervasive media attention has led some to theorize whether AOMs could be a potential solution to the obesity epidemic. In December 2025, Novo Nordisk released a pill version of Wegovy® and, in less than three weeks, 150,000 prescriptions were filled.[33] According to the manufacturer, most prescriptions are from new patients and 9 out of 10 paid out of pocket.[34]

Pervasive media attention has also led GLP-1s to being used off-label for non-obese patients to lose small amounts of weight.[35] While GLP-1s are being used off-label by individuals who do not meet obesity criteria, there are significant considerations required in prescribing an AOM. There is a marked difference between AOMs being prescribed for chronic, long-term use and for short-term use without the guidance of a medical professional. Compounded versions of the GLP-1 injectables were made available in early 2022 when brand name versions were in short supply. Under Section 503A and 503B of the Federal Food, Drug, and Cosmetic (FD&C) Act, compounded drugs are allowed when the brand-name drug is on the FDA's official Drug Shortages list. While the FDA provides some flexibility, the agency may act if an outsourcing facility continues to fill new orders

for more than 60 days after the drug has been removed from the Drug Shortages list. In the case of GLP-1 medications, the FDA removed the injectables from the list in February 2025 but allowed a brief window for compounders to wind down operations with 503A pharmacies allowed to continue until April 22, 2025 and 503B outsourcing facilities until May 22, 2025.[36] Despite the timeline, and the FDA warning telehealth companies against illegal marketing of compounded GLP-1s, Hims & Hers™ was still offering its versions of injectable weight-loss drugs until March 2026 when it struck a deal with Novo Nordisk to sell Wegovy® at a discounted rate.[37,38]

Treatment discontinuation of tirzepatide and semaglutide remains high and is a significant issue as it is associated with increased risks of cardiovascular events and mortality. Randomized trials, such as SURMOUNT-4, demonstrate that discontinuation of pharmacotherapy leads to weight re-gain reinforcing the chronic nature of obesity treatment.[39] Cost or insurance-related (insurance denial, expiration of manufacturer discount coupon, or out-of-pocket cost) hurdles were cited as the most common reason, by half of respondents (47.6 percent).[40] Side effects were the second most cited reason with 14.6 percent of respondents. For comparison, side effects and efficacy are cited as the most common reason for treatment discontinuation of medication for chronic medical conditions.[41] In general, high-risk, non-oral medications for conditions like diabetes, asthma, and glaucoma often have higher initial discontinuation rates.[42] Furthermore, younger patients, those with comorbidities, and patients who are non-White may have higher rates of discontinuation.[43]

COVERAGE OF ANTI-OBESITY MEDICATIONS

Despite an increasing body of evidence to suggest that emerging AOMs are effective treatments, coverage of GLP-1s for obesity treatment remains limited. Indeed, coverage is sparse for individuals through Medicaid, Affordable Care Act (ACA) Marketplace plans, and those who work in large employer firms, and coverage in Medicare for treatment of obesity is, for now, prohibited.[44,45,46] While all Medicaid programs cover GLP-1s for the treatment of diabetes, coverage is optional for the treatment of obesity. As of October 2025, 16 state Medicaid programs covered GLP-1s for obesity treatment, 11 states cover GLP-1s for weight loss under their state employee health plan, and five provide coverage under both programs.[47] Some of these Medicaid programs, however, have already announced they will discontinue coverage or restrict those who can qualify. North Carolina Medicaid, for example, ended coverage of GLP-1s for obesity in October 2025, citing shortfalls in state funding.[48] Additionally, California, New Hampshire and South Carolina will end coverage at the beginning of 2026.[49] Further, starting next year, Michigan Medicaid will limit coverage to people who are "morbidly obese," (BMI of 40 or higher).[50] Lastly, Pennsylvania, Rhode Island and Wisconsin are also considering new restrictions.[51]

Private insurance coverage is often based on the insurance plan or employer decision to include the benefit; even if the coverage is offered, its initial and continued coverage is restricted by stringent prior authorization criteria. As of 2025, 39.4 percent of individuals with private insurance and 45.1 percent of individuals with employee sponsored insurance had at least one GLP-1 medication covered by their plan.[52] Drugs solely approved to treat obesity have minimal to no coverage on most ACA Marketplace formularies. Among ACA Marketplace plans with these drugs on formulary, prior authorization is required by most plans (greater than 98 percent).[53] Step therapy, a utilization management tool that requires patients to try and fail lower cost medications before coverage is provided for more expensive medications, is less commonly used, with 1 in 4 marketplace plans requiring it.[54] Quantity limits are imposed in most plans among those including these drugs.[55] With such a high demand for and short supply of GLP-1 agonists, some patients have taken to procuring them from alternative sources, such as online vendors, medical spas, or compounding pharmacies selling products not evaluated by the FDA, some of which may contain different ingredients.[56] The FDA is increasing enforcement against compounded GLP-1 drugs, as

1 many shortages have been resolved, removing the exemption that allowed pharmacies to create
2 copies of branded drugs.[57] The agency is targeting companies, including telehealth providers, for
3 selling non-FDA-approved, mass-marketed "copycat" versions that pose safety risks.[58]
4
5 Despite a notable increase in employers covering GLP-1 medications for weight loss, the high costs
6 associated with obesity medications raise significant concerns. While recognizing their benefit,
7 many employers are considering scaling back coverage due to their high cost and higher than
8 expected use. Approximately 34 percent of non-elderly people with employer-sponsored health
9 insurance (36.2 million) have a body mass that would medically qualify them for GLP-1 drugs.[59]
10 The share of firms with 5,000 or more workers covering these medications for weight loss
11 increased significantly (from 28 percent in 2024 to 43 percent in 2025).[60] However, only 19 percent
12 of firms with 200 or more workers cover GLP-1 drugs for weight loss in their largest health plan in
13 2025.[61] Furthermore, for those firms that cover GLP-1s for weight loss, about a third require
14 enrollees to meet with a dietician, case manager, therapist, or participate in a lifestyle program.[62]
15
16 While insurance coverage of GLP-1 medications for obesity remains lower than other medications,
17 there is a roadmap to broader access with comparable treatments. Bariatric surgery coverage has
18 evolved from a rarely covered, high-risk procedure in the early 1990s to a widely accepted,
19 insurance-covered treatment for severe obesity. Driven by improved safety and proven metabolic
20 benefits, a major milestone occurred when the Centers for Medicare & Medicaid Services (CMS)
21 expanded Medicare coverage in 2006 for patients with specific comorbidities.[63] Currently, bariatric
22 surgery is generally covered for obesity when deemed medically necessary, a specific BMI
23 threshold is met with obesity-related comorbidities like diabetes and sleep apnea. Additionally,
24 coverage requires documentation of failed, previous weight loss attempts, a supervised diet
25 program, and mental health evaluations.[64]
26
27 Rebates for GLP-1 medications are widespread and, as of 2025, are estimated to be 40 percent or
28 higher for major products like Wegovy® and Zepbound®.[65] They are most readily used by
29 pharmacy benefit managers (PBMs) to secure formulary placement, reducing high list prices to
30 lower net costs for payers. The rebates are a primary tool used to secure preferred coverage on
31 insurer formularies, with some discounts at 50 percent.[66] Additionally, states received substantial
32 rebates for brand-name GLP-1s, with usage growing and accounting for eight percent of Medicaid
33 prescription drug spending before rebates in 2024.[67] However, these manufacturer-to-payer rebates
34 do not always translate directly into lower out-of-pocket costs for individual users and frequently
35 rely on copay assistance coupons to manage costs.
36
37 PBMs play a central, controversial role in the high cost of GLP-1 medications. By controlling
38 access via formularies and negotiating large, often opaque rebates, PBMs are criticized for favoring
39 higher-priced drugs for larger rebates and, therefore, keeping net costs high for employers.[68,69]
40 PBMs argue their negotiating power is used to counterbalance high list prices set by manufacturers,
41 sometimes securing lower out-of-pocket costs for members. However, limited transparency makes
42 it difficult to distinguish how and if the discounts are passed on to employers or patients.[70] PBMs
43 can also implement strict utilization controls including mandatory prior authorization, step therapy,
44 and BMI requirements to limit access and manage costs.[71] While utilization controls can be useful,
45 it is argued that PBMs may use unfair criteria or a patient facing restricted access despite it being a
46 clinically appropriate treatment.
47
48 A study from 2025 showed that there was significant disparities in AOM prescription rates based
49 on gender, race/ethnicity, age, insurance type, insurance carrier, and adjusted gross income
50 (AGI).[72,73] For instance, Black patients, Hispanic individuals, and those of other racial or ethnic
51 backgrounds had lower prescription rates, compared with white patients.[74] Furthermore, men had

lower rates than women and, compared with privately insured individuals those with Medicaid, traditional Medicare, Medicare Advantage, self-paying, and other insurance types had lower rates of prescription.[75] Lastly, those with the highest level of income had the highest prescription rate compared to those with the lowest income.[76] Patients filling their prescription differed as well, though less significantly than those receiving an AOM prescription. While Hispanic patients were less likely to fill their prescription compared with White patients, Black patients had similar filling rates.[77] Patients who were older or women were more likely to fill their prescription higher odds of AOM fill.[78] Furthermore, Medicaid, traditional Medicare and Medicare Advantage insurance types were associated with lower odds of AOM fill, compared with private insurance category.[79] Interestingly, insurance carriers or AGI did not produce any significant difference in filling rates.[80]

WORLD HEALTH ORGANIZATION GUIDELINES ON THE USE OF GLP-1 THERAPIES[81]

In December 2025, and in response to requests from its member nations, the WHO published an evidence-informed guideline on the use of GLP-1 therapies in the treatment of obesity in adults. The guideline outlines a strategic foundation to help countries accelerate their response to the obesity crisis, brings together the current evidence base, details the development process, and distills the implications for expanding equitable access to these medications while shaping a more comprehensive ecosystem for obesity management. In the report, two practice statements were outlined with partnering recommendations. First, obesity was recognized as chronic, complex disease that requires lifelong care beginning in clinical assessment and early diagnosis. It was recommended that in adults living with obesity, GLP-1 receptor agonists or GIP/GLP-1 dual agonists may be used as long-term treatment for obesity. Second, people living with obesity should receive context-appropriate counselling on behavioral and lifestyle changes as an initial step toward more structured behavioral interventions. Thus, it was recommended that in adults living with obesity who are prescribed GLP-1 receptor agonists or GIP/GLP-1 dual agonists, intensive behavioral therapy may be provided as a co-intervention within a comprehensive multimodal clinical algorithm.

