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REPORT OF THE BOARD OF TRUSTEES

BOT Report 02-I-26

Subject: American Medical Association Optimal Health Outcomes Annual Report

Presented by: Toluwalasé A. Ajayi, MD, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted [Policy D-180.981](#), directing our American Medical Association (AMA) to “develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional guidance via Policy [H-180.944](#): “Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for Health Equity (Center) in April 2019, the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (Plan) in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy [H-65.946](#) specified that this report will also include “updates on [the AMA’s] comprehensive diversity and inclusion strategy.”

Towards the end of 2025, the AMA made the decision to strengthen its work in the pursuit of optimizing health outcomes; merging the Center for Health Equity (CHE) and the Improving Health Outcomes (IHO) business unit into the Center for Optimal Health Outcomes (COHO) with the goal of leveraging the talents of each of the units to support the US healthcare system in achieving optimal health for all.

At the 2026 Annual Meeting, the AMA Optimal Health Outcomes Annual Report ([BOT Report 09-A-26](#)) was [referred](#) with report back at the 2026 Interim Meeting requesting additional updates regarding the merger of CHE and IHO and the impact on the AMA’s ability to accomplish its goals as outlined in existing HOD policy.

DISCUSSION

Impact of the CHE/IHO Merger

The CHE/IHO merger was a strategic decision by AMA management. The purpose of the CHE/IHO merger was to build on the momentum established by CHE to engage communities in addressing health disparities and leveraging IHO staff’s clinical expertise, health system engagement, and community health organization partnerships. COHO maintains the same budget as CHE. While AMA management reduced staff with the CHE/IHO merger, this allowed COHO to achieve efficiencies while maintaining AMA’s goal to advance health equity and improve health outcomes.

The COHO team is a cross-functional workforce that bolsters AMA capabilities to support physicians, communities and organizations to close gaps and reduce health disparities. COHO is committed to taking measurable action and partnering to build and scale data-driven solutions to optimize health outcomes for everyone. COHO aims to do so by:

- Creating knowledge and generating evidence through research about what physicians need to know and do to improve patient health outcomes;
- Implementing physician-led solutions and contributing to what is effective in community health;
- Working with health care delivery systems and their affiliates to deliver and ensure access to high-quality medical care for patients; and
- Building strategic partnerships to advance policy that catalyzes change across health care on a local and national level.

The AMA is ultimately fulfilling the goals outlined in policy D-180.981, directing our AMA) to “develop an organizational unit, e.g., **a Center or its equivalent**, to facilitate, coordinate, initiate, and track AMA health equity activities” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements” as well as in policy H-180.944 which not only defines health equity as optimal health for all, but instructs our AMA to “... [advocate] for health care access, research, and data collection; [promote] equity in care; [increase] health workforce diversity; [influence] determinants of health; and [voice and model] commitment to health equity.” The creation of COHO allows for greater collaboration internally and externally, positioning AMA to take measurable action and build data-driven solutions to optimize health outcomes for all.

The following is a brief snapshot of some of COHO’s work that is directly related to the HOD policies outlined above:

Overview of COHO Programs and Impacts of the CHE/IHO Merger

The following table demonstrates programs that were led by CHE and IHO, as well as the combined post-merger efforts that have resulted in greater operational efficiencies, expanded programs and enhanced overall impact.

Prior Unit Management	Program	Status	Summary of Developments
CHE	Medical Justice in Advocacy Fellowship (MJAF)	Expanded	• Expanded to 20 fellows • Expanding opportunities for MJAF alumni
CHE	Policy Analysis Tool	In Progress	• Tool to be platformed on the AMA website in 2027 • Training will be offered to AMA staff and members
CHE	Disability Advisory Group (DAG)	In Progress	• Caring for People with Disabilities series launched in May 2026

			- Supported improvements to accessibility at HOD and other AMA meetings - DAG approved for a 2-year term extension
CHE	Professional Societies Learning Network	In Progress	- Launched in June 2026 - This year's cohort includes 10 geographically-based societies and national/ specialty or subspecialty societies
Advocacy	Health Law Summer Internship and Fall Externship Program	In Progress	- Summer health law internship program previously overseen by Advocacy - Developing new connections with diverse groups to promote the internship - Established a new Health Law Fall Externship program beginning in Fall 2026
CHE/IHO	Community Health Impact Lab Micro Grants	Initiated	\$50k awards to 20 physician-led community health projects at local organizations - AMA will lead engagement with physician leaders and deepen insights into community health.
CHE/IHO	Release the Pressure (RTP) Campaign	Expanded	- Refresh of RTP's national media and communications campaign, including updated website content, social media outreach, and culturally relevant educational materials - Developing and disseminating community-based educational handouts and hypertension resources to new community partners - Expanding the number of in-person events to promote RTP across the country - Partnership with iHeart Radio to amplify RTP messaging across key markets.
IHO	Million Hearts	In Progress	- COHO aims to support capacity building - In partnership with Alliance Chicago, COHO is engaging 6 Health Center Control Networks, and supporting 24 different health centers (urban

			and rural) across 9 states to improve the quality of care in blood pressure control and cholesterol management.
IHO	AMA MAP™ Solutions	In Progress	• Helping health care organizations strengthen cardiovascular disease prevention through practical, evidence-based improvement strategies • 125 health care delivery organizations have implemented one or more AMA MAP™ Solutions, and 30 of those organizations have reported measurable impact.
IHO	Validated Blood Pressure Device Listing (VDL)	In Progress	• In 2026, 30 new devices, 7 of which are for pregnancy, have been added to the VDL • VDL continues to prioritize increasing the number of devices used during pregnancy and during the post-partum period.
CHE	Social Return on Investment	In Progress	• COHO staff continued to refine a methodology for quantifying the social return on investment in partnership with Kearney • Healthcare Anchor Network, invited COHO staff to present findings from this work at 2 convenings
IHO	GLP-1 RAs Research	In Progress	• COHO staff continued to explore the utilization and spending for GLP-1 RAs. • COHO is also studying the relationships of pairing behavioral and lifestyle medicine principles and practice with GLP-1 RAs and other anti-obesity Medications. • COHO's research was presented at the American College of Preventive Medicine.
IHO	Self-Measured Blood Pressure	In Progress	• COHO staff continued to examine the economic maternal and infant outcomes

	Return on Investment		of self-measured blood pressure (SMBP) monitoring
IHO	Maternal Health Pilot	Initiated	The COHO team is collaborating with UMMC to pilot a Diabetes Prevention Program tailored for women with gestational diabetes in rural Mississippi.
CHE	Studies of Physician-Patient Dyads	In Progress	COHO staff worked with Elevance Health to finish three major empirical studies of racial concordance
CHE	External Research Advisory Group	In Progress	- COHO staff continued to organize and meet with an external research advisory group. - Group includes 12 research leaders from across the health care ecosystem.

Overview of COHO Programs and Programs Post-Merger

Policy Development

Medical Justice in Advocacy Fellowship

The Medical Justice in Advocacy Fellowship (MJAF), created by the AMA and the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine, will begin its fourth cohort in September 2026. This collaborative educational initiative aims to empower physician-led advocacy that advances optimal health for all people and communities and mobilize physicians to be part of the next generation of advocacy leaders, driving meaningful policy changes that produce optimal health outcomes in the communities they serve. With support of AMA leadership, the fourth cohort of the fellowship has doubled in size, expanding to 20 fellows. The fellowship curriculum, a fourteen-month engagement, includes both virtual learning sessions and in-person engagements. Additionally, COHO is continuing to develop opportunities for the 33 MJAF alumni to deepen their engagement and connection with each other and facilitate mentorship and learning with the new cohort of fellows. COHO is also investing in opportunities for the MJAF alumni to continue to build on the policy development, advocacy, and communication and scientific writing and publication skills they develop as fellows.

Policy Analysis Tool

The Policy Analysis Tool is intended for AMA staff and AMA physician members to support the development of inclusive policies that advance equitable health outcomes for all populations, particularly marginalized and minoritized communities. The tool will provide an interactive set of criteria and guiding questions to assess the potential health equity impact of policies, resulting in a more equity-oriented policy landscape. COHO is leading the adoption and implementation of this interactive tool to be platformed on the AMA website in 2027. Training will be offered to AMA staff and members to support inclusive policy development.

Health Workforce Diversity

1 The AMA is sponsoring the National Medical Fellowships (NMF) 80th Anniversary Homecoming
2 Weekend in Chicago, October 1–4, 2026, with Dr. John Whyte serving as a Weekend Co-Chair.
3 The partnership supports NMF’s work to strengthen pathways into medicine through scholarships,
4 mentorship, career development, and physician leadership. As part of the weekend, AMA will lead
5 an educational session focused on how cross-sector partnerships can drive impactful community
6 health programs, amplifying COHO’s Live Health Chicago, West Side United, and the Atlanta
7 Hypertension Initiative partnerships. In addition, AMA will host a brunch recognizing physician
8 leadership, honoring Dr. Camille Clare, president of the American College of Obstetricians and
9 Gynecologists. COHO is also supporting MedEd’s sponsorship of the 2026 STEMM Pathways to
10 Health Equity Symposium, further advancing efforts to build diverse STEMM and health-
11 profession pipelines from campus to career. Together, these investments support the development
12 of the next generation of diverse health professionals and leaders while strengthening partnerships
13 that advance health equity.

14 Disability Advisory Group

15 The AMA Disability Advisory Group (DAG) was established by HOD policy to form an advisory
16 group composed of AMA members who themselves have a disability to ensure additional
17 opportunities for including physicians and medical students with disabilities in all AMA activities
18 and promote and foster educational and training opportunities for AMA members and the medical
19 community at large. The DAG has met regularly since its establishment in late 2024, with two
20 active workgroups focused on Education and Workplace Inclusion & Accommodations. The
21 Education Workgroup has contributed to the creation of foundational [educational materials](#) to
22 address ableism in medicine. Most recently, COHO and the workgroup collaborated with the
23 University of Colorado Anschutz School of Medicine to create the new AMA Ed Hub™ [Caring for](#)
24 [People with Disabilities series](#), which supports physicians and medical students in learning to
25 improve health outcomes for people with disabilities. The initial education modules in the series
26 launched on May 12, 2026, and additional content will be published throughout the year. The
27 Workplace Inclusion & Accommodations Workgroup has contributed to extensive improvements
28 to accessibility at HOD and other AMA meetings and will continue to work on developing tools
29 and resources for physicians and students with disabilities to advocate for improvements in their
30 local work environments. The DAG was approved for a 2-year term extension from 2027-2028.

32 Professional Societies Learning Network

33 The Professional Societies Learning Network (PSLN) (previously titled the [Equitable Professional](#)
34 [Societies Learning Network](#) (EPSN)) is a program designed to support professional societies that
35 are members of the AMA’s Federation of Medicine in identifying gaps and improving health
36 outcomes for the communities they serve by gaining deeper knowledge of social and structural
37 drivers of health disparities and implementing interventions to address them. Through a series of
38 six modules, which will include pre-work, live facilitated learning, and post-session technical
39 support via office hours, staff and physician leaders from participating professional societies move
40 beyond basic awareness to gain skills that allow them to actively engage with these issues in ways
41 that foster system-level changes. The program launched in June 2026 and is designed to be flexible
42 to support each participating society’s individual goals for optimizing health outcomes in the
43 communities they serve. This year’s cohort includes the Society of Maternal-Fetal Medicine, the
44 American Society of Hematology, the American Epilepsy Society, the American Academy of
45 Neurology, and the American Psychiatric Association.

Policy Development Initiatives and Comment Letters

COHO leverages members of minoritized physician groups, community partners, and other stakeholders to draft comments for proposed rules, support letters for federal legislation, and responses to requests for information (RFIs) to support the AMA Advocacy business unit.

“Still at Risk” Initiative

The AMA has been working with the Preeclampsia Foundation on the “Still at Risk” postpartum hypertension awareness and action wristband initiative. This public-private partnership is focused on improving postpartum health outcomes through the creation, promotion, dissemination, and impact measurement of wristbands for postpartum women at risk of developing hypertension. The AMA has provided the Foundation with a [letter of support](#) and provided remarks during the launch of the initiative at the U.S. Department of Health and Human Services (HHS) National Conference on Women’s Health.

TN-Meharry Medical College HBCU Wellness Project

The HBCU Wellness Project at Meharry Medical College is an intervention to promote health and modify risks for chronic diseases among individuals living in the surrounding communities while training undergraduate students interested in health professions. To date, this initiative has trained more than 1,000 students primarily from Fisk University, Lane College, LeMoyne-Owen College and additionally students from Tennessee State University, Austin Peay State University, Middle Tennessee State University, and the University of Tennessee at Chattanooga. The program’s peer reviewed curriculum provides an intensive overview of essential research principles and frameworks, including human subjects protections, ethics, epidemiology, social determinants of health, institutional review board protocols, and other foundational topics that prepare students to research and address optimal health outcomes in resource-limited populations. The AMA is partnering with Meharry Medical College to provide \$100,000 in funding to help recruit, train and engage students as well as strengthen the program’s capacity to attend national conferences to further promote the work. Partnership in this initiative puts AMA at the forefront of providing education to and opportunities for students looking to deepen their research careers and contributions to health programming in local communities.

