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REPORT OF THE BOARD OF TRUSTEES

BOT Report 11-I-26

Subject: Opposing Unilateral Downcoding of Physician Services by Insurance Companies

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates adopted Policy D-70.940, which states:

1. Our American Medical Association (AMA) will work with state medical associations, specialty societies, and regulatory authorities to challenge payer-initiated downcoding policies through regulatory, legislative and when appropriate, legal channels.
2. Our AMA will report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Interim Meeting.
3. Our AMA will develop and disseminate guidance and educational materials for physicians regarding insurer downcoding and recoding practices, including how to document, appeal, and report inappropriate payer conduct to regulators and AMA advocacy channels.

Accordingly, this report discusses the development of AMA model legislation and related state and federal advocacy efforts, as well as AMA guidance and educational materials to assist physician practices.

BACKGROUND

Effective January 1, 2021, major changes were made to the Evaluation and Management (E/M) services Current Procedural Terminology CPT® code set and reporting guidelines to reduce documentation burden and simplify medical coding. Under the 2021 guidelines, selection of the appropriate level for an outpatient E/M visit is based on the level of medical decision making (MDM) or total time spent on the date of the encounter; history and physical exam are no longer key components in selecting the appropriate E/M level. Notably, documentation from the medical record is needed to confirm the level of MDM or total time spent on the date of the encounter and establish the appropriate E/M CPT code.

Unfortunately, some health plans have implemented E/M downcoding programs that fail to align with the 2021 CPT guidelines. Downcoding policies reduce the level of service from what was submitted on the physician's claim, leading the physician to receive payment for a lower level of care than was provided. Many health plans downcode claims automatically, without first requesting and reviewing the underlying clinical record. Some payers use augmented intelligence (AI), software algorithms, and other automated decision-making tools to downcode claim payments. In many instances, the diagnosis code reported on a claim is used as a proxy for the level of care to adjust payment. Such methodology—and indeed any program that reduces E/M payment solely based on information on the claim—is wholly inappropriate, as documentation from the medical record is needed to confirm the level of MDM or total time spent on the date of the encounter. Notably, CPT guidelines for E/M reporting clearly discredit this approach: “The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may

be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.”¹

Automatic downcoding programs pose several critical problems for physician practices. First and foremost, inappropriate downcoding can lead to significant losses in practice revenue and sustainability. While the reduced payment for a lower-level E/M code may not appear substantial for an individual claim, the aggregated effect of decreased payment over many office visit claims adds up and can endanger practices’ financial viability. This is particularly true when a health plan targets a physician’s E/M claims for global prepayment review.

Beyond the obvious economic harms, the manner in which health plans implement downcoding programs presents additional challenges to physician practices. Some health plans implement downcoding policies without providing notice to individual physicians and instead rely on provider bulletins that are buried on payer websites. Additionally, health plans may pay E/M claims at the adjusted lower rate without changing the billed code or providing clear information on the remittance advice indicating that the service has been downcoded, making these changes extremely difficult to identify in revenue cycle audits. The lack of transparency with which health plans conduct downcoding means that without hypervigilance on claim payment details, physicians and practice staff may not identify reduced E/M payments until after months of lost revenue.

Finally, fighting inappropriately downcoded services results in significant administrative burdens for physicians and their staff. Assembling and submitting clinical documentation to health plans takes time and resources away from patient care—particularly when plans only offer manual data transmission options, such as a dedicated fax line, to appeal downcoded claims. Moreover, while practices face an overwhelming, claim-by-claim fight for correct payment, health plans deploy AI or automated systems, which can quickly reduce E/M levels for large claim volumes. The practice administrative costs associated with disputing downcoded claims, as well as the time spent waiting for the health plan to reconsider the E/M level, incentivizes many physicians to accept inappropriately reduced payments without appealing—or to refrain from billing higher level E/M codes altogether to avoid downcoding hassles.

Importantly, the negative consequences of payers’ downcoding programs extend to patients’ access to care. Lost revenue from downcoding threatens the financial viability of practices already struggling to stay afloat under the increasing pressures of payments that have failed to keep up with inflation. The culmination can result in practice closures and impede patient access to care. Similarly, physicians may be forced to leave plan networks if draconian downcoding programs threaten practice sustainability, also affecting patient access. Downcoding policies may also place pressure on physicians to shorten office visits or see more patients in order to keep their practices open. All of these factors can disrupt the patient-physician relationship, reduce patients’ access to their physicians, and serve as barriers to medically necessary care.