The guideline emphasizes the importance of fair access to GLP-1 therapies and preparing health systems for use of obesity medicines. Without deliberate policies, the WHO suggests access to GLP-1 therapies could exacerbate existing health disparities. Additionally, in September 2025, the WHO added GLP-1 therapies to its Essential Medicines List for managing type 2 diabetes in high-risk groups.[82] With the guideline, the WHO issues conditional recommendations for using therapies to support people living with obesity, as part of a comprehensive approach that includes healthy diets, regular physical activity, and support from health professionals.

INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW REPORT: AFFORDABLE ACCESS TO GLP-1 OBESITY MEDICATIONS[83]

In April 2025, the Institute for Clinical and Economic Review (ICER) released the report Affordable Access to GLP-1 Obesity Medications: Strategies to Guide Market Action and Policy Solutions. In the report, ICER presented potential strategies to guide market action, policy solutions, and federal policy interventions to improve access to GLP-1 medications, and AOMs in general.

Five market strategies were suggested, informed by ICER's interviews with different stakeholders and their advantages and limitations are outlined for each option in Appendix B. For instance, temporary coverage denial was a solution, suggesting that some purchasers and insurers have concluded that they do not have the budget flexibility to provide coverage for GLP-1s for treatment of obesity at current prices. For those that are seeking a more affordable and long-term way to provide coverage for expensive drugs, such as GLP-1s, purchasers and insurers may apply enhanced utilization and could include coverage criteria. Some coverage criteria included BMI and clinical comorbidities, additional clinical or genetic factors, and/or duration of coverage. Another suggestion was that managing the network of clinical providers may improve results while controlling costs. While some purchasers may consider temporary non-coverage of GLP-1 drugs, another solution may be to utilize alternative payment arrangements to help individuals afford treatment. The last market solution that the report outlined was carve-out programs. Many purchasers or payers are delegating obesity management to a comprehensive program offered by a PBM or to an independent obesity management company.

Five federal policy interventions were suggested as potential policy reforms that the federal government could enact to address access to GLP-1 medications and the overall cost of obesity treatment. One potential policy reform was increased access through coverage of obesity drugs in Medicare. While the Trump Administration announced the coverage of GLP-1 medications for the treatment of obesity, federal law still bans Medicare from covering weight-loss drugs and requires a pilot program to evaluate coverage. At a federal level, in lieu of Medicare coverage of GLP-1s for obesity, another way to broaden coverage would be to ask the United States Preventive Services Task Force to evaluate GLP-1s and deem them as preventive treatments worthy of a rating of "A" or "B" that creates a mandate for coverage by all private insurers with no patient cost sharing. The third cited policy reform was reducing costs through aggressive drug price negotiation by the federal government. The Trump Administration, as will be outlined, recently negotiated the price for GLP-1 medications covered through Medicare and Medicaid. Additionally, the federal government negotiated during its second round of Medicare's Drug Price Negotiation Program, created by the Inflation Reduction Act (IRA) of 2022, which included diabetes and obesity drugs Ozempic® and Wegovy®. The fourth reform was to reduce costs through federal subsidies for private insurance coverage of obesity treatments. The federal government, it is suggested, could negotiate significant price concessions like the affordable prices that were negotiated for COVID-19 vaccines and treatments during the pandemic in exchange for federal subsidies to private insurers. Along with negotiating lower prices through the IRA process, the fifth intervention is to require that drugmakers license GLP-1 drugs to generic manufacturers for the express purpose of providing more affordable versions for public payers, including state Medicaid programs and state employee health plans.

RECENT REGULATORY ACTIVITY

In May 2025, the Trump Administration issued Executive Order No. 14297, Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients which instructed drug

manufacturers to reduce the prices of brand-name drugs to match the lowest price among selected high-income countries as part of its aim to deliver its most-favored-nation (MFN) drug pricing.[84] In November 2025, the Trump Administration announced an agreement with pharmaceutical manufacturers Eli Lilly and Novo Nordisk to offer their weight-loss drugs for individuals receiving Medicare and Medicaid as part of its MFN policy.[85] As part of this plan, the Medicare price for Ozempic®, Wegovy®, Mounjaro®, and Zepbound® will be $245, with Wegovy® and Zepbound® covering patients with obesity and related comorbidities for the first time. Further, in December 2025, CMS published its voluntary Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model.[86] The BALANCE Model will allow CMS to negotiate drug pricing and coverage terms with manufacturers of GLP-1 medications on behalf of state Medicaid agencies and Medicare Part D plan sponsors. Medicaid agencies can join the model beginning in May 2026, and Part D plans in January 2027. However, as previously mentioned, federal law still bans Medicare from coverage of weight-loss drugs and will require demonstration programs and waivers to proceed. Furthermore, it is unclear whether states will find the model appealing. For instance, due to recent budget cuts, many states are facing tighter budget constraints. Additionally, it is unknown how the new lower costs compare to the net prices state Medicaid programs already pay after rebates. Lastly, state interest in expanding coverage of obesity drugs has been waning due to their significant budgetary impact and sustainability.

Legal challenges and negative feedback from stakeholders led to the withdrawal of prior proposals introduced during the first Trump Administration: International Pricing Index (IPI) Model and MFN Model. The IPI Model sought to lower drug costs and reduce out-of-pocket costs for patients. CMS solicited public comments on options considered for testing changes to payment for separately payable Medicare Part B drugs to align with international prices more closely. Similarly, the proposed MFN Model negotiated for the lowest price that drug manufacturers received in other similar countries for high-cost Medicare Part B drugs. While both were withdrawn, these policies provided the outline for the Trump Administration's second attempt to lower prescription drug costs.

While Novo Nordisk and Eli Lilly have committed to lowering the prices for private insurance and group health plans, it is unclear how the negotiated prices will affect them. The agreement does not include pricing obligations in the commercial market. Some experts suggest price reductions will transition over to group health plans and private insurance, while others believe manufacturers will make up the difference by lowering rebates or increasing prices. Others have expressed concern over MFN policies, suggesting that price controls trade short-term benefits for long-term risk. Further, while the Trump Administration has indicated its desire to codify MFN pricing, it is unclear if Congress will be agreeable citing concern potential threats to medical innovation, reduced access to new medicines, and increased government intervention in the health care market.

In November 2025, CMS announced the prices that the federal government negotiated during its second round of Medicare's Drug Price Negotiation Program (MDPNP), created by the IRA, which included Ozempic® and Wegovy®.[87] According to a spokesperson for CMS, MFN prices will supersede MDPNP prices and that MFN drug prices will supersede "maximum fair prices" negotiated under the IRA where there is a conflict.

Finally, the Trump Administration launched TrumpRx in February 2026 – a government run, direct to consumer website designed to deliver MFN prices directly from manufacturers. Not all medications will be available, with five manufacturers participating and 40 of the nation's highest-cost brand-name drugs listed on the website. For instance, not all AOM are available for purchase - Wegovy® and Zepbound® are listed while Saxenda® is not. Details are still emerging, and questions remain regarding who will benefit.

AMA POLICY

Policy H-110.997 supports programs whose purpose is to contain the rising costs of prescription drugs, most notably that: all patients have access to all prescription drugs necessary to treat their illnesses and physicians have the freedom to prescribe the most appropriate drug and method of delivery. Additionally, Policy H-110.997 encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs, to consider the prescribing of the least expensive drug product, and to become familiar with the price in their community of the medications they prescribe.

Policy H-110.959 supports efforts to ensure that patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription costs.

Policy H-110.987 encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies, encourages the Federal Trade Commission actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition, and supports legislation to shorten the exclusivity period for biologics.

Policy D-110.987 supports the active regulation of PBMs under state departments of insurance, supports improved transparency of PBM operations, and details that the AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.

Policy H-150.953 urges physicians and managed care organizations and other third-party payers to recognize obesity as a complex disorder and all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

Policy D-330.954 supports federal legislation which gives the Secretary of the Department of Health and Human Services (HHS) the authority to negotiate contracts with manufacturers of covered Part D drugs, works toward eliminating Medicare prohibition on drug price negotiation, and prioritizes the AMA's support for CMS to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Finally, Policy H-440.801, which is amended by Resolution 230, urges state delegations to directly advocate for their insurance agencies and insurance providers to, most notably: allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance and reduce the prior authorization burden for the coverage of anti-obesity medications.

DISCUSSION

The Council recognizes the changing landscape of AOMs, their role in the treatment of obesity, and the emergence of GLP-1s as a "game-changing" pharmacological treatment for patients with obesity, diabetes, and comorbid conditions. Their clinical efficacy is clear, but they are expensive. Although many employer-sponsored insurance or private insurance plans do not cover GLP-1 medications for the treatment of obesity, that could change in the future as there have been several developments toward improved affordability and access. Starting in July 2026, Medicare will significantly expand coverage for GLP-1 medications for patients with obesity and comorbid conditions. Patients will have access to these drugs with copays capped at $50 per month,

supported by the short-term demonstration program acting as a bridge to the broader BALANCE model launching in 2027 which will also serve as a pilot program for state Medicaid programs. Moreover, the proliferation of direct-to-consumer marketplaces, which bypass traditional insurance and retail pharmacies, offer lower list prices and enhance medication access. Likewise, the recently approved pill versions of Wegovy® ¬and soon to be approved non-peptide GLP-1 called Orforglipron® ¬ enhance affordability. Additionally, the emergence of more effective AOMs set to enter the marketplace within the next few years will improve their affordability and access. Furthermore, while some states have rescinded coverage of GLP-1 medications for the treatment of obesity, the demand for AOMs and potential payment structures lessening variability may improve access organically.

Nonetheless, the Council recognizes the importance of more immediate coverage and the potential value of the market strategies and policy reforms outlined in the ICER report. Therefore, the Council recommends several new policies to supplement AOM affordability and access. The Council recommends support for innovative payment arrangements and pilot programs consistent with several recently announced Medicare and Medicaid demonstrations intended to increase the affordability of GLP-1 medications.

It also is becoming more evident that patients with chronic obesity may need to take these medications long-term. As such, the Council supports the long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiers, and benefit structures. The Council also acknowledges pharmacological treatment may not be effective, in some cases, without concurrent disease management treatment which may not be accessible for all patients. With that in mind, the Council supports equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity.

Medication affordability and access continue to be significant concerns for many patients, including those that need AOMs for chronic obesity. As such, the Council recommends reaffirming Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients, and Policy H-110.959, which encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. The Council also recognizes the contribution of PBMs to high drug costs and their lack of clarity on rebate driven formularies. Therefore, the Council recommends reaffirming Policy D-110.987, which supports efforts to increase PBM transparency and regulation. Additionally, the Council notes that negotiating for Medicare drug prices is crucial to reducing high out-of-pocket costs for seniors and lowering government health care spending. Thus, the Council recommends reaffirming Policy D-330.954, which supports CMS negotiating pharmaceutical pricing for all applicable medications covered by CMS and indicates the AMA's support for federal legislation giving the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Medicare Part D drugs. The Council appreciates the important role of the physician in the treatment of chronic obesity and, as such, recommends reaffirming Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, physicians having the freedom to prescribe the most appropriate drug and method of delivery, and encourages all physicians to become familiar with the price in their community of the medications they prescribe.