Memberships, Sponsorships, and Other Engagements

COHO is engaging the AMA with minoritized physician groups, community partners, and other stakeholders. COHO has worked to make AMA a member of the National Health Council, the National Rural Health Association, and the National Produce Prescription Collaborative. The AMA has also provided grants to several organizations to support professional development and promoting optimal health outcomes. COHO continues to seek opportunities to collaborate with and support organizations such as the National Medical Association, the National Hispanic Medical Association, the National Council of Asian Pacific Islander Physicians, the Association of American Indian Physicians, and GLMA.

Health Law Intern and Externship Program

COHO is working to develop a robust pipeline of highly qualified health law attorneys and lobbyists through the continuation of a summer health law program, previously overseen by Advocacy. COHO is maintaining existing relationships and developing new connections with a diverse group of law schools and professional organizations to promote the internship and full-time employment opportunities at the AMA.

Community Health

Community Health Impact Lab Micro Grants

The Community Health Impact Lab's micro grant initiative supports physician-led, community-centered initiatives that improve health outcomes—particularly for populations with demonstrated health needs. AMA awarded a total of \$1 million in micro grants. Awards support a total of 20 physician-led community health projects at local organizations at \$50,000 each. The projects are representative of 16 states and Washington, DC. Topics range from expanding access to preventive care and maternal health services to addressing mental health, nutrition, and chronic disease in diverse populations, including rural and indigenous populations, women, children, and other underserved or marginalized groups. During this inaugural micro grant cycle, AMA will lead engagement with physician leaders and deepen insights into community health.

Release the Pressure

Release the Pressure (RTP) is AMA's national hypertension awareness and engagement campaign focused on populations with high risk factors— combining patient education, community partnership, physician engagement, policy development and advocacy to improve heart health outcomes.

National Environmental Education Foundation (NEEF)

COHO is partnering with the National Environmental Education Foundation (NEEF) to administer the Veterans and Nature Grant Program to support veterans' health and well-being through nature-based experiences, education, and stewardship activities. The \$125,000 grant supports community-based and veteran-serving organizations, including those serving under-resourced and rural communities, with the goal of increasing access to nature-based activities that promote physical health, mental well-being, social connection, and overall wellness. The program will also assess participation, reach, and early health and well-being outcomes to inform future programming.

West Side United

A coalition of healthcare systems, community organizations, and residents is working to close Chicago's West Side life expectancy gap through coordinated investments across health, education, economic vitality, and neighborhood improvement. The AMA has recommitted an additional investment of \$3M over the next three years as an Anchor Mission Partner and continues to support local hiring, community events, and procurements. AMA has continued to offer \$250K sponsorship to capacity building in local hiring, BP screening in the community, and workforce development, including Community Health Workers (CHW), care coordinators, and nursing. AMA's engagement and collaboration in this initiative continues to advance the knowledge and evidence on the impact of Social Return On Investment (SROI).

Live Healthy Chicago

The AMA continues to support Rush University Medical Center (and other organizations) in leading and advancing the Live Healthy Chicago (LHC) initiative. LHC is a civic initiative that brings together partners, programs, and resources from across the health care ecosystem to reduce cardiovascular disease (CVD) risk in 27 West and South Side neighborhoods where cardiovascular risk is nearly double the citywide rate and mortality from heart attacks and strokes is disproportionately high. This innovative initiative is offering primary care practices for the [AMA](#)

[MAP™](#) Hypertension QI Program and implementation support to improve blood pressure control rates, deploying mobile community care teams, and launching a public health awareness campaign.

Atlanta Hypertension Initiative

The Atlanta Hypertension Initiative (AHI) brings together public health, health care, community, government, academia, and professional associations to address longstanding health outcome differences in hypertension control across metro Atlanta. Grounded in truth and accountability for disparate outcomes, AHI focuses on repair and healing through community partnership, continuous quality improvement, and shared capacity-building. Over the next five years, the initiative aims to improve blood pressure control for more than 500,000 adults. The initiative is utilizing the [AMA MAP™](#) framework and AMA tools and resources, with support from COHO subject matter experts. COHO has supported the design and implementation of the AHI monthly QI webinars for all participating partners. COHO solutions are utilized to support the implementation and evidence-based practices and community engagement.

Million Hearts

AMA was awarded a multi-year Cooperative Agreement by the U.S. Centers for Disease Control and Prevention (CDC), Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health. As part of this Cooperative Agreement, COHO aims to support capacity building using implementation science principles, [AMA MAP™ Framework](#), evidence-based quality improvement (QI) strategies, data-driven decision-making, and peer learning to improve blood pressure control and reduce heart attacks and strokes. Working in partnership with Alliance Chicago, COHO is engaging 6 Health Center Control Networks, and supporting 24 different health centers (urban and rural) across 9 states to improve the quality of care in blood pressure control and cholesterol management.

Health Systems Engagement

AMA MAP™ Solutions

This year, AMA MAP™ Solutions advanced the AMA's strategic priorities by helping health care organizations strengthen cardiovascular disease prevention through practical, evidence-based improvement strategies. These efforts also reinforce AMA leadership in practice of transformation, clinical quality, and physician support while helping organizations translate proven CVD strategies into measurable, sustained improvements for care teams and patients. To date, 125 health care delivery organizations have implemented one or more AMA MAP™ Solutions, and 30 of those organizations have reported measurable impact.

Validated Blood Pressure Device Listing (VDL)

The list of blood pressure measurement devices independently validated for clinical accuracy and meeting the [VDL](#) Criteria continues to expand. In 2026, 30 new devices, 7 of which are for pregnancy, have been added. The VDL continues to prioritize increasing the number of devices used during pregnancy and during the post-partum period.

Remote Area Monitoring (RAM)

Remote Area Medical (RAM), a nationally recognized nonprofit, delivers free, high-quality medical, dental, and vision care through pop-up clinics, mobile health units, and telehealth services in rural, under-resourced, and high-risk communities. COHO is collaborating with RAM on blood pressure monitor device donations and volunteering to advance the AMA's strategic priorities of

promoting health equity, improving access to care, expanding preventive screenings, and strengthening community-clinical linkages. RAM reaches individuals most affected by chronic disease and unmet health needs, including those who often forgo care due to cost barriers, competing life priorities or limited access to providers.

MIPS Adoption of Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

AMA's electronic clinical quality measure (eCQM), *Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes*, has been adopted by CMS for use in MIPS. The 2026 measure description and specifications are available on the [eCQI website](#). COHO is supporting organizations in implementing the measure for its inaugural reporting year in 2027 to help establish baseline performance. Additionally, COHO is gathering feedback from users on implementation challenges and developing a roadmap for future tools and resources to support its adoption.

Research and Evaluation

COHO is well-equipped to advance efforts to eliminate health disparities and improve health outcomes using quantitative, qualitative, econometric, social epidemiologic research methodologies and evaluation tools. COHO researchers work in close collaboration with AMA colleagues and with key external partners in health systems, community health organizations, and academic institutions. Findings are disseminated in peer-reviewed journal publications and presented at national conferences, which helps COHO establish an evidence base. This evidence supports the translation of research into policy and the development of innovative tools and products to mitigate inequities in care to improve health outcomes for all.

Healthcare Anchor Network / Social Return on Investment

COHO staff continued to refine a methodology for quantifying the social return on investment in partnership with Kearney associated with West Side United's social impact investing strategy. This work has drawn the interest of the Healthcare Anchor Network, who invited COHO staff to present findings from this work at their August convening in Chicago and at their October annual meeting in Denver. COHO staff has worked closely with West Side United on this work.

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs)

COHO staff continued to explore research topics studying the utilization and spending for GLP-1 RAs. Using credible and timely data, the team continues to measure the accessibility, affordability, and safety of GLP-1 RAs, both in the overall population and among marginalized populations. They are also exploring how the relationships of pairing behavioral and lifestyle medicine principles and practice with GLP-1 RAs and other anti-obesity Medications. Data is extracted from multiple sources including Medicaid claims, pharmaceutical fills, and federally qualified health center networks. This work was presented at the American College of Preventive Medicine.

Self-Measured Blood Pressure Return on Investment

COHO staff continued research to examine the economic maternal and infant outcomes of self-measured blood pressure (SMBP) monitoring, which enables more frequent measurements and potentially earlier detection and management of hypertension (HTN) during pregnancy and the postpartum period for Medicaid beneficiaries. The work supports a targeted Medicaid coverage strategy that pairs SMBP with explicit protocols for reviewing elevated readings, confirming persistent hypertension, and initiating or intensifying treatment.

Maternal Health Pilot

The COHO team is collaborating with The University of Mississippi Medical Center (UMMC) to pilot a Diabetes Prevention Program tailored for women with gestational diabetes in rural Mississippi. The pilot will consist of three phases including (1) pre-implementation, (2) semi-structured interviews, and (3) implementation and evaluation. Collectively, the teams will work together to develop a lifestyle change program curriculum/guide tailored for this specific population, embed clinical workflows for providers, and enhance efforts to provide continuity of care post-partum via connections to local providers, telehealth or other modalities.

Elevance Health – Studies of Physician-Patient Dyads

COHO staff worked with research collaborators at Elevance Health to finish three major empirical studies of racial concordance using AMA’s Physician Professional Data and Elevance Health’s data on colorectal cancer screening, statin adherence among individuals with cardiovascular disease and diabetes care adherence. Each of the studies examined the importance of physician-patient concordance, while accounting for area-level social vulnerability and other relevant factors. These very large studies (the colorectal cancer analysis is based on over 5 million patient-year observations) are well positioned to make an impact on the literature on racial concordance, and ultimately all provide evidence of the importance of the clinical relationship.

External Research Advisory Group

COHO staff continued to organize and meet with an external research advisory group. The group includes twelve research leaders from across the health care ecosystem. Discussions center around strategy and feedback on COHO research projects.

Plans for Developing a New Strategy Under the Direction of New COHO Leadership

COHO is excited to welcome Denise Fair Razo, MBA, MPH as COHO’s group vice president, effective August 3, 2026. Fair Razo brings to the AMA more than two decades of executive leadership experience spanning large-scale ambulatory care and healthcare organizations, public health and community partnerships. Most recently, she served as chief public health officer and chief operating officer of the City of Detroit Health Department, where she strengthened public health infrastructure and oversaw more than 40 programs spanning maternal and child health, immunizations, community health services, behavioral health, and environmental health. Under Fair Razo’s leadership, COHO will develop and expand on data-driven solutions that improve health outcomes and build a healthier future for all.

CONCLUSION

While there have been staffing changes, the AMA remains committed to the pursuit of health equity and optimizing health outcomes for all populations. The creation of COHO allows for greater collaboration internally and externally, positioning AMA to take measurable action and build data-driven solutions to optimize health outcomes for all. COHO’s cross-functional workforce bolsters AMA capabilities to support physicians, communities and organizations to close gaps and reduce health disparities. Under the direction of new COHO leadership, COHO will create a new short and long-term strategy guided by data-driven solutions that improve health outcomes and build a healthier future for all.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 13-I-26

Subject: Enhancing the Work of the Center for Digital Health and AI

Presented by: Toluwalasé A. Ajayi, MD, Chair

1 Policy G-615.998 Creation of an AMA Council with a Focus on Digital Health Technologies and
2 AI, directed the American Medical Association (AMA) to establish a task force by the 2024
3 Interim Meeting focused on digital health, technology, informatics, and augmented/artificial
4 intelligence (AI) with the potential to transition this task force to a new council and report back at
5 the 2025 Annual Meeting on this transition.

6
7 Board of Trustees Report 25-A-25 amended the policy to direct the task force on AI, Digital
8 Health, and Informatics to work toward an informed recommendation on the long-term model for
9 House of Delegates (HOD) input with a report back at the 2026 Interim Meeting.

10
11 This report shares the work of the task force and presents the creation of a physician network of
12 experts with representation from the HOD and all AMA members to provide guidance to the
13 Center on Digital Health and AI. The network will also be available to provide other entities of the
14 AMA, including the Board of Trustees and Councils with expertise as needed and requested.

15 16 BACKGROUND

17
18 Policy G-615.998 directed the AMA to establish a task force by the 2024 Interim Meeting focused
19 on digital health, technology, informatics, and augmented/artificial intelligence, with the potential
20 to transition the task force to a council. The task force was constituted before the 2024 Interim
21 Meeting and first convened in February 2025. Over four meetings between February 2025 and
22 January 2026, it progressed from defining its purpose and substantive priorities to evaluating the
23 long-term governance structure for AMA leadership in these fields.

24 25 *Task Force Selection and Composition*

26
27 The founding charter authorized up to 22 members and established a deliberate, multi-source
28 selection process. Members of the HOD could self-nominate through an application process; each
29 of the AMA's seven councils nominated a liaison; and the Senior Management Group identified
30 additional candidates with relevant expertise. Final membership was approved by the Chair of the
31 AMA Board of Trustees. The resulting task force combined HOD members, representatives of
32 every existing council, AMA Board members, and external physician and nonphysician experts
33 serving as public or group members. This design gave the task force both a direct connection to the
34 HOD and the technical breadth needed to address rapidly evolving issues.