A recent physician survey conducted by the Illinois State Medical Society (ISMS) quantifies the impact of payers’ downcoding policies for physicians practicing in that state.² In the ISMS survey, a strong majority (72 percent) of physicians reported that their practice has experienced automatic downcoding of appropriately coded and documented claims, with 77 percent saying that automatic downcoding has increased in the past five years. Alarming, only 16 percent of physicians surveyed by ISMS indicated that their remittance advice usually or always provides information indicating that a claim has been downcoded, and 72 percent reported that even when the remittance advice indicates a downcoded claim, it rarely or never includes a specific reason for the payment reduction. These data clearly illustrate the characteristic lack of transparency of payers’ downcoding programs. According to ISMS data, appeals of inappropriately downcoded claims

achieve mixed success, with surveyed physicians reporting that payers uphold over one-half (53 percent) of their original decisions on these payment reductions.

Health plans' downcoding programs have expanded to the degree that they are capturing national mainstream media attention. A recent NBC News story notes that payer downcoding has "taken off in the last few years" and showcases the specific challenges several physicians have faced with these policies.³ The story also highlights the AMA's objections to automatic downcoding policies and advocacy to combat these practices.

AMA EFFORTS TO ADDRESS DOWNCODING

Direct Payer Engagement

The first component of the AMA's multi-pronged effort to fight insurers' automatic downcoding policies involves direct engagement with plans. For example, in a July 2024 letter, the AMA urged Aetna to halt implementation of an update to its Claim and Code Review Program that automatically downcodes E/M emergency department services for physician and facility claims.⁴ In August 2025 correspondence, the AMA requested that Cigna rescind its E/M Coding and Accuracy policy, under which the plan reduces E/M codes "to a single level lower when the encounter criteria on the claim does not support the higher level E/M CPT code reported."⁵ The AMA has also directly engaged health plan associations on this issue, including March 2025 letters to AHIP and Blue Cross Blue Shield Association.^{6,7} In these letters and in follow-up conversations with health plan leaders, the AMA has repeatedly stated that automatic downcoding policies conflict with E/M coding guidelines and impose unfair, unwarranted payment reductions on practices at a time when physicians already face unprecedented financial challenges. Unfortunately, despite these ongoing efforts at direct payer advocacy, plans have largely refused to voluntarily rescind their downcoding programs, maintaining that these payment reductions are legitimate and justified.

Legislative Advocacy

Given payers' unwillingness to suspend automatic downcoding policies and the escalating harm on physician practices, the AMA has added a legislative strategy to its advocacy on this issue. This work stream includes the development of model legislative language and efforts supporting introduction and passage of state and federal bills that place guardrails around insurers' downcoding practices.

Model Legislation

Recognizing that legislative action was needed on payers' harmful downcoding programs, the AMA Advocacy Resource Center (ARC) began exploring legislative solutions. In June 2025, the AMA Council on Legislation and the Board of Trustees adopted a state model bill to address ongoing downcoding concerns entitled the "Transparency in Downcoding Act." The goal of the model bill is to assist in state efforts to curb the use of automatic downcoding tools by health insurers and increase transparency and clinical justification when downcoding is used. Specifically, the model bill:

- Prohibits automatic downcoding of claims without a documented review of clinical records;
- Prohibits downcoding based solely on diagnosis codes, requiring that any reduction in service level be based on actual clinical review;

- Requires the use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to notify physicians when a claim has been downcoded and explain the reason for the change;
- Mandates that payers disclose a clear process for appealing downcoded claims;
- Permits physicians to batch similarly downcoded claims for appeal;
- Prohibits discriminatory downcoding practices targeting physicians who routinely treat complex patients or patients with chronic conditions; and
- Establishes enforcement mechanisms and penalties for noncompliance, including administrative fines and claim reprocessing orders.