Lastly, the Council recognizes the complexity, prevalence, and impact of obesity and, therefore, recommends reaffirming Policy H-150.953, which recognizes obesity as a complex health disorder, urges all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and appropriate federal agencies

work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Subclauses 1e and 1g of Resolution 230-A-25, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support:
    a. Potential innovative payment arrangements to help individuals afford treatment for emerging anti-obesity medications (AOMs);
    b. Pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management, such as glucagon-like peptide-1 and glucose-dependent insulinotropic polypeptide-based medications;
    c. The long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability;
    d. Equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity. (New HOD Policy)

2. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-110.959, which supports efforts to ensure patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, that all patients have access to all prescription drugs necessary to treat their illnesses, and physicians have the freedom to prescribe the most appropriate drug and method of delivery. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-330.954, which supports Centers for Medicare & Medicaid Services (CMS) negotiating pharmaceutical pricing for all applicable medications covered by CMS, AMA working toward the elimination Medicare prohibition on drug price negotiation, and indicates the AMA's support for federal legislation giving the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-150.953, which recognizes obesity as a complex health disorder, urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and

1 appropriate federal agencies work with organized medicine to develop coding and payment
2 mechanisms for the evaluation and management of obesity. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Appendix A
GLP-1 Obesity Medications Approved by the FDA

Drug	Effectiveness	FDA Approval Indication	Year Approved
Liraglutide (Saxenda®) GLP-1 Receptor Agonist Daily subcutaneous injection	63% lost at least 5% reduction of body weight	Adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in: 1) Adult patients with an initial body mass index (BMI) of •30 kg/m2 or greater (obese), or •27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition; 2) Pediatric patients aged 12 years and older with body weight above 60 kg and an initial BMI corresponding to 30 kg/m2 for adults (obese) by international cut-offs	2014
Semaglutide (Wegovy®) GLP-1 Receptor Agonist Weekly subcutaneous injection	80% lost at least 5% reduction of body weight	GLP-1 receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: •to reduce the risk of major adverse cardiovascular events in adults with established cardiovascular disease and either obesity or overweight • to reduce excess body weight and maintain weight reduction long term in: 1) Adults and pediatric patients aged 12 years and older with obesity; 2) Adults with overweight in the presence of at least one weight-related comorbid condition	2021
Semaglutide (Wegovy®) GLP-1 Receptor Agonist Once-daily oral administration	76% lost at least 5% reduction of body weight	GLP-1 receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: • chronic weight management in adults with obesity (BMI ≥ 30) or overweight (BMI ≥ 27) with weight-related conditions; • reduced calorie diet/exercise to lower cardiovascular risk in adults with established heart disease and to treat MASH	2025
Tirzepatide (Zepbound®) Combined GLP-1/GIP Receptor Agonist	85% lost at least 5% reduction of body weight	GIP receptor and GLP-1 receptor agonist indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in indicated in combination with a reduced-calorie diet and increased physical activity:	2023

Weekly subcutaneous injection		• to reduce excess body weight and maintain weight reduction long term in adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition. • to treat moderate to severe obstructive sleep apnea (OSA) in adults with obesity.	

Appendix B
Potential Strategies to Guide Market Action: Institute for Clinical and Economic Review (ICER) Report

1) Temporary Coverage Denial: Some purchasers and insurers have concluded that they do not have the budget flexibility to provide coverage for GLP-1s for treatment of obesity at current prices. Some purchasers believe that, within a year or two, providers will be more efficient and effective, more will be known about how to maintain long-term use of all AOMs, and competition may bring lower pricing.
    a. Advantages: For purchasers with high employee turnover and limited resources, this perspective can provide a compelling argument for holding off on providing coverage until the landscape changes. Additionally, individuals may be able and willing to bear the cost of GLP-1 drugs outside of insurance, although much of that access was made possible through far less expensive, and less reliable, compounded versions.
    b. Limitations: Clinical trials have demonstrated relatively rapid reductions in cardiac events among patients with existing cardiac conditions after treatment initiation and, therefore, temporary non-coverage may be untenable for those with serious medical conditions. Additionally, the broader societal goal of reducing disparities in access to effective treatments for obesity across socioeconomic and racial categories may make temporary non-coverage insupportable. Furthermore, there is an equity concern about requiring people with one medical condition to bear the financial burden alone when most costs of other conditions are covered by insurance.
2) Enhanced Prior Authorization and Formulary Management: For those seeking a more affordable and long-term way to provide coverage for expensive drugs, such as GLP-1s, purchasers and insurers may apply enhanced utilization and could include coverage criteria. Some coverage criteria included BMI and clinical comorbidities, additional clinical or genetic factors, and/or duration of coverage. Two additional formulary management options were suggested: covering only a single GLP-1 drug; or step therapy through earlier AOMs.
    a. Advantages: Using more restrictive BMI and comorbidity thresholds for coverage can be seen as a principled, evidence-based approach to targeting coverage to those individuals at highest risk for short-term adverse events and who therefore stand to benefit most from treatment.
    b. Limitations: Coverage criteria narrower than the FDA label language can be criticized by clinicians and patients as being inappropriately restrictive. For example, BMI, the main patient characteristic being used for limiting coverage eligibility, is an imperfect measure of obesity-related health risks. Additionally, data from clinical trials suggest that patients stopping GLP-1 treatment often regain much or all the weight lost. Furthermore, some patients who merit treatment will face delays or other barriers to effective care.
3) Network Management: Managing the network of clinical providers may improve results while controlling costs. Some options include - open prescribing with attendant tighter utilization management could allow all primary care providers to prescribe GLP-1 drugs as part of their practice, limiting prescribing by a curated expert network with lighter or no utilization management, or carve-out clinical care and prescribing to external weight loss management firms.
    a. Advantages: Open prescribing maximizes access to the most effective obesity treatment, thereby reducing disparities in access across socioeconomic, racial, and other categories. In addition, integrating GLP-1 prescribing into primary care helps keep medication use coordinated across other clinical conditions, such as diabetes and

hypertension. Limited prescribing has the opposite advantages of an open prescribing model. Setting up a "Centers of Excellence" approach to obesity medication prescribing maximizes the likelihood of appropriate comprehensive care for patients with obesity, including the use of GLP-1 drugs.

b. Limitations: The drawbacks of open prescribing begin with the likelihood that a certain proportion of GLP-1 drugs will be prescribed for patients who could do well with other, less expensive AOMs. Combining open prescribing with tight utilization management criteria is one way to try to provide wide access without producing high rates of inappropriate use. Negatives to limited prescribing are that there are nowhere near enough obesity specialists to manage the number of people seeking GLP-1 treatment and long waiting lists would result.

4) Innovative Payment Arrangements: While some purchasers may consider temporary non-coverage of GLP-1 drugs, another solution may be to utilize alternative payment arrangements to help individuals afford treatment. For instance, performance agreements by linking rebates to a weight goal, to a particular percentage weight loss target, or to adherence to treatment are an option. Other options include volume-based rebates and subscription models.
   a. Advantages: Performance agreements sometimes include aligned patient incentives to maintain adherence or to achieve clinical goals. Additionally, subscription models guarantee financial certainty for purchasers but also guarantee recurring revenue for manufacturers.
   b. Limitations: There are many reasons that patients might not reach their goal, whether from lack of drug availability, ineffectiveness of the drug, side effects, or financial barriers. Furthermore, some performance agreements have little study on their efficacy.
5) Carve Out Programs: Many purchasers or payers are delegating obesity management to a comprehensive program offered by a PBM or to an independent obesity management company. The common features of these programs are a national network of clinical experts who engage with patients virtually, clinical algorithms that help identify patients for whom less expensive treatment options are appropriate, an integration of interventions on diet and activity as part of lifestyle management, and a per member per month payment model, often with guarantees on adherence to medication use and overall cost reductions.
   a. Advantages: Carve-out companies can bring not only clinical expertise but a more comprehensive approach to ensuring that all patients receive individualized care, including appropriate lifestyle management interventions
   b. Limitations: One challenge is the distribution of rebate dollars - rebates from GLP-1 manufacturers in many cases go directly to the carve-out program and not to the purchaser. Additionally, carving out obesity care runs the risk of creating a lack of coordination with the care for other conditions. Lastly, obesity carve-out companies have been using compounded versions of GLP-1 drugs as another way to achieve lower overall costs of care.

Council on Medical Service Report 7-A-26
Private Insurance Coverage of Anti-Obesity Medications
Policy Appendix

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801

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:
    a. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
    b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
    c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
    d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
    e. Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change.
    f. 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.
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.

(Res. 224, A-23; Appended: Res. 230, A-25)

Obesity as a Major Public Health Problem H-150.953

1. Our American Medical Association will urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.
2. Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs.
3. Our AMA will urge federal support of research to determine:
    a. the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
    b. the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
    c. effective interventions to prevent obesity in children and adults; and
    d. the effectiveness of weight loss counseling by physicians.
4. Our AMA will encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight.
5. Our AMA will urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity.

6. Our AMA will urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain.
7. Our AMA will encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients.
8. Our AMA will urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
9. Our AMA will urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

(CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19; Appended: Res. 806, I-23)

Prescription Medication Price Negotiation H-110.959

1. Our AMA supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services.

(CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

Cost of Prescription Drugs H-110.997

1. Our American Medical Association supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied:
    a. physicians must have significant input into the development and maintenance of such programs;
    b. such programs must encourage optimum prescribing practices and quality of care;
    c. all patients must have access to all prescription drugs necessary to treat their illnesses;
    d. physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and
    e. such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs.
2. Our AMA reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices.
3. Our AMA encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products.
4. Our AMA encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies.
5. Our AMA will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies.

6. Our AMA encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic).
7. Our AMA encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

(BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed: CMS Rep. 04, I-24)

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

(CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:

- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

(CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24; Reaffirmed: CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

Prescription Drug Prices and Medicare D-330.954

1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

(Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-26

Subject: Nonprofit Status

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

Resolution 221, "Nonprofit Status," was introduced by the New York delegation at the 2025 Interim Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association advocate that the granting and maintenance of health care entities not-for-profit status be reassessed by both the state legislature and the U.S. Congress.