Inaugural Task Force Members

Member	Representation / selection source	Specialty or expertise
Adam Prater, MD, MPH	House of Delegates	Radiology
Carolyn Maureen Clancy, MD, MACP	House of Delegates	Internal medicine / Veterans Affairs
Christopher Libby, MD, MPH, FACEP	House of Delegates	Emergency medicine
David Aizuss, MD	AMA Board member; task force co-chair	Ophthalmology
Druv Bhagavan	House of Delegates	Medical student
Eric Langshur	Public member; Abundant Ventures	Nonphysician member
Gary R. Katz, MD, MBA, FACEP	Council on Long Range Planning and Development	Emergency medicine
Jerry P. Abraham, MD, MPH, CMQ	Council on Constitution and Bylaws	Family medicine
Lisa Dykstra	Public member; former CIO; CHIME	Nonphysician member
Lynn Jeffers, MD, MBA	AMA Board member	Plastic surgery
Mark Synovec, MD	House of Delegates	Pathology
Michael Suk, MD	AMA Board member; task force co-chair	Orthopaedic surgery
Padmini Ranasinghe, MD, MPH, FACP, FACPM	Council on Science and Public Health	General medicine
Rebecca Weintraub Brendel, MD, JD	Council on Ethical and Judicial Affairs	Psychiatry
Robyn Chatman, MD, MPH, FAAFP, CPHIMS, CHEP	House of Delegates	Family medicine / addiction medicine
Roxana Lupu, MD, MBA, FACP	Public/group member	Hospital medicine
Seema Sidhu, MD	Council on Medical Education	Obstetrics and gynecology
Steven L. Chen, MD, MBA	Council on Medical Service	Surgical oncology
Tom Lawry	Public member; Second Century Tech LLC	Nonphysician member
Tripti Kataria, MD, MPH, MBA, FASA	Council on Legislation	Anesthesiology
Vincent Liu, MD, MSc	Public/group member	Internal medicine

Evolution of the Task Force's Work

The task force intentionally separated its work into two related tracks. The first was substantive: to define the role and scope of AMA leadership in AI, digital health, and clinical informatics. The second was organizational: to determine what an enduring physician-led body should look like, including whether it should become a council, remain a task force, or take another form, and how it should interact with the newly established Center for Digital Health and AI.

On the substantive track, the task force identified five foundational areas for AMA leadership: health technology policy frameworks; liability and risk mitigation; physician education and upskilling; standards for responsible use in clinical environments; and governance for the integration of digital health and AI. It also emphasized evaluation frameworks, physician leadership in technology design and deployment, safe, transparent, and equitable adoption, coverage and pathways to payment, and stronger communication with the HOD.

On the organizational track, the task force considered an elected council, an appointed council, a standing task force, a standing advisory committee, and phased or hybrid approaches. It assessed the options against authority, continuity, agility, cost, access to specialized expertise, responsiveness to the HOD, and fit with the existing councils. The analysis demonstrated that AI, digital health, and informatics are not a discrete jurisdiction: they affect ethics, medical education, payment, legislation, public health, clinical workflow, and practice sustainability. The task force therefore concluded that the durable structure should coordinate expertise across councils and the AMA enterprise rather than duplicate or compete with existing council responsibilities.

DISCUSSION

The Center for Digital Health and AI

During 2025, the AMA established the Center for Digital Health and AI as the operational home for this work. The Center creates a business unit capable of commissioning research, building evaluation frameworks and educational resources, convening coalitions, and engaging technology developers, regulators, policymakers, health systems, and innovators. Its purpose is to help ensure that physicians shape technological change and that digital health and AI improve patient care, strengthen the patient-physician relationship, and earn public trust.

The Center is organized around four pillars:

- Policy and regulatory leadership: shaping benchmarks and policy frameworks for the safe and effective use of AI and digital health technologies.
- Clinical workflow integration: creating opportunities for physicians to shape tools so they fit clinical workflows and improve patient and clinician experience.
- Education and training: equipping physicians and health systems to evaluate, adopt, and use AI and digital health technologies effectively.
- Collaboration: building partnerships across technology, research, government, health care, and organized medicine to advance innovation aligned with patient needs.

The Center has already expanded the AMA's presence and physician support in this space through physician roundtables, the AI Evaluation Guide, an AI Specialty Collaborative involving more than 25 national specialty societies, policy and model-legislation work on AI-generated physician deepfakes, and a legislative framework addressing mental health chatbots. As the Center matures, its work may also include product development, standard-setting and validation, and additional partnerships and coalitions.

Role and Scope of the Network of Experts

The network of experts will be modeled after the Food and Drug Administration's network of experts which is used to provide rapid access to expertise when it is needed to supplement existing knowledge and expertise across multiple Centers.

The Center does not make AMA policy and is not intended to replace the HOD. Policy authority remains with the HOD. The network of experts will make expansive physician leadership and expertise continuously available to the Center and other AMA entities seeking expert insights while preserving those governance boundaries. It will advise Center leadership, provide perspective on strategy, ethics, implementation, risk and liability, interface with existing councils and the Board, and elevate issues requiring HOD policy consideration, as well as other entities seeking expert insights on AI related issues.

This relationship addresses both dimensions of the task force's work. Substantively, the network of experts will provide a nexus of physician expertise across AI and digital health. Organizationally, it will connect that expertise to the Center's operational capacity, the existing councils' subject-matter jurisdictions, the Board's oversight, and the HOD's policy-making authority.

1 Conclusion

2
3 The Center for Digital Health and AI is constituting a network of experts to be used as advisors on
4 all digital health and technology issues. All members of the House of Delegates and members of
5 the AMA will have the opportunity to self-enroll as members of the network with a designation of
6 specific expertise. The expertise of this network will be available to the Board of Trustees, the
7 House of Delegates, and all AMA Councils as needed to provide expertise on all issues. This
8 network of experts combines continuity, adaptability, cross-council coordination, and specialized
9 expertise. This network of experts aligns with the original resolution that created the task force and
10 further aligns with the direction of the task force.
11

12 In a field that is rapidly changing, having access to the expertise of more individuals will expand
13 the Center's own reach and expertise. The self-enrollment process will allow the Center to harness
14 the vast expertise of our members while not adding unnecessary meetings or obligations. The
15 Center will be able to reach out as needed to experts for feedback, testimony, field testing, and
16 myriad other issues. This model will allow the Center to have immediate access to expertise and
17 will be able to convert guidance and expertise into operational work.

EXECUTIVE SUMMARY

This report is submitted for the information of the House of Delegates (HOD). [Policy G-640.005](#), “AMA Advocacy Analysis,” calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on the American Medical Association’s (AMA) most prominent advocacy activities for the year to date. (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

At the start of 2026, the AMA achieved several measurable, high-visibility wins that advance physician practice sustainability, defend physician-led care, and shape national healthcare policy. H.R. 7148, the “Consolidated Appropriations Act of 2026” included Medicare telehealth extensions; restoration of Alternative Payment Model (APM) incentives; virtual expansion of the Medicare Diabetes Prevention Program; Medicare Advantage provider directory accuracy reform; a five-year extension of Acute Hospital Care at Home; reauthorization of the “Dr. Lorna Breen Health Care Provider Protection Act;” Pharmacy Benefit Managers (PBM) reform; and two maternal health bills.

On Medicare payment, the chairs of the GOP and Democratic Doctors Caucuses—Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC) and Kim Schrier, MD (D-WA)—along with 23 original cosponsors, introduced the “[Patients First Act](#)” ([H.R. 9693](#)), a comprehensive, bipartisan proposal to reform the Medicare physician payment system. The legislation was developed over the past year through extensive consultation with the AMA and other physician organizations. The bill addresses all four of the core reforms organized medicine has sought for more than a decade: annual inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and expanded opportunities to participate in APMs. There are several more targeted Medicare payment reform bills under consideration as well.

The AMA is also lobbying extensively at the federal level and working with the Federation at the state level to attempt to mitigate any potential patient coverage losses due to implementation of H.R. 1, the “One Big Beautiful Bill Act” (OBBBA). Along with our lobbying efforts, the AMA is seeking to provide resources that can be used by physicians to directly help patients.

This report includes updates on these issues as well as prior authorization, augmented intelligence, physician wellness, reproductive health, and other key physician and patient advocacy topics.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 19-I-26

Subject: 2026 AMA Advocacy Efforts

Presented by: Toluwalasé A. Ajayi, MD, Chair

This report is submitted for the information of the House of Delegates (HOD). [Policy G-640.005](#), “AMA Advocacy Analysis,” calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on the American Medical Association’s (AMA) most prominent advocacy activities for the year to date. (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

DISCUSSION OF 2026 ADVOCACY EFFORTS

H.R. 7148, the “Consolidated Appropriations Act of 2026”- Enacted

At the federal level, 2026 started with the AMA producing measurable, high-visibility wins that advance physician practice sustainability, defend physician-led care, and shape national healthcare policy. The AMA was instrumental in securing bipartisan support for important physician and patient priorities in the federal budget deal enacted in February, H.R. 7148, the “Consolidated Appropriations Act of 2026.” This legislative package included extensions and reforms in telehealth, value-based care, diabetes prevention, and efforts to tackle physician burnout. These illustrate AMA’s ongoing influence on national health policy outcomes.

- Medicare telehealth extensions - Section 6209 extended Medicare telehealth flexibilities for two years, through Dec. 31, 2027. The AMA strongly supported this extension and continues to advocate for permanent authorization of Medicare telehealth flexibilities.
- Alternative payment model (APM) incentives restored - Section 6204 reinstated APM incentive payments at 3.1 percent for the 2026 performance year/2028 payment year. These provisions responded directly to AMA advocacy following the expiration of APM bonuses and the automatic Qualifying Participant (QP) threshold increase in 2025.
- Medicare Diabetes Prevention Program—virtual expansion - Section 6214 included the “PREVENT DIABETES Act,” an AMA-endorsed policy expanding access to the Medicare Diabetes Prevention Program (MDPP). For the first time, CDC-recognized virtual diabetes prevention programs will be included in the MDPP expanded model on a trial basis from Jan. 1, 2026, through Dec. 31, 2029.
- Medicare Advantage provider directory accuracy reform - Section 6220 included the “Requiring Enhanced and Accurate Lists of (REAL) Health Provider Act,” shaped by extensive AMA input. Medicare Advantage (MA) plans must maintain accurate, regularly updated provider directories and publicly report accuracy rates. It also includes Centers for Medicare & Medicaid Services (CMS) oversight, GAO evaluation, public reporting, and dedicated funding strengthen accountability and enforcement.

- 1 • Five-year extension of Acute Hospital Care at Home - Section 6210 extended the Acute
2 Hospital Care at Home (AHCaH) waiver for five years, through 2030. This preserved a proven,
3 physician-led model delivering hospital-level care safely in the home.
- 4 • “Dr. Lorna Breen Health Care Provider Protection Act” reauthorization - Section 6508
5 reauthorized and expanded the Dr. Lorna Breen Health Care Provider Protection Act for five
6 years, through FY 2030. The bill continued funding, mandates annual stigma-reduction
7 campaigns, broadens grant eligibility to address administrative burden, and aligns grant periods
8 with the authorization length.
- 9 • Pharmacy Benefit Managers (PBM) reform - The legislation included targeted pharmacy
10 benefit manager reforms to enhance transparency, curb abusive Medicare drug rebate practices,
11 and strengthen enforcement against anti-competitive behavior. These provisions represent
12 tangible progress toward lowering prescription drug costs and improving fairness in the drug
13 supply chain.
- 14 • Maternal health - The bill reauthorized the “PREEMIE Reauthorization Act” to expand federal
15 research on preterm birth and improve outcomes for premature infants. It also reauthorized the
16 “Preventing Maternal Deaths Act,” increases authorized funding to \$100 million annually
17 through 2030, expanded the scope of state maternal mortality review committees, and directed
18 federal agencies to more regularly disseminate best practices.

19
20 These eight provisions reflect multiple policy areas important to physicians and patients. They are
21 the result of a tireless advocacy effort by the AMA that spanned several Congresses and included
22 testimony, formal comment letters, legislative drafting input, coalition coordination, and sustained
23 committee engagement. Each provision addresses a discrete policy issue; collectively, they
24 represent measurable progress across several long-standing AMA advocacy priorities.

25 26 *Medicare Payment Reform*

27
28 The AMA and the Federation have a clear vision for fixing the nation’s Medicare physician
29 payment system. The AMA is calling on policymakers to reform the “Medicare Access and
30 CHIP Reauthorization Act” (MACRA) along four key pillars:

- 31
- 32 • Annual payment updates tied to the Medicare Economic Index (MEI);
- 33 • Reforms to budget neutrality;
- 34 • Overhaul of the Merit-based Incentive Payment System (MIPS); and
- 35 • Modifications to alternative payment models.
- 36

37 The year began with Congress providing a hard-fought one-time 2.5 percent Medicare payment
38 update for 2026 that was enacted in the “One Big Beautiful Bill Act” (H.R. 1) (OBBBA); however,
39 Congress must act to address payment rates in future years. In line with our reform pillars, the
40 AMA is advocating for:

- 41
- 42 • H.R. 6160, the “Strengthen Medicare for Patients and Providers Act,” to provide physicians
43 with a permanent inflationary update equivalent to the MEI, which has been reintroduced by
44 Reps. Raul Ruiz, MD (D-CA), Gus Bilirakis (R-FL), Jimmy Panetta (D-CA), Ami Bera, MD
45 (D-CA) and Kim Schrier, MD (D-WA).
- 46 • H.R. 8163, the “Provider Reimbursement Stability Act” which would make targeted
47 improvements to the statute governing budget neutrality requirements within the Medicare
48 Physician Fee Schedule. (In May, the bill passed the House Ways and Means Committee
49 unanimously.) The Senate has introduced a companion bill (S. 5180) sponsored by Senators

John Boozman (R-AR), Peter Welch (D-VT), Roger Marshall, MD (R-KS), Angus King, (I-ME), Thom Tillis (R-NC), and Jeanne Shaheen (D-NH).