AMA Advocacy staff worked to distribute the model bill to all state medical associations and national medical specialty societies. In addition, the model legislation and related resources have been presented in webinars and workgroup meetings to encourage Federation support and action.

State Activity

States have been active on the issue of downcoding in the past two legislative sessions, and state medical associations are doing significant work to educate lawmakers on the importance of increased transparency and guardrails to protect physician practices. In fact, more than a dozen states, including Arkansas, California, Connecticut, Illinois, Indiana, Missouri, Maryland, New Jersey, New York, Ohio, Tennessee, Oregon, Utah, and Virginia have introduced bills, and several have been able to push those bills across the finish line.

For example, in March 2026, after significant work by the Indiana State Medical Association (ISMA), and in collaboration with the AMA, Indiana's Governor signed legislation that reflects the AMA's model legislative solution in that it requires plans to notify physicians when a claim is being downcoded, bars a plan from downcoding a claim based on a diagnosis alone, and requires a clear appeals process that permits the batching of downcoded claims.⁸ The new law also prohibits a plan from using an automated process, program, or tool, including AI, as the sole basis for downcoding a claim and prevents downcoding from being used to target physicians caring for patients with complex medical conditions. As with most legislative efforts, compromise was needed, and a provision in the new law prevents physicians from submitting an AI-generated claim that has not been reviewed by a clinician. ISMA worked closely with their members to vet this provision and determine the impact, which ultimately was accepted.

Similarly, the Illinois legislature recently passed Senate Bill (SB) 3114, the "Transparency in Downcoding Act," legislation supported by ISMS, and, at the time of this writing, awaiting the Governor's signature.⁹ The legislation aims to address the use of automated downcoding programs by payers to reduce intensity levels and physician payment without justification or review of the patient's medical record. Specifically, SB 3114 would prohibit a health insurer from using an automated process, system, or tool to downcode a claim; ensure that a physician will be notified when a claim has been downcoded and reimbursed at a lower level, to include the clinical reason for downcoding; require health insurers to establish a clear and accessible process for disputing downcoded claims; and prevent health insurers from using downcoding to discriminate against physicians who commonly treat patients with complex or chronic conditions. The AMA worked closely with ISMS on this legislation, and ISMS received one of the first AMA State Accelerator grants to help develop the resources needed to achieve this victory, including the previously cited ISMS survey.²

In April 2026, the Governor of Virginia signed SB 164/HB 484.^{10,11} This legislation places limits on plans' ability to downcode claims based solely on CPT codes and diagnosis, requires more detailed explanations when a claim is downcoded, and creates a more transparent appeals process in which claims can be appealed in batches to reduce burden.

Meanwhile, the Maryland Insurance Administration (MIA) recently determined that Cigna improperly downcoded E/M claims submitted by physicians, reducing reimbursement levels in violation of Maryland's insurance statutes governing claim payment and processing.¹² The MIA imposed an administrative penalty on Cigna and ordered that health plans stop the practice. MedChi, the Maryland State Medical Society, has long advocated for changes, including with the introduction of legislation earlier in the session, and applauded the MIA's actions.¹³ The AMA ARC anticipates that state legislative and regulatory activity on this issue will continue in the 2027 legislative sessions, as staff work closely with state medical association to educate lawmakers about the need for reform.

Federal Legislative Advocacy

The proliferation of payer automatic downcoding programs and the resulting outcry from physician practices have also captured the attention of federal legislators. AMA Congressional Affairs staff have been working with members of Congress to introduce a federal downcoding bill. The AMA's model language on this issue has been shared with both House and Senate offices, and members of Congress have been receptive to AMA input on draft legislation. AMA Congressional Affairs staff will continue to meet with members of both the House and Senate to advocate for introduction and passage of federal legislation that would curb insurers' unfair automatic downcoding policies.