Resolution 221-I-25 was referred largely due to concerns about vague language and the potential for unintended consequences. The Reference Committee report noted that technical questions regarding federal and state tax law should be considered to ensure that the American Medical Association (AMA) does not advocate for an outcome with harmful consequences. This report provides a review of the topic and recommendation to modify current AMA policy.

BACKGROUND

Nonprofit hospitals account for 58 percent of community hospitals in the United States and most of these hospitals are part of a larger health system.[1] Tax-exempt nonprofit hospitals operate as 501(c)(3) organizations, which by definition must be organized and operated exclusively for specific tax-exempt purposes and must have the following characteristics determined by the Internal Revenue Service (IRS): 1) no part of their net earnings is allowed to benefit any private shareholder or individual; 2) no substantial part of their activities can consist of carrying on propaganda or otherwise attempting to influence legislation; and 3) the organization should not participate or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office.[2]

Additional requirements were added following the passage of the Affordable Care Act and are codified in Section 501(r) of the Internal Revenue Code. To retain 501(c)(3) tax-exempt status, nonprofit entities must:

- Establish a financial assistance policy (FAP) that describes who is eligible for charity care, the level of assistance provided, and how patients can apply. The FAP must be easily accessible to patients and translated into the languages commonly spoken in the community served by the hospital or health care organization.
- Cap charges to patients eligible for charity care based on fee-for-service Medicare rates, Medicaid rates, and/or commercial plan rates.
- Conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to address those needs.

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- Make reasonable efforts to determine if a patient is eligible for charity care before engaging in certain debt collection practices, including selling the patient's debt to third parties, reporting the debt to credit agencies, and taking legal action to control a patient's financial assets.[3]

Furthermore, to qualify as a 501(c)(3) tax-exempt organization, a nonprofit hospital must demonstrate that it has provided benefits to a class of people that is broad enough to benefit the community and operate to serve a public rather than a private interest. The IRS requires a tax-exempt hospital to annually file Form 990 Schedule H to provide the public with information on its policies and activities and the community benefits that its facilities provide. Schedule H broadly categorizes community benefit spending as charity care, unreimbursed costs for providing services to patients insured by government programs (Medicare and Medicaid), subsidized health services, community health improvement services and community benefit operations, research, health professions education, and financial and in-kind contributions to community groups.[4]

The IRS does not currently define specific types of services and activities that a hospital must undertake to qualify for a tax exemption. Instead, the IRS provides guidance on the types of activities that can demonstrate community benefits. IRS implementation of the Internal Revenue Code can give tax-exempt hospitals broad latitude to determine the nature and amount of community benefits they provide. Representatives from tax-exempt hospitals have shared that this provides needed flexibility in demonstrating community benefits. For example, a hospital located in a rural community may be the only hospital within hundreds of miles, making its existence the primary benefit to the community.[5] However, that lack of clarity also creates a challenge for the IRS in administering tax law. For example, a hospital could, in theory, maintain a tax exemption by operating an emergency room open to all and accepting patients on Medicare and Medicaid, which are common among hospitals while spending little to no money on charity care or other community benefits. As a result, reporting is inconsistent on many community benefit factors. Several years ago, the Government Accountability Office recommended that the IRS update Form 990 to ensure that the information demonstrating which community benefits a hospital is providing is clear and easily understood by Congress and the public. While the IRS has made minor adjustments to the form, it continues to allow hospitals to describe their community benefits in narrative form. Additionally, according to IRS officials, hospitals with little to no community benefit expenses may warrant an audit; however, the IRS was unable to provide evidence that it conducted reviews specifically related to hospital's community benefits.[6]

Because there is no explicit definition of what constitutes a community benefit, policymakers and others can reach different conclusions on whether a nonprofit hospital meets the requirements to maintain tax-exempt status or fails to do so. According to one 2024 study, 24 percent of nonprofit hospitals received more tax benefits than they spent on community benefits, but noted that the characteristics and location of nonprofit hospitals influenced the provision and composition of community benefits.[7] Some analyses on nonprofit hospital community benefits omit spending on Medicaid shortfall which can significantly impact the total amount of hospital-reported spending on community benefits. The IRS includes Medicaid shortfall as a community benefit on Form 990 Schedule H; therefore, many hospitals continue to report this amount and include it in calculations on community benefit spending. However, the calculation of Medicaid shortfall may not be reported in a standardized manner. Shortfall could be calculated using a hospital's charge master file, which may not accurately represent the actual cost of care.

Conversely, the lack of an explicitly defined list of appropriate community benefit activities can provide flexibility for nonprofit hospitals to report activities and spending based on their individual communities' needs or the focus of the hospital itself. For example, a nonprofit academic medical

center may report higher spending on medical education and research, while a children's hospital may report higher spending on Medicaid shortfall due to serving many patients on Medicaid and/or the Children's Health Insurance Program. Those advocating for more stringent guidelines from the IRS argue that the vague requirements allow for reporting of activities and spending that do not show clear community benefit. However, when interviewed, hospital executives argue that the lack of clarity leads many of their organizations to omit spending because they are not sure it would qualify under the IRS guidelines, which can result in underreporting on community impact. Examples of excluded spending include hiring local contractors, increasing supplier diversity, or building a new office or facility to improve health care access.[8]

The estimated value of tax exemption for nonprofit hospitals is estimated to be $28 billion, split between $14.4 billion from exempted federal taxes and $13.7 billion from exempted state and local taxes. According to KFF, the $28 billion total estimated value of tax exemption exceeded the total estimated charity care costs of $16 billion for nonprofit hospitals.[9] Twenty-eight states mandate some form of reporting on community benefit spending by nonprofit hospitals, although this varies significantly from state to state and the impacts on spending and community health outcomes are mixed. While states with reporting requirements often saw increases in total spending on community benefits from nonprofit hospitals, there was less spending on charity care specifically, as spending was spread across several different categories. Nonprofit hospitals in states with reporting requirements spent 0.95 percent more on total community benefits (including Medicaid shortfall) than nonprofit hospitals in states without reporting requirements.[10]

AMA POLICY

Council on Medical Service Report 1-I-24, Nonprofit Hospital Charity Care Policies, addressed a similar request to the one made in Resolution 221-I-25. CMS Report 1-I-24 generated Policy H-155.954, which states that the AMA advocates: 1) that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing; 2) to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful; 3) for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible; 4) for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities; 5) for the development of transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios; and 6) for governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.

Policy H-215.975 states that the AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.

DISCUSSION

The Council believes that nonprofit hospitals are not interchangeable, as each is part of a community with unique needs. For example, a large nonprofit health system that operates hospitals in multiple states is very different from a critical access hospital in a small rural town. While both are technically 501(c)(3) nonprofit hospitals, it should not be expected that these entities have the same resources to manage additional reporting requirements or other administrative burdens that

may result from increased scrutiny on maintaining tax-exempt status. Furthermore, as they likely serve distinct communities, they may have different interpretations of what constitutes a community benefit tailored to the needs of their respective communities. Some studies the Council reviewed questioned the inclusion of Medicaid shortfall as a category for community benefit spending. However, reimbursement for Medicaid shortfall can have a huge impact on small critical access hospitals, and in some cases may allow the hospital to stay open to provide care to a community that may not have access to another hospital nearby.

The Reference Committee heard mixed, but largely negative testimony on Resolution 221-I-25 and recommended referral of this item due to concerns about vague language and the potential for unintended consequences. Reference Committee testimony on Resolution 221-I-25 cautioned that requiring new federal or state documentation mandates could divert limited resources from patient care to compliance activities, force safety-net institutions to consider reductions in force or service closures, and/or accelerate conversion or acquisition by for-profit or private equity-backed systems, leading to greater market consolidation and diminished local control. The Council agrees with this assessment and, thus, is not recommending a definition of what should be considered a community benefit. In addition to being beyond the scope of the AMA, it is a nuanced issue where more flexibility is likely beneficial, especially for smaller nonprofit hospitals that may have limited resources. Instead, the Council recommends advocating for consistency and transparency when defining these benefits to allow policymakers and the public to assess nonprofit hospital spending on community benefits more clearly.

Physician employment by hospitals and health systems has been rising steadily in recent years. In 2024, 47 percent of physicians were directly employed by a hospital, contracted directly with a hospital, or employed by a hospital-owned practice.[11] Given that physicians employed by hospitals or health systems comprise nearly one-half of the medical community, finding a balanced solution for addressing the level of community benefits provided by nonprofit hospitals is crucial. As the AMA represents all physicians, the Council does not want to unintentionally burden those employed by hospitals or health systems by placing additional mandates on their employers. However, the Council does understand the importance of holding nonprofit hospitals accountable for faithfully maintaining their tax-exempt status.

Accordingly, the Council continues to support the recommendations in CMS Report 1-I-24 and offers amendments to Policy H-155.954, which are intended to clarify and strengthen the AMA's position on this issue. The amendments offered call for increased transparency and consistency in governmental oversight of nonprofit hospitals, so physicians and the public are better aware of efforts undertaken by nonprofit hospitals and health systems to improve the health of their communities and justify their tax-exempt status as 501(c)(3) organizations. In addition, the Council recommends adding a new clause that encourages nonprofit hospitals to share results from their federally-required CHNA, including progress that has been made since the previous assessment and areas in need of improvement. This recommendation aims to achieve transparency and consistency regarding benefits nonprofit hospitals provide their communities. It also provides an opportunity for nonprofit hospitals to work with other individuals and/or organizations in their community on projects where progress can be furthered. AMA policy supports efforts to reduce administrative burdens in health care; therefore, although the Council does not recommend increasing the level of mandated reporting by nonprofit hospitals on community benefit efforts, it does encourage nonprofit hospitals to share accomplishments within their communities, including but not limited to CHNA results.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

1. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

   NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

   1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
   2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
   3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
   4. Our AMA advocates for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities and eligibility for nonprofit status.
   5. Our AMA advocates for the development of ~~a~~ transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
   6. Our AMA advocates for transparency and consistency regarding ~~the expansion of~~ governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.
   7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement. (Modify Current HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 9-A-26
Nonprofit Status
Policy Appendix

Nonprofit Hospital Charity Care Policies, H-155.954

1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a “community benefit” when evaluating community health improvement activities.
5. Our AMA advocates for the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios.
6. Our AMA advocates for the expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.