- H.R. 8622, the “Medicare Physician Data-driven Performance Payment System Act of 2026” which was introduced by Reps. Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ). This legislation would make key, targeted reforms to the MIPS program in hopes of making it more efficient, useful and fair for all participating physicians.

The AMA is still highly concerned about the Medicare payment efficiency adjustment promulgated by CMS in the 2026 Medicare Physician Fee Schedule, and we will continue to look for opportunities to modify this policy.

In a major development, on July 15, the chairs of the GOP and Democratic Doctors Caucuses—Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC) and Kim Schrier, MD (D-WA)—along with 23 original cosponsors, introduced the [Patients First Act \(H.R. 9693\)](#), a comprehensive, bipartisan proposal to reform the Medicare physician payment system. The legislation was developed over the past year through extensive consultation with the AMA and other physician organizations. The bill addresses all four of the core reforms organized medicine has sought for more than a decade: annual inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and expanded opportunities to participate in APMs.

Most importantly, the bill establishes a permanent annual payment update tied to the MEI, built into the baseline so that Medicare payment tracks growth in the actual costs of running a practice. The legislation also incorporates the budget neutrality reforms of the “Provider Reimbursement Stability Act” (H.R. 8163/S. 5180), raising the outdated \$20 million threshold, correcting CMS utilization misestimates, and capping year-to-year conversion factor swings. In addition, the bill replaces MIPS with the new Patient Outcome Improvement National Tabulation System (POINTS); freezes the APM Qualifying Participant threshold at 50 percent; extends and increases the work Geographic Practice Cost Index (GPCI) floor benefiting rural areas and 34 entire states; and establishes a fully funded, five-year hybrid payment demonstration for independent primary care practices that is exempt from budget neutrality. On July 22, the AMA sent the sponsors a [letter of support](#) signed by AMA CEO John Whyte, MD, MPH, commending their bipartisan leadership in crafting this significant legislation and urging colleagues on both sides of the aisle to join as cosponsors.

Finally, the AMA has also kept pressure on Congress through our grassroots efforts including close to 2 million visitors to FixMedicareNow.org; over 758,000 direct contacts to Congress on Medicare Reform; over 12.3 million engagements with FixMedicareNow content; and 225+ earned media placements reaching an estimated audience of over 1+ billion.

For a more detailed look at this issue and the AMA’s efforts, please see BOT Report 20-I-26, “AMA Efforts on Medicare Payment Reform.”

Medicaid

When the OBBBA was enacted by Congress in 2025, it introduced sweeping funding cuts and policy changes to Medicaid, the Health Insurance Marketplace, Medicare physician payment and medical student loans. Over one year later, these changes have had a significant impact on many physicians and their patients’ access to care. Throughout the OBBBA debate, the AMA was vocal about the potential harms to patients. Now, we are working on multiple fronts to protect patient

1 access to affordable coverage and ensure that states and advocates have the resources they need to
2 help limit the law's impact.

3
4 The AMA is engaged in extensive advocacy relating to the implementation of new community
5 engagement requirements (or "work requirements") in Medicaid. Prior to the issuance of an interim
6 final rule (IFR) implementing the work requirements in June of 2026, the AMA engaged directly
7 with CMS officials, including Dan Brillman, the Director of the Center for Medicaid and CHIP
8 Services and the federal official responsible for implementing the OBBBA's Medicaid and CHIP
9 provisions. In March, the AMA sent a [letter](#) to Director Brillman outlining the AMA's priorities for
10 implementing work requirements (such as streamlined eligibility procedures to avoid procedural
11 disenrollments and a comprehensive and flexible definition of "medical frailty" to ensure that
12 patients are appropriately exempted from work requirements). In May, upon learning of reports that
13 the forthcoming IFR would diverge from what CMS had been leading states and other stakeholders
14 to expect in informal guidance, the AMA sent a [letter](#) to CMS, urging the agency to follow the
15 approach it had been preparing states and stakeholders for and in particular to avoid making the
16 medical frailty exemption standards too narrow. Unfortunately, the June IFR issued by CMS
17 narrowly defines medical frailty and introduces numerous other extra-statutory elements (such as a
18 requirement that individuals must be determined to be unable to comply with work requirements to
19 receive a medical frailty exemption) that are expected to lead to high numbers of procedural
20 disenrollments and an increased administrative burden for physician practices. Although the IFR is
21 effective on July 31, 2026, without any additional action by CMS, the AMA submitted a comment
22 [letter](#) describing the dire consequences of the approach taken by the IFR and recommending that
23 CMS revise the rule to prevent significant harm to the Medicaid program. The AMA is also leading
24 an [amicus brief](#) in support of a coalition of states that is seeking to enjoin the implementation of the
25 IFR. Unfortunately, the trial court sided with the Administration. Finally, the AMA is working
26 with the Federation on strategies to help physicians and patients navigate work requirement
27 policies.

28
29 The AMA also sent a comment [letter](#) urging CMS to revise a proposed rule that would restrict state
30 use of two payment mechanisms: state directed managed care payments and targeted practitioner
31 fee-for-service payments. Like the work requirements IFR, this proposed rule exceeds what is
32 mandated by Congress in the OBBBA, and threatens states' ability to operate their Medicaid
33 programs efficiently and economically while ensuring an adequate provider network and high-
34 quality care for beneficiaries, as required by statute. The AMA urged CMS to revise the rule so as
35 to align with the requirements of the OBBBA, and emphasized that the mechanisms subject to
36 restriction under the proposed rule are important tools for states to improve frequently inadequate
37 reimbursement rates for Medicaid services.

38
39 Further, the AMA is providing individualized assistance to state medical associations as they
40 collaborate with state health agencies to secure funding from the Rural Health Transformation
41 Program (RHTP). The AMA was extremely active in shaping state applications for funding and
42 continues to lead on RHTP issues.

43
44 The AMA is offering extensive educational efforts on the OBBBA's changes to Medicaid and
45 CHIP, including [webinars](#) and other live learning opportunities and the creation of numerous
46 [resources](#) covering topics from changes to Medicaid financing to exemptions from Medicaid work
47 requirements. The AMA also produced a [patient guide](#) to new Medicaid work and community
48 engagement rules which is intended as an educational resource for physician practices. States are
49 now implementing OBBBA's policy changes, and the AMA continues to work closely with state
50 and specialty medical associations to understand the state-specific impacts of OBBBA on patients
51 and physicians and offer tailored solutions that respond to individual state needs. The AMA is also

assisting state medical associations with building tools and resources, including analyses, policy options, and other advocacy resources to support state advocacy. Further, the AMA is also convening Federation partners to share information and strategies as implementation continues and coordinating with state officials and national organizations to amplify physician perspectives.

Prior Authorization

Prior authorization is a remarkable frustration for physicians due to its excessive use by insurance companies to delay or deny patient care, and its use directly correlates with poorer healthcare outcomes. According to the most [recent AMA research](#):

- Patient harm - More than one in four physicians (26 percent) reported that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.
- Poor outcomes - More than nine in 10 physicians (92 percent) reported that prior authorization has a negative impact on patient clinical outcomes.
- Delayed care - More than nine in 10 physicians (95 percent) reported that prior authorization delays access to necessary care.
- Disrupted care - More than three-fourths of physicians (79 percent) reported that patients abandon treatment due to authorization struggles with health insurers.
- Added burden - Physicians complete an average of 40 prior authorizations per week, and nearly one in three (32 percent) report that requests are often or always denied.
- Physician burnout - More than nine in 10 physicians (94 percent) say prior authorization contributes to burnout.
- Denial trend - Three-quarters of physicians (74 percent) report that denials have increased over the past five years, and six in 10 express concern that augmented intelligence (AI) may further increase denial rates.
- Diverted time and resources - Prior authorization consumes an average of 13 hours of physician and staff time each week, and two in five physicians (40 percent) employ staff dedicated exclusively to prior authorization tasks.
- Wasted health resources - More than four in five physicians (88 percent) report that prior authorization increases overall healthcare utilization, contributing to waste rather than savings. Physicians cite ineffective initial treatments (75 percent), additional office visits (73 percent), urgent or emergency care (47 percent), and hospitalizations (32 percent) as consequences of prior authorization requirements.

The House and Senate both reintroduced the “Improving Seniors’ Timely Access to Care Act of 2025” (H.R. 3514/S. 1816). This bicameral, bipartisan legislation seeks to reform prior authorization in Medicare Advantage plans by improving transparency through public reporting of program metrics and streamlining the process using standard electronic transactions. The legislation has garnered tremendous bipartisan congressional support, specifically securing 70 Senate and 284 House cosponsors, and it passed the House Ways and Means Committee on July 15, 2026, and the House Energy and Commerce Committee on July 21, 2026.

Another piece of federal legislation introduced by Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC) and Kim Schrier, MD (D-WA), (the “Medicare Advantage Improvement Act” H.R. 8375/S. 4384) is a sweeping bipartisan bill that places major restrictions on the use of prior authorization within Medicare Advantage. The bill includes more stringent timeframes for MA plans to issue final PA decisions (no less than 24 hours for emergent, no less than 72 hours for all others), widespread transparency requirements, mandates for real-time PA decisions, prohibitions

on additional prior authorizations during ongoing treatment regimens, cuts to MA plans if they do not meet quality assurance standards, expansion of the star ratings program, codification of the two-midnight rule, and network adequacy standards. This legislation is currently cosponsored by six bipartisan cosponsors. The Senate companion bill was introduced on April 27th by Senators Roger Marshall, MD (R-KS) and Sheldon Whitehouse (D-RI).

There has again been a great deal of state activity on prior authorization. States that have passed prior authorization laws this year include: Alabama, Indiana, Iowa, Kentucky, Louisiana, New Mexico, New York, South Dakota, Utah, Virginia, and Washington. Reform themes include increased transparency, volume reduction, data reporting, automation, decreasing response times, and ensuring that licensed physicians are making the medical necessity determination (including in the context of AI). The AMA's model bill serves as the basis for many state laws, and we provide states with data, analysis, talking points, issue briefs, testimony and more to advance their efforts.

The AMA is also continuing our work with national policy making organizations to encourage national attention on the issue (e.g., the AMA was instrumental in the National Council of Insurance Legislators' (NCOIL's) recent adoption of a PA model bill and worked at the National Association of Insurance Commissioners (NAIC) on their recent PA white paper). This year, two NAIC committees are addressing the issue of prior authorization/utilization management, and we are already engaged there, including an upcoming presentation on prior authorization to the Health Innovations Workgroup in August.

Further, in response to growing concerns about the use of AI in PA and other utilization management processes, several states have recently enacted legislation to establish clearer safeguards, transparency requirements, and oversight mechanisms. These laws vary in scope but share a common emphasis: AI must not replace licensed clinicians in determining medical necessity, and AI tools must be deployed in a transparent, auditable, and nondiscriminatory manner. States that have adopted AI-related legislation in this space include Alabama, Arizona, California, Colorado, Illinois, Indiana, Iowa, Maryland, Minnesota, Nebraska, Texas, Utah, and Washington.

Reports have documented health plans using AI to deny, delay, or prematurely end coverage for medically necessary care, including post-acute and rehabilitation services, even when a physician recommends continued treatment. Patients may be forced to wait, navigate lengthy appeals, pay out of pocket, or forgo care. These harms necessitate enforceable federal safeguards requiring disclosure of AI use, independent validation and auditing, and individualized review of adverse decisions by a qualified physician. Health plans must be held accountable when AI coverage harms patients.

In addition to state legislative activity, national policymaking organizations are also advancing state AI regulatory efforts. For example, NAIC issued a model bulletin which reminds all insurance plans, including health insurance plans, that decisions or actions impacting consumers that were made or supported by AI tools must comply with applicable insurance laws and regulations. As of June 2026, 25 jurisdictions had adopted NAIC's model bulletin and four jurisdictions had adopted insurance-specific regulations or guidance.

Federal agencies have also begun to scrutinize the use of AI by health plans, though clear regulatory guidance is still emerging. In February 2024, CMS clarified that MA organizations may use AI and related technologies to assist in making coverage determinations, provided the tools do not override standards related to medical necessity or established MA plan coverage rules. In its final rule for Calendar Year 2026, CMS declined to adopt new AI-specific provisions for MA but

acknowledged the broad interest in AI and affirmed its intent to revisit the subject in future rulemaking. Finally, in January 2026, CMS launched a new model—the Wasteful and Inappropriate Service Reduction (WISeR) Model—a six-year pilot in six states that uses AI and third-party technology contractors to conduct prior authorization review for select Medicare services. The AMA raised serious concerns regarding the WISeR model when it was announced and has been continually working with CMMI to improve and refine the program to minimize patient care delays and physician practice burdens.

Federal legislation was recently introduced that would curb the use of AI by MA plans. H.R. 9734, the “Protecting Patients from Automated Denials Act,” would require MA plans to provide their qualified physician reviewers’ attestations to providers requesting PA, allow direct communication with the reviewing physician, disclose AI usage, retain all AI-related denial records for at least 10 years, and submit detailed reports to HHS every 90 days. The AMA strongly supports passage of this bill.