(CMS Rep. 01, I-24)

Uniform Standards for Not-For-Profit and For-Profit Hospitals, H-215.975

The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.
(Res. 705, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-26)

Introduced by: Private Practice Physicians Section

Subject: The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models

Referred to: Reference Committee G

Whereas, the COVID-19 pandemic revealed the strength of U.S. physicians' professionalism and intrinsic motivation as physicians (and other healthcare professionals) learned rapidly and did what needed to be done—no performance measures or financial incentives from value-based programs (VBPs) were required to prompt their efforts; and

Whereas, VBP models risk undermining these strengths and our greatest resource for improving care[1]; and

Whereas, VBP model metric reporting and demoralizing score boosting tasks coupled with the burden of an average of 7.3 hours in electronic health records per eight hours of scheduled patients have led to a "burnout" epidemic among primary care clinicians[2, 3, 4]; and

Whereas, the work of VBP programs was acknowledged by the Centers for Medicare & Medicaid Services as they relieved physicians of reporting requirements "so the healthcare delivery system can direct its time and resources toward caring for patients"[5]; and

Whereas, in 2024, compliance costs of the Merit-Based Incentive Payment System resulted in penalties for 32 percent of small practices and 46 percent of solo practitioners[6]; and

Whereas, free medical education appears ineffective at encouraging students to pursue primary care as evidenced by 2024 data showing U.S. medical school graduates filled only 35 percent of categorical internal medicine residency positions and non-U.S. citizen international graduates filled 30 percent[7]; and

Whereas, worrisomely, a 2023 Elsevier survey revealed that over half of U.S. medical students envisioned their education as a stepping stone to careers outside direct patient care[8]; and

Whereas, the Pay Primary Care Providers Act, currently before the 119th Congress, seeks to increase primary care physician reimbursement in hopes of bolstering primary care but also seeks to move more physicians and patients into VBP arrangements (capitation); and

Whereas, these measures are not expected to save money and doubling down on VBP models will exacerbate the exodus of physicians from primary care fields[9,10]; and

Whereas, it is evident that relying on physician resilience, dedication, adjustments to VBP programs, streamlining reporting requirements (Data-Driven Performance System proposed by the AMA), team-based care, efforts to increase the number of students pursuing primary care, optimizing technology, forthcoming advances promised by artificial intelligence, and even

1 increasing compensation for primary care physicians are insufficient to address the crisis in the
2 availability of primary care physicians; and
3
4 Whereas, ignoring this crisis will, ultimately, relegate our patients to a lower standard of care, as
5 numerous county and state health commissioners support independent practice by physician
6 assistants and nurse practitioners to alleviate the shortage of primary care physicians; and
7
8 Whereas, the consensus opinion is that the vast majority of VBP models have failed to reduce
9 healthcare expenditures or improve the quality of life meaningfully with considerable evidence
10 that they have resulted in the opposite—increasing costs and declining quality of care[11,12,13,14];
11 and
12
13 Whereas, small independent practices (ten or fewer physicians) have 33 percent fewer
14 preventable hospital admissions and lower per-beneficiary spending than larger practices, thus
15 removing obstacles to their survival is an efficient way to lower costs and improve the quality of
16 care[15,16,17]; therefore be it
17
18 RESOLVED, that our American Medical Association will advocate for the immediate
19 discontinuation of required participation in value-based programs (VBP) arrangements for
20 practices with ten or fewer physicians, regardless of practice revenue. (Directive to Take Action)
21

Fiscal Note: Minimal – less than $5,000

Received:

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RELEVANT AMA POLICY

Value-Based Insurance Design H-185.939

Our American Medical Association supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).

Citation: CMS Rep. 2, A-13; Reaffirmed in lieu of: Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-18; Reaffirmed; CMS Rep. 06, A-19; Reaffirmed: BOT Rep. 14, A-23.

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors

that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.
Citation: Res. 247, A-18; Reaffirmed: BOT Rep. 13, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-26)

Introduced by: Pennsylvania

Subject: Physicians Who Do Not Practice in Hospital Setting

Referred to: Reference Committee G

Whereas, in order to address payment issues associated with unfair insurance panels, our AMA created policy D-230.981 which states:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.; and

Whereas, in response to this AMA policy some insurance payers in Pennsylvania adopted insurance requirements of some other states, to require that their network physicians have hospital privileges; and

Whereas, this imposes an unreasonable burden on physicians who do not work in hospital settings; and

Whereas, when a hospital ceases operations, a physician credentialled only at that hospital may lose their network status jeopardizing access to care for their patients; therefore be it

RESOLVED, that our American Medical Association amend D-230-981 as follows:

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.
3. Our AMA advocate that hospital privileges not be a requirement for insurance network participation.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/26

RELEVANT AMA POLICY

D-230.981 Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation

1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.
2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.

Res. 238, I-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-26)

Introduced by: Obesity Medicine Association

Subject: Parity in Pricing for Anti-Obesity Medications

Referred to: Reference Committee G

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1 Whereas, our American Medical Association recognizes obesity as a disease state with multiple
2 pathophysiological aspects requiring a range of interventions to advance obesity treatment and
3 prevention; and
4
5 Whereas, our AMA has elevated obesity to be one of its public health priorities, advocating for
6 the creation of a multidisciplinary federal task force to better recognize and treat obesity as a
7 chronic disease; and
8
9 Whereas, existing AMA policy (H-150.953) urges all payers to ensure coverage parity for
10 evidence-based treatment of obesity, including FDA-approved medications without exclusions
11 or additional carve-outs; and
12
13 Whereas, in spite of this policy, the majority of private insurers do not cover anti-obesity
14 medication treatments, and patients are accessing these treatments purchasing directly from
15 pharmaceutical manufacturers; and
16
17 Whereas, AMA policy (H-440.801) explicitly supports allowing a patient's established physician
18 to prescribe anti-obesity medication and have it covered by insurance, without requiring that
19 patients receive the prescription only from contracted disease management companies; and
20
21 Whereas, pharmaceutical manufacturers have recently agreed to sell GLP-1 anti-obesity
22 medications to telehealth companies at a reduced cost; and
23
24 Whereas, these discounted pricing structures threaten established doctor-patient relationships
25 by inappropriately incentivizing patients to abandon their regular physicians to pursue care with
26 telehealth companies solely to access lower medication prices; and
27
28 Whereas, obesity medicine practices are increasingly being driven out of business due to
29 patient diversion to closed networks by insurers, as well as patients seeking coverage through
30 med spas or by filling out online forms; and
31
32 Whereas, this diversion contradicts current AMA policy, which explicitly advocates for allowing a
33 patient's established physician to prescribe anti-obesity medication and have it covered by
34 insurance, without the requirement that patients must receive their prescription only from
35 contracted disease management companies; and
36
37 Whereas, offering preferential pricing for customers of online sales models further degrades the
38 ability of patients to receive continuous, comprehensive obesity care from their primary care or
39 established obesity medicine physician; therefore be it

40 RESOLVED, that our American Medical Association actively oppose preferential pricing
41 strategies by pharmaceutical manufacturers that offer discounted medications exclusively to
42 telehealth or online providers, as such practices undermine the established physician-patient
43 relationship and the continuity of care. (Directive to Take Action)
44

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/13/26

REFERENCES

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RELEVANT AMA POLICY

Advocacy Against Obesity-Related Bias by Insurance Providers (H-440.801):
This policy supports allowing a patient's established physician to prescribe anti-obesity medications and have them covered by insurance, without requiring that patients receive the prescription exclusively from contracted disease management companies. (Res. 224, A-23; Appended: Res. 230, A-25)

Obesity as a Major Public Health Problem (H-150.953):
This policy urges all payers to ensure coverage parity for the evidence-based treatment of obesity, which includes FDA-approved medications without exclusions or additional carve-outs. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19; Appended: Res. 806, I-23)

Recognition of Obesity as a Disease (H-440.842):
This policy formally establishes that the AMA recognizes obesity as a disease state with multiple pathophysiological aspects that require a range of interventions to advance treatment and prevention. (BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22)

Recognizing and Taking Action in Response to the Obesity Crisis (D-440.980):
This directive elevates obesity to one of the AMA's primary public health priorities and advocates for a multidisciplinary federal task force to better recognize and treat obesity as a chronic disease. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17; Modified - BOT Action in response to referred for decision: Res. 403, A-21; Appended: Res. 427, A-25)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-26)

Introduced by: Mississippi

Subject: Advocating Against Automatic Refill Requests

Referred to: Reference Committee G

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1 Whereas, multiple studies show the tremendous financial and human resource burden imposed
2 upon physician practices by health insurance companies; and
3
4 Whereas, while filling medications is foundational to Prescription Drug Adherence (PDA), it does
5 not guarantee that a patient will take the medication as prescribed; and
6
7 Whereas, patients must have regular visits with physicians (as well as laboratory studies) in
8 order to safely continue medication orders; and
9
10 Whereas, non-patient-initiated refill requests are burdensome to the physician and often
11 unnecessary; and
12
13 Whereas, non-patient-initiated refill requests could cause physicians to errantly approve a
14 medication without an appropriate history, exam, and pertinent laboratory studies; therefore be it
15
16 RESOLVED, that our American Medical Association communicate effectively with large
17 pharmacy chains and conglomerates for the purpose of explaining the unnecessary
18 administrative burden of automatic, non-patient-initiated refill requests and petitioning them to
19 require all medication refill requests use a patient directed "opt-in" approach (Directive to Take
20 Action); and be it further
21
22 RESOLVED, that our AMA petition the Centers for Medicare and Medicaid Services to restrict
23 participating pharmacies from sending medication refill requests to physicians unless the patient
24 "opts-in" to using the refill request. (Directive to Take Action)
25

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

Received: 4/13/26

RELEVANT AMA POLICY

D-120.984 Streamlining the Process for Prescription Refills
Our American Medical Association will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety. [Sub Res. 522, A-03 Reaffirmed: BOT Rep. 8, A-11 Reaffirmed: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-26)

Introduced by: American Academy of Family Physicians

Subject: Recognizing Physicians as Sexual Assault Forensic Examiners

Referred to: Reference Committee G

Whereas, there is a national shortage in Sexual Assault Forensic Examiners, resulting in delays in care for sexual assault survivors[1]; and

Whereas, rural areas and tribal communities have the largest gap in sexual assault examiner coverage[2,3]; and

Whereas, he standard of care as listed in the Department of Justice's "A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents" Third Edition (2024) states: "Clinicians, in the context of the medical forensic examination, may be registered nurses, advanced practice nurses, physician assistants or physicians, depending on factors such as local protocols, support for specialized clinical programs, and available education."[4]; and

Whereas, the American College of Emergency Physicians' 2022 Model of the Clinical Practice of Emergency Medicine includes "Sexual assault examination" within the section Procedures And Skills Integral To The Practice Of Emergency Medicine[5]; and

Whereas, physicians, including family medicine physicians, emergency medicine physicians, and pediatricians are part of the workforce that comprises Sexual Assault Medical Forensic Examiners; therefore be it

RESOLVED, that our American Medical Association Policy H-80.999 "Sexual Assault Survivors" be amended from "Our AMA will advocate for increased patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations." to "Our AMA will advocate for increased patient access to Sexual Assault Forensic Examiners in the emergency department for medical forensic examinations," (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA Policy H-80.999 be amended from "Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers." to "Our AMA supports the implementation of a national database of Sexual Assault Medical Forensic Examiners." (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

REFERENCES

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4. A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents Third Edition U.S. Department of Justice Office on Violence Against Women, September 2024, https://www.justice.gov/ovw/media/1367191/dl?inline
5. Beeson MS, Bhat R, Broder JS, et al. The 2022 Model of the Clinical Practice of Emergency Medicine. J Emerg Med. 2023;64(6):659-695. doi:10.1016/j.jemermed.2023.02.016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-26)

Introduced by: New York

Subject: Discharge Summaries from Skilled Nursing Facilities

Referred to: Reference Committee G

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1 Whereas, when patients transition between different settings, i.e. community to hospital,
2 hospital to skilled nursing facility (SNF), and SNF to community, the quality of care and patient
3 safety can be compromised due to high rates of medication errors, incomplete/inaccurate
4 information transfer, and lack of follow-up care (1,2,3,4,5,6), and
5
6 Whereas, published recommendations for optimization of transitions of care including a 2016
7 best practice consensus from SGIM-AMDA-AGS (7) includes a recommendation that SNFs
8 transmit a formal discharge summary to the patient's outpatient PCP within 72 hours of patient
9 discharge from SNF; and
10
11 Whereas, the Centers for Medicare and Medicaid Services (CMS) has issued a policy regulation
12 (8) in 2017 requiring SNFs to create a discharge summary that includes but is not limited to a
13 recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of
14 illness/treatment or therapy, medications/ Medication Reconciliation and pertinent lab, radiology,
15 and consultation results, to improve follow-up care; therefore be it
16
17 RESOLVED, that our American Medical Association educate their members as to Centers for
18 Medicare and Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF)
19 responsibility to create and timely deliver a comprehensive patient discharge summary to a
20 patient's outpatient primary care physician (PCP). (Directive to Take Action)
21

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-26)

Introduced by: New York

Subject: Malpractice Insurance for Employed Physicians

Referred to: Reference Committee G

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1 Whereas, an increasing percentage of physicians are employed by a variety of corporate
2 structures; and
3
4 Whereas, employers often select “claims-made” malpractice insurance policies to reduce
5 expenses; and
6
7 Whereas, the gold standard for malpractice coverage is an “occurrence” policy, which provide
8 coverage for any incident that occurs during the policy period, regardless of when the claim is
9 filed; and
10
11 Whereas, a claims-made policy requires the purchase of a costly “tail” policy after leaving
12 employment to maintain coverage for prior acts, and the cost of this tail coverage may be
13 prohibitive; therefore be it
14
15 RESOLVED, that our American Medical Association support a requirement for employers to
16 purchase only occurrence malpractice insurance policies for their employed physicians, fellows
17 and residents. (New HOD Policy)
18

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-26)

Introduced by: New York

Subject: Oppose Imposition of Fees on Physicians for Electronic Payment Transfers

Referred to: Reference Committee G

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1 Whereas, AMA Advocacy has on multiple occasions asked for halfway measures, and instead
2 of asking to ban VCC (virtual credit cards) on ERA transactions, it has asked for “further study at
3 an NCVHS meeting”; and
4
5 Whereas, AMA advocacy, well aware that CMS “Guidance” does not carry the weight of law as
6 has been pointed out to it on numerous occasions at the AMA PPPS meeting and AMA
7 meetings, has asked CMS recently for more of the same, well aware that another Guidance will
8 provide zero benefit to physicians; and
9
10 Whereas, “Guidance” issued by federal agencies does not carry the weight of law and is “non-
11 enforceable, which is well-known to any attorney vaguely familiar with the Administrative Law
12 (and it states so on the bottom of every Guidance issued by CMS), however despite that being
13 pointed out the AMA Advocacy, the AMA persists in asking CMS to do what is illegal: enforce a
14 non-enforceable “Guidance” in June 10, 2025 letter to CMS, instead of asking CMS for what is
15 really needed, a legally sound regulation issued in an APA (Administrative procedure act
16 compliant manner with 60 day notice and comment period; and
17
18 Whereas, AMA Advocacy adopted the talking points of Visa, MasterCard, Zelis, and UHC that
19 “virtual credit cards” are legal, whereas there is no legal basis for such assertion, as they have
20 never been adopted or proposed to be adopted under an APA-compliant process; therefore be it
21
22 RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid
23 Services (CMS) to issue a legally-binding rules compliant with the Administrative Procedure Act
24 with a notice and comment period preventing the use of virtual credit cards or imposition of
25 electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and
26 Accountability Act (HIPAA) standard electronic transactions. (Directive to Take Action)

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

Received: 4/14/26

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2. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfh.zip/2025-7-10-Letter-to-Kennedy-re-HHS-RFI-on-Deregulation-v3.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-26)

Introduced by: New York

Subject: Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine

Referred to: Reference Committee G

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1 Whereas, health plans require preauthorization for certain tests, procedures, consultations,
2 treatments, and medications, and such determinations may affect patient diagnosis, treatment,
3 and outcomes; and
4
5 Whereas, physicians requesting preauthorization are required to identify themselves to
6 insurance utilization review entities, including providing their National Provider Identifier (NPI);
7 and
8
9 Whereas, under the Health Insurance Portability and Accountability Act (HIPAA), physicians
10 must verify the identity and authority of individuals requesting access to a patient's protected
11 health information when those individuals are not already known to them; and
12
13 Whereas, utilization review and peer-to-peer review processes may involve physicians making
14 determinations that directly affect patient care, yet in some instances such reviewers do not
15 disclose their identity to the requesting physician; therefore be it
16
17 RESOLVED, that our American Medical Association seek legislation and/or regulation regarding
18 insurance company utilization reviewers to require the person charged with authorization
19 decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to
20 maintain transparency, fulfill the requirements of the Health Insurance Portability and Privacy
21 Act (HIPAA), and allow for accountability should the decision be called into question (Directive
22 to Take Action); and be it further
23
24 RESOLVED, that our American Medical Association seek legislation and/or regulation regarding
25 utilization review so that the reviewing physician be licensed in New York State and therefore,
26 accountable to New York State authorities for the consequences of these clinically important
27 decisions (Directive to Take Action); and be it further
28
29 RESOLVED, that our American Medical Association amend their Policy H-285-939, subsection
30 (2) to amended to read as follows:
31
32 That medical directors of insurance entities be held accountable and liable for medical decisions
33 regarding contractually covered medical services <u>including prior authorizations</u>.
34
35 (2) that medical directors of insurance entities be held accountable and liable for medical
36 decisions regarding contractually covered medical services; and (3) that our AMA continue to
37 undertake federal and state legislative and regulatory measures necessary to bring about this
38 accountability.
39 (Modify Current HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-26)

Introduced by: American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons, Obesity Medical Association, American Academy of Sleep Medicine, American Association of Clinical Endocrinology, Medical Student Section

Subject: Parity in Access to Evidence-Based Obesity Treatment

Referred to: Reference Committee G

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1 Whereas, the American Medical Association recognized obesity as a disease state with multiple
2 pathophysiological aspects in 2013 (H-440.842) and elevated obesity as a top-tier public health
3 priority in 2025 (D-440.980); and
4
5 Whereas, the prevalence of obesity among adults in the United States has risen from 30.5% in
6 1999–2000[1] to 41.9% in 2017–2020[2], and current estimates exceed 42%, with severe obesity
7 (BMI ≥40) affecting approximately 9.7% of the adult population[3]; and
8
9 Whereas, the prevalence of obesity among children and adolescents in the United States is
10 approximately 19.7%[4], having tripled since 1980, and affected youth face increased lifetime risk
11 of type 2 diabetes, cardiovascular disease, and psychosocial harm, yet pediatric obesity
12 treatment faces many of the same coverage barriers as adult treatment; and
13
14 Whereas, obesity is a root cause of more than 200 comorbid conditions[5] including type 2
15 diabetes, cardiovascular disease, certain cancers, obstructive sleep apnea, and nonalcoholic
16 fatty liver disease, and is estimated to contribute to approximately 300,000 excess and
17 premature deaths annually in the United States[6]; and
18
19 Whereas, the annual economic cost of obesity in the United States is estimated to exceed $260
20 billion in direct medical costs and lost productivity[7], representing a significant burden on the
21 healthcare system, employers, and patients; and
22
23 Whereas, despite the AMA's recognition of obesity as a chronic disease more than a decade
24 ago, a systematic and pervasive failure of payers to provide equitable coverage for evidence-
25 based obesity treatments persists[8], creating a treatment access crisis unlike that faced by
26 patients with any other AMA-recognized chronic disease; and
27
28 Whereas, Medicare Part D has historically excluded coverage of anti-obesity medications under
29 Section 1927(d)(2) of the Social Security Act, and while a proposed CMS reinterpretation and a
30 CMMI pilot program announced in 2025 represent incremental progress[9], no statutory fix has
31 been enacted and millions of Medicare beneficiaries remain without reliable access to FDA-
32 approved anti-obesity medications; and
33
34 Whereas, only approximately 25 states have implemented some form of taxpayer-funded
35 coverage for anti-obesity medications[10], and coverage in the ACA individual and small-group
36 marketplace remains virtually nonexistent, with fewer than 1% of plans covering GLP-1 receptor
37 agonists for weight management as of 2024[11]; and