Scope of Practice

The best care and safest outcomes for patients depend on healthcare teams working together—with physicians in the lead. However, every year we see an increasing number of legislative efforts, especially at the state level, that try to inappropriately expand the scope of practice of non-physicians. This year is no different. The AMA Scope of Practice Partnership (SOPP), a coalition of 113 national, state and specialty medical and osteopathic associations, has been instrumental in defeating scope expansion bills across the U.S. Since 2007, the SOPP has awarded more than \$5.7 million in grants to its members to fund advocacy tools and campaigns. In January, the AMA announced a commitment of \$1 million annually to support the work of the SOPP, beginning in 2026. The SOPP has awarded 19 grants for 2026 to the following states: Arizona, California, Delaware, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maryland (MedChi), Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, South Carolina, and Tennessee. Of note, Arizona, Delaware, and Kentucky received grants for the 2025-2026 legislative sessions.

So far in 2026, the AMA, in collaboration with the SOPP, has successfully blocked over 70 proposed bills in 40 states that would have inappropriately expanded the scope of practice for physician assistants, optometrists, pharmacists and more. State efforts include:

- Idaho: With the help of a Scope of Practice Partnership (SOPP) grant, the Idaho Medical Association defeated physician assistant independent practice legislation and a bill that would have granted lay midwives broad authority to administer prescription drugs.
- Indiana: The Indiana State Medical Association delivered an important victory by defeating an advanced practice registered nurse independent practice bill.
- New Hampshire: The New Hampshire Medical Society scored a major win by securing a veto of an optometry surgery bill.
- Tennessee: Thanks to diligent advocacy and an SOPP grant, the Tennessee Medical Association was able to stop nurse practitioner and physician assistant independent practice bills, pharmacist test and treat legislation, and a psychologist prescribing bill.
- Washington: The Washington State Medical Association successfully defeated multiple scope bills this year including psychologist and naturopath prescribing legislation, as well as legislation that would have granted pharmacists the authority to diagnose and prescribe.

- 1 • West Virginia: The West Virginia State Medical Association successfully protected physician-
- 2 led care by defeating physician assistant and nurse practitioner independent practice bills and a
- 3 naturopath licensure bill.
- 4 • Wisconsin: With the help of an SOPP grant, the Wisconsin Medical Society secured a decisive
- 5 win by defeating legislation that would have removed physician supervision of physician
- 6 assistants and permitted them to change their title to “physician associate.” It was also
- 7 successful in defeating pharmacist and audiologist scope expansion legislation.
- 8

9 At the federal level, we achieved a major victory earlier this year with the passage of the
 10 “Consolidated Appropriations Act of 2026” which did not include the “Equitable Community
 11 Access to Pharmacist Services Act,” (ECAPS) which would have expanded pharmacists’ scope of
 12 practice. This bill is still a threat and under consideration, so the AMA will continue our opposition
 13 at each stage.

14
 15 The AMA, through the Litigation Center, continued to be active in the courts supporting physicians
 16 on scope of practice issues.

- 17
- 18 • In June 2026, the Litigation Center, the Wisconsin Medical Society, the American Academy of
- 19 Ophthalmology, and the Wisconsin Academy of Ophthalmology filed a lawsuit in Wisconsin
- 20 state court seeking a declaratory judgment and injunction that would prohibit Wisconsin
- 21 optometrists from performing laser eye surgery.
- 22 • In February 2026, the Litigation Center joined the California Medical Association in an amicus
- 23 brief in the case *Palmer v. Bonta*, which involves a California statute prohibiting nonphysicians
- 24 from publicly representing that they are “doctors.” The case is pending in the federal Ninth
- 25 Circuit Court of Appeals following a favorable decision in the district court.
- 26 • In November 2025, a West Virginia trial court struck down a West Virginia Optometry Board
- 27 regulation, which had authorized state optometrists to perform eyelid surgery. The Litigation
- 28 Center provided financial support for the case.
- 29

30 *Physician Well-Being*

31
 32 Physicians, residents and medical students should be able to seek and receive care for mental health
 33 or substance use without fear of stigma and with full confidentiality protections. The AMA
 34 strongly urges all licensing boards, hospitals, health systems, liability carriers and credentialing
 35 bodies to remove from their applications inappropriate questions about mental health and treatment
 36 for a substance use disorder that create unnecessary barriers to care. Success on this issue has been
 37 due to a vibrant collaboration among the AMA, the Dr. Lorna Breen Heroes’ Foundation, the
 38 Federation of State Medical Boards, the Federation of State Physician Health Programs, the
 39 National Association of Medical Staff Services, and all the other organizations that helped to make
 40 positive changes a reality.

41
 42 Nearly 200 health systems have taken their commitment to physician well-being even further and
 43 earned recognition in the AMA Joy in Medicine® Health System Recognition Program.
 44 As of May 2026, 44 state medical licensing boards and 3,300+ health systems, hospitals, medical
 45 centers, clinics and other care facilities have so far taken action to improve their licensing or
 46 credentialing applications and ensure that they are free from stigmatizing language and intrusive
 47 questions about past mental healthcare or substance use disorder treatment. This advocacy has
 48 benefitted more than 3.35 million physicians and other healthcare professionals. AMA advocacy
 49 and policy have been part of nearly every one of these efforts.

Shaping the Future of Digital Health and AI

In October of last year, the AMA announced the creation of the AMA Center for Digital Health and AI, a new endeavor that will put physicians at the center of shaping, guiding and implementing technologies transforming medicine. The Center for Digital Health and AI focuses on policy and regulatory leadership; clinical workflow integration; education and training; and collaboration and partnerships.

The AMA recently conducted a [survey](#) of physicians to capture the sentiment of practicing physicians regarding the increased usage of AI in healthcare, and the results are exciting, but also should serve as a bit of a warning to developers and regulators. Four in 10 physicians are equally excited and concerned about AI applications in healthcare and how it may impact the patient-physician relationship. About 70 percent recognize AI's potential to support diagnoses and improve workflow efficiency. Physicians' top concerns about AI are that if it is not designed and implemented correctly, it has enormous potential to negatively impact and, in fact undermine the patient-physician relationship.

In April, the AMA sent letters to key congressional caucuses focused on AI and digital health and pointed to growing concerns following reports of chatbots encouraging self-harm or suicide among vulnerable individuals. The issues were among those raised in prior congressional hearings that highlighted risks such as emotional reliance on AI, distorted perceptions of reality from prolonged use, and the absence of consistent safety standards.

In our message, we emphasized that AI tools have the potential to play a meaningful role in addressing gaps in mental healthcare access, particularly where cost and availability limit support. When designed responsibly, these technologies could help expand access to reliable information, identify early signs of mental health issues, and connect patients with appropriate care, while supporting clinicians and easing workforce shortages.

Responding to the escalating risk of AI-manipulated images, videos and audio that impersonate physicians, the AMA in April announced a new comprehensive policy [framework](#) to establish clear, enforceable protections for physicians against unauthorized AI-generated "deepfakes." In May, the AMA sent a letter of support to the [House](#) and [Senate](#) supporting the "NO FAKES Act," which would prohibit creation and dissemination of deepfakes of individuals and is partnering with interested stakeholders across several industries to urge passage. The AMA will continue to advocate for either broad or physician-specific deepfake protections.

The AMA continues to work with state medical associations and track state legislative efforts related to AI in healthcare, sharing issue briefs, data, and reviewing regulatory and legislative language to ensure it aligns with AMA Policy.

Vaccine Policy

In response to threats to undermine sound vaccine policy, the AMA announced in February that it is collaborating with the Vaccine Integrity Project and national medical specialty societies to launch an evidence-based review process to assess vaccine safety and effectiveness for the 2026–27 respiratory virus season. The review will focus on immunizations for influenza, COVID-19, and respiratory syncytial virus (RSV). The AMA has also been outspoken about other changes and potential changes to various vaccine protocols.

- The AMA issued a [statement](#) on changes to the childhood vaccine schedule.
- The AMA issued a [statement](#) on the Advisory Committee on Immunization Practices (ACIP) chair's comments on polio, routine vaccinations.
- The AMA further [joined](#) 130+ medical, nursing, public health and patient groups expressing deep concern regarding the significantly revised ACIP charter.
- The AMA issued a [statement](#) on the Executive Order directing CDC to assess the childhood vaccine schedule noting that there is no credible scientific evidence to support changing the current childhood vaccine schedule.
- The AMA joined a 2025 [amicus brief](#) (PDF) in the case of *AAP vs. Kennedy* calling for government recommendations regarding the COVID-19 vaccine to reflect the full body of medical evidence and to follow the statutory process for the provision of vaccine guidance.
- The AMA issued a [statement](#) on the federal court vaccine ruling calling it an important step toward protecting the health of Americans, particularly children.
- The AMA also issued a [statement](#) on August 10, 2026, in response to the Executive Order changing the childhood vaccine schedule. AMA President Willie Underwood III, MD, MSc, MPH stated in part, "Decisions about how and when vaccines are used should be driven by rigorous scientific evidence, patient safety, and independent medical and public health expertise. Altering a proven vaccination schedule without credible evidence risks weakening public confidence and putting children's health at risk."

Reproductive Health

The AMA remains deeply engaged in advocacy to protect access to reproductive healthcare and preserve the patient-physician relationship amid ongoing legislative and legal challenges. Across the states, the reproductive health policy landscape remains highly active. In August, the Massachusetts governor signed legislation removing restrictions on abortions after 24 weeks and replacing the prior framework with language allowing physicians to exercise their professional judgment. At the same time, harmful proposals continue to emerge: in 2026, eight states introduced bills explicitly criminalizing a pregnant individual for obtaining an abortion, though none have been enacted. States have also continued to legislate in related areas, including efforts to distinguish abortion care from pregnancy loss care, as reflected in South Dakota's newly enacted law excluding care for pregnancy loss from the definition of abortion.

States are also taking divergent approaches to medication abortion, shield laws, and broader reproductive rights protections. Several states introduced bills criminalizing the sale, purchase, or distribution of medication abortion; four have been enacted in Iowa, Mississippi, Oklahoma, and South Dakota. By contrast, Hawaii and Oregon expanded existing shield law protections in 2026, with Oregon's H.B. 4088 adding extradition protections and limiting information-sharing with federal officials regarding protected healthcare. Since *Dobbs*, ballot initiatives have remained a key avenue for protecting access to care. Voters in Idaho, Nevada, and Virginia are set to consider abortion-related measures in November 2026, while Missouri voters will consider whether to repeal the constitutional abortion protections adopted in 2024. A similar measure remains pending in Colorado. Protections for contraception have also advanced, with nine bills enacted across Georgia, Maryland, South Carolina, and Virginia, including Virginia's new right-to-contraception law.

Against this backdrop, the AMA has continued to prioritize reproductive health as a core advocacy issue and to devote significant resources to supporting physicians, trainees, and patients navigating abortion bans and restrictions. Through AMA-led work, informed by the Task Force to Preserve the Patient-Physician Relationship, the AMA has developed practical resources addressing legal

considerations, clinical care, practice management, medical education, physician well-being, and patient support. This includes the [Reproductive Health Resource Navigator](#), a public-facing hub containing more than 300 resources for physicians navigating abortion bans and restrictions, including materials related to EMTALA, legal representation, and physician well-being. The AMA has also continued to advance operational and advocacy efforts to protect access to care, including research on the impact of abortion restrictions on the physician workforce; collaboration to expand legal assistance and state law guidance for physicians; support for institution-level guidance on pregnancy-related medical emergencies in restrictive states; and engagement with prosecutors to reduce the risk of criminalization for physicians providing medically necessary care. In addition, the AMA has supported residents and medical students affected by abortion bans through funding for out-of-state abortion training and resources addressing moral distress and learner well-being. Together, this work reflects the AMA's sustained commitment to reproductive health advocacy and its continued prioritization of policies and resources that protect patients, support physicians, and preserve evidence-based medical care.

Immigration Policy

Non-U.S. citizen international medical graduate (IMG) physicians, residents and fellows play a critical role in helping to alleviate the physician shortage by providing healthcare to many Americans, especially in communities in need as they tend to choose primary care specialties and work in areas of the country with higher rates of poverty. The AMA continues to push back on restrictions that hinder care provided by these physicians, residents, and fellows.

- On March 10, 2026, the AMA [sent a letter](#) to HHS concerning the U.S. Exchange Visitor Program.
- On April 13, 2026, the AMA [sent a letter](#) strongly supporting H.R. 7961, the "H-1Bs for Physicians and the Healthcare Workforce Act." This legislation would exempt physicians and healthcare workers involved in direct patient care from the \$100,000 fee implemented by the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers."
- On Feb. 27, 2026, the AMA [sent a letter](#) to the U.S. Department of Homeland Security and the U.S. Department of State urging the exemption of physicians from the partial and complete suspension of entry into the U.S., as indicated in Proclamation 10998 entitled "Restricting and Limiting the Entry of Foreign Nationals to Protect the Security of the United States."
- On April 15, 2026, the AMA [signed onto a letter](#) in support of the "H-1Bs for Physicians and the Healthcare Workforce Act" (H.R. 7961). This bipartisan legislation would exempt physicians and other health professionals from the \$100,000 H-1B fee.
- On May 26, 2026, the AMA [sent a letter](#) commenting to the U.S. Department of Labor (DOL) on DOL Docket No. ETA-2026-0001: Improving Wage Protections for the Temporary and Permanent Employment of Certain Foreign Nationals in the United States. By significantly raising prevailing wage floors, the proposed rule would make it more difficult for many employers to sponsor H-1B physicians, especially in underserved areas.
- On June 1, 2026, the AMA [sent a letter](#) to the Department of State advocating for International Medical Graduates that have matched into accredited U.S. residency and fellowship training programs for the upcoming academic year to have their visa applications processed in a timely manner so that they can begin their residency training by July 1.
- On June 22, 2026, the AMA [signed onto a letter](#) regarding barriers preventing internationally-born physicians and international medical graduates (IMGs), including medical students, resident physicians, researchers, fellows, and practicing physicians, from entering the United States or remaining lawfully in the country to continue their training and practice.

Payer Issues

The AMA has been fighting Elevance's "Facility Administrative Policy" which disincentivizes hospitals if out-of-network physicians are used for non-emergent procedures. This is a clear attempt to circumvent the "No Surprises Act" (NSA). The AMA has engaged directly with Anthem on this policy and supported successful state legislative efforts in Indiana and Iowa. The AMA has also raised this problematic policy to federal lawmakers for their review. Advocacy is working closely with colleagues in our Litigation Center to explore options for litigation as well.

The AMA is also actively engaging members of Congress and their staff for enactment of "No Surprises Act Enforcement Act." One of our recent tools to keep the issue front and center was a sign-on letter to sponsors with every state medical association and dozens of specialties. While the NSA is working, it needs stronger enforcement around it.

Meanwhile, there have been significant regulatory wins on NSA implementation. The Departments of Health and Human Services, Labor and the Treasury ("the Departments"), and the Office of Personnel Management recently issued the Independent Dispute Resolution Operations final rule. The proposed rule was published in November of 2023, and the AMA submitted detailed comments on the proposed rule in early January 2024. Broadly, the final rule is positive for physicians and looks to streamline the entire dispute process, require more information to be provided to physicians along the way, formalize the open negotiations process and create some accountability for plans to participate, and reduce the costs associated with participating in the process. It is worth noting a generally positive tone in the final rule toward physicians and other providers, and an attempt to recognize and address the asks and concerns the AMA and other physician groups brought to the Departments in our comments on the proposed rule. The final rule reflects many of the AMA's asks in our comments on the proposed rule including:

- Requires plans to use claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) on paper or electronic remittance advice in response to a claim for payment for healthcare items or services furnished by an entity with which it does not have a direct or indirect contractual relationship.
- Requires more information to be disclosed in the initial payment or notice of denial of payment.
- Streamlines the efficiency and increases the formality of the Open Negotiation process by placing the initiation and response in the federal IDR portal.
- Requires plans and issuers to register in a new Federal IDR portal so that their information is available to physicians and other parties.
- Allows for more flexibility in batching items or services into a single dispute, including extending the number of allowed line items from 25 to 50.
- Reduces the administrative fee from \$115 to \$15.
- Shortens the "cooling off period" for batched disputes from 90 business days to 30 business days.

Most recently, on July 17, 2026, the Departments issued guidance on the use of RARC as required in the new rules, requiring the use of specific RARC by January 1, 2027.

The AMA is also working to limit insurer downcoding practices, including and especially related to automated downcoding programs. The AMA authored model legislation, and 10 states introduced bills on this issue this year. Three states enacted new laws including Indiana, Illinois, and Virginia. Additionally, the Maryland Insurance Administration (MIA) recently determined that Cigna

improperly “downcoded” evaluation and management (E/M) claims submitted by physicians, reducing reimbursement levels in violation of Maryland’s insurance statutes governing claim payment and processing. The MIA imposed an administrative penalty on Cigna and ordered that health plans stop the practice. The AMA is also working with congressional offices to see a federal bill introduced.

Maternal Health

As discussed earlier in the report, the AMA was very encouraged that H.R. 7148 was enacted and included the “PREEMIE Reauthorization Act.” This section of H.R. 7148 will expand federal research on preterm birth and improve outcomes for premature infants. It also reauthorizes the “Preventing Maternal Deaths Act,” increases authorized funding to \$100 million annually through 2030, expands the scope of state maternal mortality review committees, and directs federal agencies to more regularly disseminate best practices.

The AMA is also pleased that CMS adopted AMA’s recommendations in a proposed rule to update the Maternity Care Services code set. Beginning January 1, 2027, the CPT code set will be updated to comprehensively revise the maternity codes, reflecting modern obstetric practice. The new code set will provide much needed transparency for patients, and the increased granularity will improve the ability of physicians and researchers to better understand the drivers of maternal mortality. The AMA is not supportive of CMS’ solicitation for comments on maintaining current coding through the creation of HCPCS G-codes. This proposal will unfortunately create confusion for care teams. The AMA is urging CMS to finalize the Maternity Care Services CPT code set without maintaining the historical global structure via HCPCS G-codes.

Other pieces of legislation that the AMA supports in this Congress related to maternal health include:

- On March 4, 2025, [the AMA supported](#) the Preeclampsia Foundation in the “Still at Risk” postpartum hypertension awareness and action wristband initiative. This public-private partnership is focused on improving postpartum health outcomes through the creation, promotion, dissemination, and impact measurement of wristbands for postpartum women at risk of developing hypertension.
- The AMA signed into two letters ([Letter One](#); [Letter Two](#)) requesting level funding of \$2 million to support the continued implementation of the Stillbirth Working Group’s recommendations under the Office of the Secretary of Health and Human Services.
- On July 22, 2026, the bipartisan Rural Obstetrics Readiness Act (S. 380) advanced out of the Senate Health, Education, Labor, and Pensions (HELP) Committee with a 22-1 vote, moving to the full Senate floor. The [AMA supports](#) this important piece of legislation.

State Accelerator Grants

The AMA State Advocacy Accelerator Grant Program, initiated in January 2026, provides targeted, high-impact funding to state medical associations to help them “cross the finish line” on key state legislative and regulatory priorities. Modeled after the highly successful Scope of Practice Partnership (SOPP) grant program, this project will help state medical associations leverage national AMA expertise and resources at a pivotal moment in time for their specific state advocacy campaigns.

As of July 2026, 16 grants have been awarded totaling close to \$600,000 in funding to cover issues aligned with AMA policy and state level priorities, including downcoding, out of network issues,

1 and prior authorization; physician wellness/creation of a physician health program; medical
2 liability reform; and noncompete clause-related issues. States that have received a grant include
3 Alaska, Georgia, Illinois, Iowa, Louisiana, Massachusetts, Michigan, Missouri, New Mexico,
4 Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, and Wisconsin.

5 6 AMA ADVOCACY ONGOING UPDATES AND MEETINGS

7
8 The AMA offers [several ways to stay up to date on our advocacy efforts](#), and we urge the HOD to
9 avail themselves of all of them to stay informed and advance our grassroots efforts:

- 10
11 • Please [sign up for AMA Advocacy Update](#) a weekly newsletter that provides updates on AMA
12 legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on
13 the email list, but if you are not receiving AMA Advocacy Update, please subscribe and
14 encourage your colleagues to do so as well. Subscribers can read stories from previous editions
15 [here](#).
16 • [Join the Physicians Grassroots Network](#) for updates on AMA calls to action on federal
17 legislative issues. And if you have connections with members of Congress, or are interested in
18 developing one, the [Very Influential Physician \(VIP\) program](#) can help grow these
19 relationships.
20 • Connect with the Physicians Grassroots Network on [Facebook](#), [X](#), and [Instagram](#). Connect
21 with the AMA on [Facebook](#), [X](#), [Instagram](#), [LinkedIn](#), [TikTok](#), [BlueSky](#) and [YouTube](#).
22

23 The AMA also encourages HOD members to attend the [State Advocacy Summit](#) and [National](#)
24 [Advocacy Conference](#). The 2027 State Advocacy Summit will take place on Jan. 7-9 at the
25 Terranea Resort in Rancho Palos Verdes, California. The 2027 National Advocacy Conference will
26 occur on Feb. 22-24 at the Mayflower Hotel in Washington, DC.
27

28 Finally, please consider contributing to [AMPAC](#) as another way to engage in AMA advocacy
29 efforts.
30

31 CONCLUSION

32
33 The AMA continues to fight for physicians and patients on the most important healthcare issues.
34 Along with the Federation, we have achieved important victories in the first half of 2026, but much
35 work needs to be done. Grassroots involvement is key, and we urge the HOD to continue its
36 important work in their home states and districts as our advocacy continues.

REPORT 20 OF THE BOARD OF TRUSTEES (I-26)
AMA Efforts on Medicare Payment Reform

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-385.945, “Advocacy and Action for a Sustainable Medical Care System,” and amended Policy D-390.922, “Physician Payment Reform and Equity,” together declaring Medicare physician payment reform an urgent priority and directing the Board of Trustees to report at each Annual and Interim Meeting on the progress of that work until a predictable, sustainable, and fair payment system is achieved. At the 2025 Annual Meeting the House further adopted Policy D-400.981, “Increasing Transparency of AMA Medicare Payment Reform Strategy,” calling for regular reporting to members on advocacy barriers, strategy gaps, and recommendations for improvement. This report is responsive to those directives and covers activity for the year to date.

Physicians continue to face structural instability under the current Medicare payment system. The CY 2025 fee schedule finalized a 2.83 percent cut, and while Congress provided a temporary 2.5 percent update for 2026, that patch left the underlying flaws unresolved. Statutory Medicare Access and CHIP Reauthorization Act (MACRA) updates are not tied to inflation, and Medicare physician payment has declined approximately 33 percent since 2001 when adjusted for practice cost inflation. The pressure falls hardest on small, rural, and independent practices, where continued instability threatens access to care for the seniors and patients with disabilities they serve. Fixing this system remains one of the AMA's highest legislative priorities.

Since the previous report, that sustained work culminated in the July 15, 2026, introduction of the Patients First Act, H.R. 9693, comprehensive bipartisan legislation developed with extensive AMA consultation that reflects the AMA-developed Characteristics of a Rational Medicare Physician Payment System and addresses each of the four core reforms organized medicine has sought for more than a decade. Its introduction was preceded by momentum-building steps earlier in 2026, including unanimous Ways and Means approval of budget neutrality reform in H.R. 8163, introduction of targeted Merit-based Incentive Payment System (MIPS) reform in H.R. 8622, and a series of Energy and Commerce hearings at which the AMA testified. The AMA also engaged MedPAC as the Commission moved toward recommending a permanent update formula approximating the one established in Title I of the bill.

The AMA will continue to advance this work across its four advocacy pillars of legislative advocacy, regulatory advocacy, Federation engagement, and grassroots and public outreach, with its immediate priority the enactment of a permanent, Medicare Economic Index (MEI)-based payment update through H.R. 9693 and the securing of a positive physician payment update for 2027 as broader structural reforms advance. The AMA will continue to coordinate closely with state medical associations and national specialty societies to demonstrate unified physician support, sustain the Fix Medicare Now campaign and its grassroots networks to keep the issue before Congress and the public, and press Centers for Medicare & Medicaid Services (CMS), the Administration, and MedPAC to close the widening gap between physician payment and the cost of delivering care. The AMA will continue to report on this progress until a sustainable, fair, and effective Medicare physician payment system is achieved.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 20-I-26

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Toluwalasé A. Ajayi, MD, Chair

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-385.945, “Advocacy and Action for a Sustainable Medical Care System” and amended Policy D-390.922, “Physician Payment Reform and Equity.” Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. In addition, the House adopted Policy D-400.981 “Increasing Transparency of AMA Medicare Payment Reform Strategy” at the Annual 2025 House of Delegates Meeting, which calls on the AMA to:

1. 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. 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.

The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in advance based on approval deadlines and more recent developments may not be reflected herein.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA’s Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the [“Characteristics of a Rational Medicare Payment System”](#) which were endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and

- Greater opportunities for physician practices that want to transition to advanced alternative payment models (APMs).

The AMA's unwavering commitment to reforming the Medicare physician payment system is reflected in four central actions that support our strategic approach: legislative advocacy; regulatory advocacy; Federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our Federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

Physicians continue to face significant financial instability under the current Medicare physician payment system. The calendar year (CY) 2025 Medicare Physician Fee Schedule finalized a 2.83 percent reduction in physician payment rates, continuing a pattern of recurring cuts that has persisted for several years. In response to sustained advocacy from the AMA, Federation partners, and the broader physician community, Congress included a provision in the One Big Beautiful Bill Act (OBBBA) providing a 2.5 percent Medicare physician update for 2026 to partially mitigate these reductions. While this action provided temporary relief, it addressed only a portion of the cut and did not resolve the structural flaws that continue to destabilize Medicare physician payment.

The AMA also remains concerned about the Medicare payment efficiency adjustment promulgated by CMS in the CY 2026 Medicare Physician Fee Schedule, which reduced work relative value units for most services and offset a portion of the update Congress provided. H.R. 7520, the "Efficiency Adjustment Delay Act," was introduced to delay implementation of the efficiency adjustment until January 1, 2030. However, the legislation faces significant headwinds: it is opposed by primary care organizations, lacks the support of the chairs or ranking members of the relevant committees of jurisdiction, and the Administration has communicated its opposition to House leadership. As a result, the legislation faces substantial obstacles to advancement in Congress. The AMA will continue to monitor the issue and look for alternative opportunities to address the impact of the efficiency adjustment on physician payment.