1 Whereas, utilization of anti-obesity medications among eligible individuals is estimated at only
2 0.5% overall and 0.27% among individuals from historically underserved populations[8],
3 demonstrating a significant access gap that disproportionately affects communities of color,
4 rural populations, and those with lower socioeconomic status; and
5
6 Whereas, bariatric and metabolic surgery remains severely underutilized, with fewer than 1% of
7 eligible patients receiving surgery[12], due in part to burdensome prior authorization requirements
8 and exclusionary insurance plan design; and
9
10 Whereas, a 2024 AMA survey found that 93% of physicians reported that prior authorization
11 delays patients' access to necessary care[13], with practices completing an average of 39 prior
12 authorization requests per physician per week, imposing a particularly acute burden in the
13 treatment of obesity; and
14
15 Whereas, some insurers terminate coverage of obesity treatments when a patient's BMI
16 improves below a threshold, which is clinically analogous to discontinuing insulin when
17 hemoglobin A1c normalizes and fundamentally contradicts the AMA's recognition of obesity as
18 a chronic disease requiring ongoing management[14]; and
19
20 Whereas, no other chronic disease recognized by the AMA, including hypertension, type 2
21 diabetes, or hyperlipidemia, is subject to comparable systematic exclusion from insurance
22 coverage or to the requirement that patients demonstrate failure of lifestyle modification before
23 receiving pharmacologic or procedural treatment[15]; and
24
25 Whereas, the continued rise in obesity prevalence since 2013, combined with persistently low
26 utilization of evidence-based treatments across all modalities, indicates that existing policy has
27 not yet achieved the systemic changes necessary to close the gap between the AMA's
28 recognition of obesity as a chronic disease and equitable patient access to treatment; therefore
29 be it
30
31 RESOLVED, that our American Medical Association promote policies and recommend to all
32 public and private health insurance plans to provide coverage parity for evidence-based obesity
33 treatments, including chronic weight management medications, bariatric and metabolic surgery,
34 intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to
35 coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular
36 disease, without exclusionary carve-outs, annual or lifetime caps specific to obesity, or "fail
37 first"/step therapy requirements not applied to comparable chronic conditions (New HOD
38 Policy); and be it further
39
40 RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare
41 Part D statutory exclusion of anti-obesity medications (Section 1927(d)(2) of the Social Security
42 Act), and further advocate that all state Medicaid programs be required to include FDA-
43 approved anti-obesity medications on their formularies as a condition of federal matching funds
44 (Directive to Take Action); and be it further
45
46 RESOLVED, that our AMA oppose as discriminatory any insurance practice that terminates,
47 reduces, or restricts coverage for evidence-based obesity treatment on insurer-defined weight
48 loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned
49 with individualized, evidence-based clinical decision-making as well as advocate for federal and
50 state regulation prohibiting such practices (New HOD Policy); and be it further

1 RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any
2 mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery
3 coverage, and advocate for the elimination of such requirements at the federal and state level.
4 (New HOD Policy)
5

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

Received: 4/15/26

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RELEVANT AMA POLICY

H-440.842 Recognition of Obesity as a Disease H-440.842

Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
Res. 420, A-13, Reaffirmed: CSAPH Rep. 08, A-23

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis

1. Our American Medical Association will advocate for the creation of a multidisciplinary federal task force, including representation from the medical profession, to review the public health impact of obesity and recommend measures to:
    a. Better recognize and treat obesity as a chronic disease.
    b. Confront the epidemic of obesity and its root causes, particularly among populations with disproportionally high incidence.

2. Our AMA will actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month".
3. Our AMA will strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention.
4. Our AMA will promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula.
5. Our AMA will make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
6. Our AMA elevates obesity to be one of its public health priorities.

Res. 405, A-03; Reaffirmation, A-04; Reaffirmation, A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17; Modified – BOT, Action in response to referred for decision: Res. 403, A-21; Appended: Res. 427, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-26)

Introduced by: Ohio

Subject: Oppose Denials Based on Origin of Referral

Referred to: Reference Committee G

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1 Whereas, patients may see another clinician in a primary care group for an acute problem or
2 visit; and
3
4 Whereas, referrals may be made by multiple members of a care team; and
5
6 Whereas, denials for surgery are happening when the referring clinician does not match the
7 primary care clinician listed with the insurer; and
8
9 Whereas, the medical necessity or timeliness is irrelevant to the approval; and
10
11 Whereas, denials delay care and harm patients; therefore be it
12
13 RESOLVED, that our American Medical Association advocate against prior authorization
14 denials based solely upon the referring physician or appropriately licensed clinician.
15 (Directive to Take Action)
16

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-26)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, Society for Investigative Dermatology

Subject: Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions

Referred to: Reference Committee G

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1 Whereas, employed physicians now often find themselves under substantial pressure to meet
2 benchmarks and productivity targets established by hospitals, health systems, and other
3 physician employers; and
4
5 Whereas, relentless focus on productivity metrics has been associated with physician burnout,
6 emotional exhaustion, moral distress, and workforce attrition, all of which may threaten patient
7 access to timely, high-quality care; and
8
9 Whereas, many commonly used productivity systems and metrics emphasize quantifiable
10 outputs while underrecognizing the substantial administrative, educational, and operational
11 work, as well as other essential responsibilities, that physicians are expected to perform for
12 hospitals, health systems, and other employers that rely on and benefit from these contributions;
13 and
14
15 Whereas, such work may include in-basket management, care coordination, quality reporting,
16 teaching, research, administrative leadership, supervision, and other activities that are essential
17 to patient care delivery but may not be fully reflected in physician productivity benchmarks,
18 creating tension between institutional productivity expectations and physicians' broader
19 professional obligations as employed clinicians; and
20
21 Whereas, increasing pressure to meet productivity benchmarks has occurred at the same time
22 as expanding clinical and administrative demands, often without corresponding physician time,
23 support, or recognition; and
24
25 Whereas, physician workforce sustainability and patient access are better supported when
26 physician expectations and performance assessments more accurately reflect the full scope of
27 work required in modern medical practice; therefore be it
28
29 RESOLVED, that our American Medical Association advocate that health systems, hospitals,
30 other physician employers, and third-party payors recognize that the profession of medicine is
31 not a commoditized entity, is fundamentally anchored in the patient-physician relationship, and
32 should not be reduced solely to productivity measures (Directive to Take Action); and be it
33 further
34
35 RESOLVED that our AMA encourage employers of physicians to utilize productivity
36 benchmarks, performance expectations, and compensation structures that recognize and
37 integrate the full scope of physician work, including clinical, administrative, educational, and

1 operational responsibilities that may not be fully captured by traditional productivity metrics
2 (New HOD Policy); and be it further
3
4 RESOLVED, that our AMA advocate for regulatory, employer, and practice models that provide
5 both employed and independent physicians with appropriate time, resources, compensation,
6 support, and recognition for non-billable work that is essential to patient care, physician well-
7 being, and health system function. (Directive to Take Action)
8

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

RELEVANT AMA POLICY

D-400.982 AMA Efforts on Medicare Payment Reform
1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.
[BOT Rep. 12, A-24 Reaffirmed: Res. 220, I-24]

D-385.945 Advocacy and Action for a Sustainable Medical Care System
1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.
[Res. 214, A-23 Reaffirmed in lieu of: Res. 225, A-25]

D-400.981 Increasing Transparency of AMA Medicare Payment Reform Strategy
1. Our American Medical Association will provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.
2. Our AMA will share with its members comprehensive reports on
our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.
[Res. 233, A-25]

D-310.968 Physician and Medical Student Burnout
1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow,

and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
1. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
2. develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
3. Our AMA supports physicians who are caregivers to alleviate physician burnout.
[CME Rep. 8, A-07 Modified: Res. 919, I-11 Modified: BOT Rep. 15, A-19 Reaffirmation: A-22 Reaffirmed: Res. 802, I-24 Appended: Res. 305, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-26)

Introduced by: North American Neuromodulation Society

Subject: Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies

Referred to: Reference Committee G

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1 Whereas, chronic pain affects approximately 20% of adults in the United States and represents
2 a leading cause of disability and healthcare utilization[1]; and
3
4 Whereas, neuromodulation therapies, including peripheral nerve stimulation, spinal cord
5 stimulation, and other device-based interventions, are evidence-based, minimally invasive, non-
6 opioid treatment options for chronic nociceptive and neuropathic pain[2,3]; and
7
8 Whereas, timely initiation of neuromodulation therapies is critical to achieving optimal clinical
9 outcomes, particularly for therapies designed to modulate neural circuits early in the disease
10 course[4]; and
11
12 Whereas, prior authorization requirements imposed by insurance providers frequently result in
13 delays in access to medically necessary, evidence-based pain treatments[5]; and
14
15 Whereas, a prospective multicenter observational cohort study of patients undergoing
16 temporary peripheral nerve stimulation demonstrated that insurance authorization delays were
17 independently associated with reduced odds of achieving clinically meaningful pain relief at both
18 60 days and 12 months[6]; and
19
20 Whereas, increasing delays in authorization were associated with progressively lower treatment
21 response rates, even after adjustment for demographic and clinical variables[6]; and
22
23 Whereas, administrative delays in care are associated with worsened patient outcomes,
24 prolonged disability, and increased reliance on less effective or higher-risk treatments, including
25 opioids[7]; and
26
27 Whereas, variability in payer coverage policies, including recent updates by Aetna to provide
28 national coverage for select neuromodulation therapies, highlights an inconsistent and evolving
29 reimbursement landscape across insurers[8,9]; and
30
31 Whereas, inconsistent prior authorization requirements across payers contribute to inequities in
32 access to evidence-based, non-opioid pain treatments; therefore be it
33
34 RESOLVED, that our American Medical Association advocate for the reduction of prior
35 authorization requirements for evidence-based neuromodulation therapies and other non-opioid
36 pain treatments when clinically indicated (Directive to Take Action); and be it further
37
38 RESOLVED, that our AMA advocate for standardized, transparent, and expedited prior
39 authorization processes across payers, including response timelines that do not exceed 72

1 hours for non-urgent requests and 24 hours for urgent requests (Directive to Take Action); and
2 be it further
3
4 RESOLVED, that our AMA work with public and private insurers to ensure that coverage
5 policies for neuromodulation therapies and other non-opioid pain treatments are evidence-
6 based, consistent across payers, and minimize administrative barriers to care (Directive to Take
7 Action); and be it further
8
9 RESOLVED, that our AMA support policies and legislation aimed at reducing administrative
10 delays that negatively impact patient outcomes and access to non-opioid pain care (New HOD
11 Policy); and be it further
12
13 RESOLVED, that our AMA encourage further research on the impact of insurance-related
14 delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation
15 and pain management therapies (New HOD Policy); and be it further
16
17 RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to
18 neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of
19 insurance type or socioeconomic status. (Directive to Take Action)
20

Fiscal Note: Moderate – between $10,000 - $50,000

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RELEVANT AMA POLICY

D-320.970 Advocating Against Prior Authorization for In-Person Visits with Physicians
Our AMA advocates against health insurance plan policies that require prior authorization for in-person visits with a physician. [Res. 708, A-25]

H-320.939 Prior Authorization and Utilization Management Reform
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. 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. 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. 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]

H-120.988 Patient Access to Treatments Prescribed by Their Physicians
Our American Medical Association confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use). Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. [Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified: CSA Rep. 3, A-97; Reaffirmed and Modified: Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: CSAPH Rep. 02, A-23; Reaffirmed: CSAPH Rep. 02, A-24]

H-120.922 Improved Access and Coverage to Non-Opioid Modalities to Address Pain
Our American Medical Association will advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient’s physician. Our AMA will advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and Our AMA will encourage the manufacturers of pharmaceutical pain care options to seek United States Food and Drug Administration approval for additional indications related to non-opioid pain management therapy. [Res. 218, A-19; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: Res. 830, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-26)