Beginning in 2026, statutory updates of 0.25 percent for most physicians and 0.75 percent for qualifying participants in advanced alternative payment models take effect under the Medicare Access and CHIP Reauthorization Act (MACRA), but these updates are not tied to inflation and fall far short of projected increases in practice costs. CMS estimates that the MEI, which measures changes in physician practice costs, will increase by 2.7 percent in 2026, further widening the gap between payment and the cost of delivering care. As a result, Medicare physician payments have effectively declined by approximately 33 percent since 2001 when adjusted for inflation in practice costs.

During this period, physician practices have experienced significant increases in expenses related to staffing, technology, regulatory compliance, and facility costs. This growing imbalance is placing increasing pressure on physician practices across the country. Small, rural, and independent

practices are particularly vulnerable to continued payment instability. When practices are forced to close, consolidate, or limit the number of Medicare patients they can treat, access to care is threatened for millions of seniors and patients with disabilities. Expanding the physician workforce alone will not solve these access challenges if newly trained physicians enter a Medicare system that remains financially unsustainable.

Fixing the broken Medicare physician payment system therefore remains one of the AMA's highest legislative priorities. The AMA continues to work closely with congressional leaders and Federation partners to move beyond the annual cycle of payment cuts and temporary patches and instead enact durable structural reforms that stabilize physician payment and support patient access to care. As detailed below, that sustained work culminated during this reporting period in the introduction of comprehensive, bipartisan reform legislation reflecting the AMA-developed framework—Characteristics of a Rational Medicare Physician Payment System.

Introduction of the "Patients First Act" (H.R. 9693)

On July 15, 2026, the bipartisan chairs of the GOP and Democratic Doctors Caucuses—Representatives John Joyce, MD (R-PA), Greg Murphy, MD (R-NC), and Kim Schrier, MD (D-WA)—introduced **H.R. 9693, the "Patients First Act,"** a comprehensive proposal to reform MACRA and the Medicare physician payment system. Over the past year, physician members of Congress met on a bipartisan basis to develop the legislation, consulting extensively with the AMA and other physician organizations throughout the drafting process. The resulting bill addresses each of the four core reforms—permanent inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and expanded opportunities for participation in alternative payment models—the AMA and organized medicine have sought for more than a decade and aligns squarely with the Characteristics of a Rational Medicare Physician Payment System. Introduction of the bill was preceded by several momentum-building developments earlier in 2026—including unanimous committee approval of budget neutrality reform legislation, introduction of targeted MIPS reform legislation, and a series of congressional hearings examining the physician payment system—described further below.

Title I of the legislation establishes, for the first time, a permanent annual Medicare physician payment update linked to the MEI and built into the baseline. Beginning in 2027, annual updates would be set at MEI minus 1 percentage point for most physicians and MEI minus 0.5 percentage points for Qualifying Participants in APMs, with a statutory floor of 25 percent of MEI ensuring the update remains positive even in low-inflation years. The practical impact is substantial: under current law, the cumulative update for most physicians from 2026 to 2036 would be essentially flat—just 0.03 percent—while under the Patients First Act it would grow by 7.7 percent, with a comparable improvement for physicians in APMs (5.1 percent under current law versus 13.1 percent under the bill). Title I also extends the 1.00 work geographic practice cost index (GPCI) floor through 2031 and increases it to 1.025, benefiting physicians in many rural areas, while providing a 2.0 percent work GPCI increase for all other localities. In addition, the bill establishes a five-year hybrid payment demonstration for independent primary care practices that is funded entirely with new money and explicitly exempt from budget neutrality, so it will not reduce payments for any other specialty.

Title II replaces MIPS, over a five-year transition, with the Patient Outcome Improvement National Tabulation System (POINTS), a quality measurement program driven by physicians and specialty societies rather than the government. POINTS sharply reduces maximum penalties—to 2 percent annually during the transition and 5 percent thereafter, down from the +/- 9 percent adjustments under MIPS—and eliminates the Promoting Interoperability category. A clinician-majority Quality

Care Reform Task Force will recommend all measures used in the program, with guaranteed representation for the relevant specialty and subspecialty societies. A new Care Efficiency category will, for the first time, give physicians credit for the Medicare savings they generate by preventing avoidable hospitalizations and complications of chronic disease. The bill also creates a bonus performance program reserved for independent physicians and small practices, prohibits penalties for any performance year in which physicians have not received timely quarterly feedback reports, and establishes a reporting pathway for clinician-led clinical data registries operated by physician professional societies.

Title III lowers barriers to APM participation by freezing the Qualifying Participant threshold at 50 percent for three years rather than the 75 percent required under MACRA, authorizing the Secretary to set lower thresholds, and requiring GAO and MedPAC reports on the barriers specialists face in joining APMs. Title IV incorporates the budget neutrality reforms of H.R. 8163, the “Provider Reimbursement Stability Act,” discussed further below.

On the day of introduction, the AMA issued a national press release, attributable to AMA President Willie Underwood III, MD, MSc, MPH, commending the bipartisan leadership of the GOP and Democratic Doctors Caucuses for proposing solutions to stabilize physician payment and protect access to care. On July 22, 2026, the AMA transmitted a formal letter of support to the sponsors, urging members on both sides of the aisle to join as cosponsors and pledging to work closely with Congress to advance the bill through the legislative process. The AMA also distributed the legislative text, a section-by-section summary, a comparison of the bill to the Characteristics of a Rational Medicare Physician Payment System, and supporting payment analyses to state medical associations. Throughout the year, the AMA also conducted a series of in-person and virtual meetings with the Washington-based government affairs staff of national medical specialty societies, as well as individual meetings with specialty society staff, to discuss the developing legislation, address specialty-specific questions, and build support for reform. In addition, the AMA facilitated two virtual meetings with the bipartisan Doctors Caucus staff and the state medical associations: the first on March 26, 2026, when the Doctors Caucuses released an outline of their proposal, and the second on July 24, 2026, following introduction of the bill, to explain the legislation and answer questions.

Medicare Payment Reform: Budget Neutrality and H.R. 8163

The AMA continues to advocate for modernization of Medicare’s budget neutrality requirements to prevent destabilizing payment reductions that occur when services are revalued or new services are added to the physician fee schedule. In May 2026, the AMA sent a letter of strong support for **H.R. 8163, “the Provider Reimbursement Stability Act,”** introduced by Representatives Greg Murphy, MD (R-NC) and Tom Suozzi (D-NY). The legislation raises the outdated \$20 million budget neutrality threshold to \$57.64 million in 2028 with regular indexing to the MEI thereafter; creates a correction process requiring CMS to reconcile utilization misestimates so physicians are no longer penalized indefinitely for estimation errors unrelated to the care they provide; requires regular updates to the direct cost inputs underlying practice expense values in consultation with physician specialty societies; and caps year-to-year conversion factor variance at 2.5 percent to prevent large, destabilizing swings in payment. H.R. 8163 was introduced with a strong contingent of members of the House committees of jurisdiction and has attracted 73 bipartisan cosponsors (49 Democrats and 24 Republicans). On May 21, 2026, the legislation passed the full House Ways and Means Committee unanimously by a vote of 44-0, demonstrating the breadth of bipartisan support for budget neutrality reform. These provisions were subsequently incorporated in their entirety as Title IV of the “Patients First Act.” AMA advocacy staff also continue to work with a bipartisan group of Senators on companion budget neutrality reform legislation in the Senate.

Medicare Payment Reform: MIPS Reform and H.R. 8622

On April 30, 2026, Representatives Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ), two bipartisan physician leaders in the House, introduced **H.R. 8622, the “Medicare Physician Data-driven Performance Payment System Act of 2026,”** targeted legislation to reform MIPS developed with close AMA engagement. The GOP and Democratic Doctors Caucuses subsequently incorporated key elements of H.R. 8622 into their comprehensive Medicare reform package, the “Patients First Act,” including the prohibition on CMS assessing penalties when it fails to provide timely quality feedback reports to practices and the reduction of the maximum penalty for practices unable to comply with reporting requirements from 9 percent to 2 percent. Together with the unanimous committee approval of H.R. 8163, the introduction of H.R. 8622 helped build the bipartisan momentum that culminated in the introduction of the “Patients First Act.”

Energy and Commerce Hearings on Healthcare Affordability

The AMA also took advantage of a series of hearings conducted by the House Energy and Commerce Subcommittee on Health on healthcare affordability to further its Medicare physician payment reform agenda and set the stage for the comprehensive Medicare reform bill being developed by the Republican and Democratic physician caucuses with the AMA’s assistance. For the first hearing in February 2026, on the health insurer landscape, the AMA shared its 2025 Update to Competition in Health Insurance: A Comprehensive Study of U.S. Markets with the Subcommittee and worked directly with subcommittee members to ensure that Medicare physician payment reform questions were asked at the hearing. This engagement led to the AMA being asked to testify at the second hearing, held on March 17, 2026, entitled Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape. Then-AMA Board Chair David H. Aizuss, MD, testified on the AMA’s behalf regarding the financial pressures facing physician practices and the need for Medicare physician payment reform. The March hearing set the stage for a third hearing in May focused specifically on examining the Medicare Physician Fee Schedule, MACRA, and opportunities for payment reform.

119th Congress AMA Advocacy Highlights

In early 2025, Representatives Greg Murphy, MD, (R-NC) and Jimmy Panetta (D-CA) introduced **H.R. 879, the “Medicare Patient Access and Practice Stabilization Act,”** bipartisan legislation designed to address the 2.83 percent Medicare physician payment cut that took effect on January 1, 2025, and to provide a positive payment update to help stabilize physician practices. The AMA worked closely with the bill sponsors and congressional physician leaders to support the legislation. More than 120 bipartisan House members cosponsored the legislation, and over 80 physician organizations, including all 50 state medical associations, joined a coalition letter urging Congress to act. Although H.R. 879 was not ultimately enacted as a standalone measure, the legislation played an important role in elevating Medicare physician payment reform as a priority issue for Congress and helped frame the policy debate that produced the “Patients First Act.”

Alternative Payment Model (APM) Progress and H.R. 7148

H.R. 7148, the Consolidated Appropriations Act, 2026, included several important AMA-supported provisions restoring incentives for participation in advanced APMs. Specifically, the legislation reinstated APM incentive payments at 3.1 percent for the 2026 performance year (2028 payment year) and reduced the Qualifying Participant (QP) revenue threshold from 75 percent back to 50 percent for the same performance year. These changes help restore meaningful incentives for

physician participation in value-based care and reduce barriers that had limited participation following the expiration of the original APM bonus and the automatic increase in the QP threshold in 2025. The law also includes several Medicare extenders that expire at the end of 2026. As a result, Congress will again need to address key Medicare payment policies before year's end, creating an important legislative vehicle and opportunity for the AMA to continue advancing broader Medicare physician payment reforms, including the "Patients First Act" and efforts to secure a physician payment update for 2027.

National Advocacy Conference – February 2026

At the February 2026 National Advocacy Conference (NAC), the following lawmakers expressed the need for Medicare physician payment reform: Senator Peter Welch (D-VT) and Representatives Greg Murphy (R-NC), Kim Schrier (D-WA), Mariannette Miller-Meeks (R-IA), John Joyce (R-PA), Jill Tokuda (D-HI), and Steven Horsford (D-NV). More than 500 physician advocates attended NAC and participated in Capitol Hill meetings and distributed advocacy kits urging lawmakers to support legislation that:

- Provides annual inflationary updates tied to practice costs
- Reforms budget neutrality
- Improves MIPS
- Expands APM options

These reforms were framed as essential to preserving patient access to care by stabilizing physician practices and thereby ensuring America's seniors have timely access to high-quality care. Each of these four reforms is now embodied in the "Patients First Act."

Senate Legislation and H.R. 1

In April 2025, Senator Roger Marshall (R-KS) introduced the Senate companion bill, S. 1640. AMA advocacy staff were highly involved in drafting this legislation, ensuring it was responsive to the real-time 2025 Medicare cuts. Separately, H.R. 1, the OBBBA, initially included strong Medicare physician payment reform provisions, including a 75 percent MEI update for 2026 and a permanent annual update of 10 percent of MEI thereafter. The AMA advocacy team was instrumental in the development and inclusion of these House-passed Medicare provisions. These provisions passed the House of Representatives; however, the Senate scaled the proposal back to a temporary 2.5 percent update for 2026 with no permanent, inflation-adjusted fix. Still, the inclusion of any update represented forward movement and provided important momentum for the introduction of the "Patients First Act" in the 119th Congress.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network (PGN), Patients Action Network (PAN), and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grass-tops" contacts in local newspapers. Digital advertisements are running targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments. The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics, a "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform, and also a link for patients and physicians to share their stories.

1 There is also an annual webinar for the PGN to help and encourage physicians to engage with their
2 Members of Congress back home during the August recess.

3
4 Following the introduction of H.R. 9693, the AMA activated its grassroots networks with a
5 national alert urging physicians and patients to contact their members of Congress and ask them to
6 cosponsor the “Patients First Act,” emphasizing that a more stable Medicare payment system will
7 protect patients’ access to care, particularly in small, rural, and independent practices.

8
9 Since its launch in the third quarter of 2023, the Fix Medicare Now campaign, in combination with
10 engagement of the PGN and PAN, has generated the following results to date:

- 11 • 358,000,000+ media impressions
- 12 • 12,300,000+ engagements with Fix Medicare Now content
- 13 • 1,970,000+ FixMedicareNow.org site visitors
- 14 • 758,000+ contacts to Congress
- 15 • 61 PGN/PAN calls to action sent
- 16 • 225+ targeted earned media placements (op-eds, letters to the editor, and white papers)
- 17 reaching an estimated audience of more than 1 billion
- 18 • 350+ third-party grass-tops communications delivered to key legislators by trusted in-
- 19 district community members

20 21 *Federation Engagement*

22
23 The AMA continues to work closely with state medical associations and national medical specialty
24 societies to build alignment around shared principles for Medicare physician payment reform.
25 Through ongoing coordination with Federation partners, the AMA has strengthened advocacy
26 efforts, reinforced consistent policy messaging, and demonstrated broad physician support for
27 legislative solutions that stabilize Medicare physician payment and protect patient access to care.

28
29 Federation engagement has been central to building support for the “Patients First Act.” Upon
30 introduction, the AMA distributed the legislative text, section-by-section summary, and sponsors’
31 press release to all state medical associations, followed by the AMA’s letter of support and
32 analyses comparing the bill to the Characteristics of a Rational Medicare Physician Payment
33 System and to current law. The AMA also convened two national calls with the leadership and
34 senior government affairs staff of state medical associations, each with direct participation from the
35 bipartisan Doctors Caucus staff who drafted the bill—one held on March 26, 2026, when the
36 Caucuses released their legislative outline and a second held on July 24, 2026, following the bill’s
37 introduction. The AMA continues its proactive outreach to national medical specialty societies to
38 answer questions about the legislation, address specialty-specific considerations, and encourage
39 formal endorsements, with the goal of demonstrating to Congress the unified support of the
40 physician community. The AMA is committed to ensuring that all Federation partners—state
41 medical associations and national medical specialty societies alike—receive timely access to AMA
42 analyses, legislative materials, the weekly Advocacy Update, and direct engagement with AMA
43 advocacy staff as reform efforts continue to advance.

44 45 *Advocacy with MedPAC and Looking Forward*

46
47 The AMA continues to engage with the Medicare Payment Advisory Commission (MedPAC) as it
48 evaluates the adequacy of Medicare physician payment and develops recommendations to
49 Congress. During its December 2025 meeting, MedPAC discussed a potential recommendation to
50 update Medicare physician payment rates in 2027 by current law plus 0.5 percent, which would
51 result in an update of approximately 1.25 percent for clinicians participating in advanced

alternative payment models and 0.75 percent for other physicians. However, the cost of providing care is expected to increase by approximately 2.1 percent, meaning that such a recommendation would allow the gap between physician payment and practice cost inflation to continue widening. In comments submitted following the meeting, the AMA urged MedPAC to recommend that Congress update physician payment in 2027 by the full increase in the MEI.

In its June 2026 report to Congress, MedPAC recommended increasing Medicare Physician Fee Schedule payment rates above current law, reflecting continued movement toward the AMA's position that physician payment must keep pace with the costs of providing care. In a briefing with reporters following the report's release, MedPAC Executive Director Paul Masi, MPP, reiterated the Commission's recommendation that fee-for-service Medicare move toward an annual physician payment update of approximately MEI minus 1 percent—the same permanent update formula established in Title I of the "Patients First Act." This alignment between the Commission's recommendations and H.R. 9693 provides important independent support for the central payment reform in the legislation as it advances through Congress.

The AMA also highlighted MedPAC data showing emerging access challenges for Medicare beneficiaries. In 2025, 29 percent of beneficiaries reported waiting six or more weeks to see a new primary care physician and 31 percent reported similar waits to see a new specialist. At the same time, growth in spending under the Medicare Physician Fee Schedule has remained modest compared to other components of Medicare Part B. The AMA will continue working with MedPAC to ensure that its recommendations to Congress reflect the growing gap between physician payment and practice cost inflation and the potential implications for patient access to care.

Call to Action

Congress must urgently address a broken Medicare payment system that places enormous financial pressure on physicians and threatens access to care. The AMA continues to urge lawmakers to:

- Cosponsor and advance H.R. 9693, the "Patients First Act," which provides annual inflation-based updates, reforms budget neutrality, replaces MIPS with a clinician-driven quality program, and expands APM opportunities; and
- Enact a positive physician payment update for 2027 to keep pace with inflation as broader structural reforms advance.

Physician practices have lost 33 percent to inflation since 2001. Physician ownership of practices has also collapsed, dropping from 61 percent in 2001 to under 50 percent in 2016. This erosion threatens the viability of community-based care. Fixing this system will remove a major financial stressor for physicians, protect patient access, and stabilize our healthcare infrastructure. Ensuring regular, adequate payment updates is vital to practice sustainability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—especially in rural and underserved communities, where practices treat four times as many Medicare patients as those in metropolitan areas. As physicians across the country continue to share their stories and advocate for reform, the introduction of comprehensive, bipartisan reform legislation demonstrates that our united efforts are breaking through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

1 CONCLUSION

2
3 The AMA will continue to press Congress to address the structural flaws in the Medicare physician
4 payment system and enact reforms that ensure stability for physician practices and protect patient
5 access to care. The introduction of the “Patients First Act” represents meaningful progress toward
6 that goal, reflecting years of sustained advocacy and the unified principles of the physician
7 community; enactment, however, will require continued legislative action and engagement.
8

9 While the CBO has not yet scored the PFA, Congressional staff estimate that it could cost up to
10 \$150 billion over the next ten years. Given the limited days left in the Congressional calendar and
11 the heated, upcoming mid-term elections, it is unlikely legislation of this magnitude can pass
12 Congress and get signed into law this year. However, assuming the PFA garners significant
13 bipartisan support in Congress and from outside stakeholders, it would be well-positioned to
14 become the starting point in the 120th Congress. Further, the stronger the support for the PFA, the
15 greater the leverage our Congressional champions will have to secure pieces of the bill in any end-
16 of-year legislative package, such as a 2027 payment update, budget neutrality reforms, and APM
17 bonus provisions.
18

19 The AMA will remain actively engaged with Congress, the Administration, and Federation
20 partners to advance H.R. 9693 and related policies that stabilize Medicare physician payment,
21 reduce administrative burden, and support physician participation in innovative care delivery
22 models. Continued engagement from physicians across the Federation will remain essential as
23 these efforts move forward.

REPORT OF THE SPEAKERS

Speakers' Report 2-I-26

Subject: Recommended Policy Reconciliations

Presented by: Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker

1 Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to
2 "present one or more reconciliation reports for action by the House of Delegates relating to newly
3 passed policies from recent meetings that caused one or more existing policies to be redundant
4 and/or obsolete."
5

6 Your Speakers present this report to update policies or portions thereof that are no longer relevant
7 or were affected by actions taken at recent meetings by the House of Delegates. Suggestions on
8 other policy statements that your Speakers might address should be sent to hod@ama-assn.org for
9 possible action.
10

11 Changes effected by this Speakers' Report will not reset the sunset clock for the items partially
12 rescinded, and all changes are implemented upon filing of this report.
13

14 RECOMMENDED RECONCILIATIONS

15
16 *Accomplished directives to be rescinded*

Policy Number	Title	Policy Language
D-600.952	AMA Bylaw Amendments Pursuant to AIPSC	Our American Medical Association will amend AMA Bylaws 2.12.2, 2.12.3.1, 5.2.4, 5.2.4.1, and 12.3 (now Bylaw 11.3) as follows: 2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on request of one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall notify each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called. 2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

		5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee's contact information then appearing on the records of the AMA. 5.2.4.1 Waiver of Notice. Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting. 12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and provided it to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.
D-600.955	Report of the Resolution Modernization Task Force Update	Our American Medical Association will amend the bylaws so that: 1. The resolution submission deadline be 45 days prior to the Opening Session of the House of Delegates with AMA Sections excluded from this deadline. 2. The definition of a late resolution shall be all resolutions submitted after the resolution submission deadline with AMA Sections excluded from the deadline and prior to the beginning of the Opening Session of the House of Delegates. 3. The definition of an emergency resolution shall be all resolutions submitted after the beginning of the Opening Session of the House of Delegates. 4. The term of committees of the House of Delegates shall commence upon their formation and shall conclude at the end of the meeting for which they were appointed, unless otherwise directed by the House of Delegates.
D-610.996	AMA Bylaws Nomination of Officers and Council Members	Our American Medical Association will amend AMA Bylaws 3.3, 6.8, 6.8.1 as follows: 3 Officers 3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made by a member of the House of Delegates at the opening session of the meeting at which elections take place. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made by a member of the House of Delegates at the opening session of the meeting at which elections take place. 6 Councils 6.8 Election – Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health 6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced

		candidates, who shall be entered into nomination by the Speaker at the Opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.
G-600.959	Delegate Apportionment and Pending Members	Pending members will no longer be counted for delegate apportionment.
G-610.089	Directives on Nominations from Speakers Report 3	The language in Bylaw 6.8.1, "Nomination and Election" be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place.

1 *Policies to be rescinded in part*

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3 Deletions are shown with strikethroughs. Given the length of some of the policies, only the affected
4 portions are reproduced.

Policy Number	Title	Policy Language	
D-275.954(23)	Continuing Board Certification	23. Our AMA will encourage the PCPI Foundation, the ABMS; and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.	The PCPI and PCPI Foundation no longer exist. Therefore, all references to them have been removed.
D-450-978	PCPI; Unfunded Performance Improvement Projects	Our AMA will: (1) continue to promote the PCPI® as the leading resource for performance measures development and maintenance; (12) continue to advocate for appropriate implementation of performance measures; (23) continue to encourage the testing and evaluation of PCPI performance measures by appropriate entities; (34) continue to communicate organized medicine's strong objections to implementation of mandatory, unfunded performance improvement projects and offer our assistance to rectify deficiencies in these programs; (45) continue to promote the AMA guidelines that provide operational boundaries that can be applied to specific components of pay-for-performance programs; and (56) monitor the National Quality Forum, a merger of the National Quality Forum and the National Committee for Quality Health Care, to determine its current and future scope.	
H-450.939	Activities of the National Quality Forum	Our AMA will: (1) continue to advocate for the Physician Consortium for Performance Improvement as the measure developer for physician-level performance measurement; (2) continue to monitor the National Quality Forum's (NQF) activities to ensure physician	

		representation and involvement in all activities and leadership.; and (3) oppose any efforts to expand the NQF's mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement's principal role in the measure development process.	
G-600.009(2)	CEJA and House of Delegates Collaboration	2. Consistent with Bylaw 2.13.1.1, the Speakers consider convening additional sessions of the Reference Committee on Amendments to Constitution <u>Ethics</u> and Bylaws when appropriate and feasible to accommodate CEJA business.	Updating policy using the new name for the reference committee.
G-600.054(1)	Procedures of the House of Delegates	1. Our AMA reaffirms <u>that the current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure serves as our parliamentary authority.</u> ; including the <u>This includes the use of the motion to table and the motion to adopt in-lieu-of as defined by this authority, and treat amendments by substitution as first order amendments.</u>	Clarifies the use of the current edition of AIPSC and removes substitution which is not referenced in our parliamentary authority.

Policy clarification

Upon review of final HOD actions following the 2026 Annual Meeting, a discrepancy was found between existing policy language in H-160.891 and the language used to proffer amendments to the policy in Resolution 241 which were adopted. The proffered language in the resolution included text that was being amended that did not appear in the existing policy. Your Speakers have reviewed the discrepancies and provide the final language for clarification. PolicyFinder has been updated accordingly with the language as shown below.

H-160.891	Corporate Investors and Other Corporate Entities	1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines: <u>supports policies that preserve physician ownership, governance, and independent medical judgment in physician practices and opposes corporate ownership or contractual arrangements that permit non-licensed entities to exercise control over the practice of medicine.</u> <u>Physicians and policymakers evaluating corporate investment in physician practices should consider the following guidelines:</u> - Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity. - Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture. - External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
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		d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered. e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management. f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment. g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship. h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity. i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships. j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to: i. Determining which diagnostic tests are appropriate; ii. Determining the need for referrals to, or consultation with another physician or licensed health professional; iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient; iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work; v. Determining the content of patient medical records; vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency; vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities; viii. Making decisions regarding coding and billing procedures for patient care services; and ix. Approving the selection of medical equipment and medical supplies. k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners. l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities. m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection
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		of faculty and trainees, as well as education and disciplinary issues related to these programs. n. <u>Physician practices delivering medical care should be majority owned by licensed physicians who are actively practicing in the entity, and those licensed physicians must retain final authority over clinical decision making and over operational and administrative decisions that affect patient care, including clinical staffing, scope of services, clinical policies and standards, compensation structures tied to clinical services, coding and billing policies, payer contracting, and practice governance.</u> o. <u>Our AMA opposes stock transfer restriction agreements, “friendly PC” arrangements, succession rights, compelled sale provisions, management agreements, or other contractual mechanisms that permit non-licensed entities to exercise direct or de facto control over physician practices or over physicians’ professional medical judgment. Physicians should review contractual provisions governing governance structures, compensation arrangements, and management responsibilities to ensure that such arrangements do not transfer control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities.</u> p. <u>Our AMA supports clear disclosure of physician practice ownership, governance, management agreements, and contractual control rights so that physicians, patients, regulators, and policymakers can identify who holds financial and operational control over the practice entity</u> 2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment. 3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians practicing in that specialty. 4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine. 5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.
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