Introduced by: American Academy of Emergency Medicine

Subject: Physician Case Log Portability

Referred to: Reference Committee G

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1 Whereas, physician case logs documenting clinical encounters and procedures are routinely
2 required for medical licensure, hospital credentialing, and the obtainment and renewal of
3 hospital clinical privileges; and
4
5 Whereas, hospitals, billing companies, management groups, and health systems typically
6 maintain exclusive custody and control of physician case logs through proprietary medical
7 record systems; and
8
9 Whereas, advances in health information technology permit rapid, secure, and reliable
10 deidentification of patient information in compliances with federal privacy standards; and
11
12 Whereas, delay or refusal to release physician case logs can delay or prevent a physician from
13 obtaining licensure and employment; and
14
15 Whereas, such delays disproportionately affect physicians leaving unsafe and unethical work
16 environments which further impairs physician well-being; and
17
18 Whereas, delays in credentialing and privileging result in measurable economic harm to
19 physicians; and
20
21 Whereas, there is currently no uniform, enforceable national standard governing timelines,
22 format, and remedies for the release of physician case logs; therefore be it
23
24 RESOLVED, that our American Medical Association advocates for federal and state policies
25 requiring physician employers, regardless of type of employment, to provide physicians, free of
26 charge, with complete and accurate copies of their case logs in a deidentified, electronically
27 transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be
28 it further
29
30 RESOLVED, that such polices establish a mandatory and enforceable timeline for production of
31 case logs, not to exceed five (5) business days (Directive to Take Action); and be it further
32
33 RESOLVED, that procedures are in place for the immediate transfer of case logs to all
34 physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)
35

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

Received: 4/20/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA

Referred to: Reference Committee G

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1 Whereas, the AMA General Counsel acknowledged that the AMA members are free to advocate
2 for any issue as they wish, and the House of Delegates is free to pass policy that serves the
3 physician interests; and
4
5 Whereas, virtual credit cards are a perennial problem to physician practices, causing significant
6 administrative burnout and imposing high costs, collectively greater than $10 billion per year;
7 and
8
9 Whereas, virtual credit cards have not been adopted as a legal payment method for health
10 plans to make electronic payments to physicians under HIPAA and their status is at best legally
11 contested; and
12
13 Whereas, the Centers for Medicare and Medicaid Services (CMS), under lobbying from the
14 virtual credit card industry including Mastercard and Zelis, decided to take a contested position
15 advocated by Mastercard and UnitedHealthcare Vpay that virtual credit cards are a legal way for
16 paying physicians by health plans, however CMS has never promulgated a proposed rule under
17 the Administrative Procedure Act to promulgate such policy as required by law; and
18
19 Whereas, CMS, incredulously and contrary to the law and under lobbying from Zelis, United
20 Healthcare Optum Vpay, Echohealth, and Mastercard took the position that even as the law
21 states that physicians are entitled to get healthcare payments via the adopted standard no-cost
22 ACH EFT, CMS decided that health plans are free to send the first payment through non-
23 standard electronic payment formats; and
24
25 Whereas, health plans allegedly coordinate with virtual credit card industry vendors to require
26 fees from physicians for getting paid by ACH EFT, a federally recognized low-cost payment
27 method, but CMS accepted vendor arguments that vendors can impose administrative costs on
28 physicians by forcing physicians to fill out the same form 700 times to enroll in the same
29 electronic transaction for every plan that is administered by virtual credit card companies or pay
30 2.5 percent of revenue while HIPAA mandates lowering administrative costs; and
31
32 Whereas, for any legally unsettled and contested issue, the American Medical Association is
33 legally free to take a position that is most favorable to its members and the legality of virtual
34 credit cards is such an issue; therefore be it
35
36 RESOLVED, that our American Medical Association will advocate that a vendor or
37 clearinghouse that offers a multi-payer platform may not create separate payer-specific
38 enrollment mechanisms into standard adopted HIPAA transactions (Directive to Take Action);
39 and be it further

1 RESOLVED, that our AMA will advocate that a health plan may not use a vendor for electronic
2 transactions that unnecessarily create duplicate administrative work for physician practices by
3 creating a separate mechanism of enrollment in the same standard transaction for different
4 health plans. (Directive to Take Action)
5

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

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RELEVANT AMA POLICY

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.

Citation: Sub. Res. 714, A-15; Reaffirmed: BOT Rep. 09, A-25

Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS D-190.965

Our American Medical Association will report at the Annual 2026 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968.
Citation: Res. 819, I-25

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.

Citation: 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.
   Citation: Res. 229, I-21; Reaffirmed: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Equal Opportunity for Payment for "On Call" Duty

Referred to: Reference Committee G

Whereas, a primary goal of the American Medical Association is enhancing the satisfaction and sustainability of medical practice; and

Whereas, traditionally, physicians were expected to be "on call" to the hospital for a minimum amount of time as a responsibility of being on the medical staff, but in recent decades, the shift to employing many physicians by a hospital included coverage duties which by definition is paid as a part of the salary of the employed physician; and

Whereas, additionally, some independent physicians are paid for "on call" duties to ensure access to a given specialty, yet others (not in short supply) are not[1]; and

Whereas, the duty to be "on call" for consultation at the hospital carries an opportunity cost of being unable to schedule or participate in other activities, quite apart from any patient care that may eventuate; and

Whereas, the independent physician may bill for direct patient care, but that does not cover the opportunity cost of simply being "on call;" and

Whereas, in at least one state (Massachusetts), that the nature of the relationship of the physician to the institution has changed in recent decades is acknowledged by policy ratified by the Massachusetts Medical Society that advocates that "hospitals engage community/independent specialty physicians on the medical staff for observation, inpatient and emergency department coverage and that the parties negotiate mutually satisfactory payment terms and service agreements for such service"[2]; and

Whereas, guidelines for such negotiation start with equitable payment for service; therefore be it

RESOLVED, that our American Medical Association will work with relevant stakeholders to advocate that all physicians, whether employed or independent, should be paid for "on call" responsibilities, whether or not patient care is separately billed. (Directive to Take Action)

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

Received: 4/20/26

REFERENCES

1. Nabity, J. (2021). Your full guide to on-call pay for physicians. *Physicians Thrive*. https://physiciansthrive.com/physician-compensation/on-call-pay-physicians/
2. Massachusetts Medical Society. (2024). *MMS Policy Compendium*. https://www.massmed.org/Governance-and-Leadership/Policies,-Procedures-and-Bylaws/MMS-Policy-Compendium-(pdf)/

RELEVANT AMA POLICY

On-Call Physicians H-130.948

Our AMA:
(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.
Citation: CMS Rep. 3, I-99; Reaffirmed: A-00; Modified: Sub. Res. 217, I-00; Reaffirmed: I-01; Reaffirmed: A-07; Appended and Reaffirmed: CMS Rep. 1, I-09; Modified: Res. 818, I-17

On-Call Coverage Models D-130.965

Our American Medical Association will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands, and educate AMA physician members regarding these options.
Citation: Res. 722, A-13; Reaffirmed: CMS Rep. 01, A-23

On-Call and Emergency Services Pay D-130.963

Our AMA will develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services.
Citation: Res. 818, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

Referred to: Reference Committee G

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1 Whereas, the United States healthcare system is complex with over 2.5 million ERISA-covered
2 group plans in 2021 according to the U.S. Department of Labor, plus over 4,000 Medicare
3 Advantage and Medicaid managed care plans and even more venders connecting to more than
4 one million physician practices and other provider in 1-to-1 connections making automation
5 neither possible nor feasible; and
6
7 Whereas, health plan identifiers (HPID), a standardized national identifier for each of the greater
8 than 2.5 million health plans was mandated by HIPAA but never implemented causing
9 numerous administrative problems, including the inability of the Centers for Medicaid and
10 Medicare Services (CMS) to administer the No Surprises Act and confusion as to who is getting
11 healthcare claims and who is paying with a health plan such as Kaiser Permanente having up to
12 five different payer IDs for the same plan, pending on the clearinghouse used; and
13
14 Whereas, true interoperability at scale is impossible with standardization and a unique health
15 plan ID; and
16
17 Whereas, the AMA has existing policy ("Promoting Electronic Data Interchange" H-190.978) that
18 calls for a national electronic transaction clearinghouse that "continues to facilitate the rapid
19 development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange
20 electronic claims and eligibility information and remittance advice with payers and others in a
21 manner that protects confidentiality of medical information and to assist physicians in the
22 transition to electronic data interchange;" and
23
24 Whereas, for the CMS Prior Authorization rule, CMS advised that healthcare providers pull out
25 their rotary phones to "connect electronically to health plans," an insane idea for implementation
26 of a modern interconnectivity technology; therefore be it
27
28 RESOLVED, that our American Medical Association advocate for implementation of the
29 standard national health plan identifier (HPID) that all transactions must be communicated
30 directly with the health plan (Directive to Take Action); and be it further
31
32 RESOLVED, that our AMA advocates for the implementation of a national centralized electronic
33 healthcare transaction clearinghouse that would allow physician practices, other providers,
34 health plans, clearinghouses, health IT vendors, state and federal regulators, digital health
35 products, and consumer apps to maintain only one standard direct connection through which all
36 electronic transactions can flow seamlessly, securely, and at low cost to any other participant
37 guided by a transaction ID and a standard identifier such as a health plan identifier (HPID)
38 and/or national provider identifier (NPI). (Directive to Take Action)
39

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/20/26

REFERENCES

1. Centers for Medicare and Medicaid Services. *HPID*. Department of Health and Human Services. https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/unique-identifiers/hpid. Accessed April 7, 2026.

RELEVANT AMA POLICY

Promoting Electronic Data Interchange H-190.978

1. Our American Medical Association:
    1. adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing:
        a. Public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice.
        b. Vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry).
        c. Vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim.
        d. All clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers).
        e. Practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products.
        f. States should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims.
        g. Federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that:
            i. any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations.
            ii. that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services.
2. continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing.
3. continues to explore EDI-related business opportunities.
4. continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange.
5. continues its leadership roles in the NUCC and WEDI.
6. through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.

Citation: BOT Rep. 9, A-96, Amended: CMS Rep. TT, I-96; Appended: Sub. Res. 702, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: I-13; Reaffirmed: A-22

Administrative Simplification in the Physician Practice D-190.974

1. Our American Medical Association strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmed: A-14; Reaffirmed: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmed: I-17; Reaffirmed: A-19; Modified: CMS Rep. 09, A-19; Reaffirmed: A-22