AMA Educational Material

While the AMA and the Federation of Medicine continue to advocate to health plans and legislatures for policy changes that will protect physicians from inappropriate downcoding policies, it is important that, in the meantime, physicians and practice staff have resources and tools to fight unjustified payment reductions. For that reason, the AMA has created an educational resource titled "Payer Evaluation and Management (E/M) Downcoding Programs: What You Need to Know."¹⁴ This document provides an overview of E/M downcoding mechanics, including examples of downcoding scenarios and tips to help practices recognize downcoded claims. The resource reviews how to document and select the correct E/M level for an office visit based on MDM or time. Practices can also learn how to effectively challenge downcoded claims and take advantage of sample appeal letters. Finally, the resource links to an informal survey through which the AMA collects information on insurer downcoding policies to identify trends and support ongoing advocacy efforts. This material is currently being reviewed and updated to reflect anticipated E/M guideline changes for medication therapy management. The AMA will continue to monitor physicians' educational and advocacy needs related to downcoding and will create new and/or revised tools and resources as appropriate.

AMA POLICY

Although downcoding programs have accelerated in the last several years, at least in part due to health plans' use of AI and other automated tools, the AMA has extensive, long-standing policy opposing inappropriate lowering of service levels and corresponding payment. For example, [Policy H-335.984](#) calls on the AMA to initiate regulatory amendments or legislation to abolish Medicare carriers' arbitrary downcoding of claims. [Policy H-70.937](#) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers and states that the AMA will develop a

1 national policy for intervention with carriers or payers that use unreasonable business practices to
2 unilaterally recode or inappropriately bundle physician services and support legislation to
3 accomplish this.

4
5 [Policy H-320.948](#) calls for transparency in downcoding programs, stating that both physicians and
6 patients should receive timely written notification containing the principal reason and clinical
7 rationale for downcoded claims, as well as appeal instructions. [Policy D-320.995](#) directs the AMA
8 to work with the Federation of Medicine to gather information from physicians regarding
9 downcoded claims and respond with appropriate legislation, advocacy, and communication
10 initiatives. [Policy H-70.924](#) states that the AMA Litigation Center will continue to support lawsuits
11 seeking redress from insurers engaging in inappropriate or inaccurate downcoding practices.
12 More recently adopted policy reflects the current landscape of plans' downcoding programs. [Policy](#)
13 [D-320.972](#) vigorously opposes health plans using software, algorithms, or methodologies, other
14 than manual review of the patient's medical record, to deny or downcode E/M services, except
15 correct coding protocol denials, based solely on the CPT/Healthcare Common Procedure Coding
16 System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers
17 submitted on the claim. This policy also states that in cases where it is appropriate to lower the
18 level of service reported on a claim based on medical record review, health plans should clearly
19 indicate downcoded services using CARCs and RARCs on the remittance advice. The policy
20 directs the AMA to advocate for legislation prohibiting automated downcoding and requiring
21 transparency on all claims processing, as well as to evaluate legal action. Most recently, [Policy D-](#)
22 [70.940](#), in addition to requesting this report, directs the AMA to challenge payer downcoding
23 policies through regulatory, legislative, and legal channels, as well as to create and disseminate
24 guidance and educational materials for physicians regarding downcoding practices.

25 26 DISCUSSION

27
28 This report provides an overview of the current landscape surrounding health plans' downcoding
29 programs and details how they harm physician practices and patients. In response to these rapidly
30 escalating concerns, the AMA has engaged in a multi-pronged campaign to address inappropriate
31 automatic downcoding of claims, including direct payer engagement, efforts to introduce and pass
32 both state and federal legislation that would place guardrails around downcoding programs, and
33 creation of practice educational material to assist physicians and staff in addressing unfair
34 downcoding programs. The AMA has also adopted numerous policies on this topic, including
35 several in the last few years that focus on plans' use of automation and the lack of transparency
36 characteristic of contemporary downcoding programs.

37
38 While the AMA already has adopted extensive policy on payer downcoding programs and
39 developed a robust advocacy strategy, there are a few specific areas that could be further
40 strengthened to meet emerging or newly identified needs. First, in order for practices to fully
41 benefit from legislative guardrails, physicians and staff must be aware of these protections. The
42 AMA, in partnership with state medical associations, could communicate these legislative wins to
43 physician practices and encourage reporting of compliance failures to the appropriate regulatory
44 body for enforcement. Physicians should be made aware of the importance of reporting violations
45 of downcoding laws to regulators, as such individual complaints draw attention to compliance
46 issues and lead to enforcement action. Secondly, Policy D-70.940 directs the AMA to create
47 educational materials on downcoding practices. As discussed, the AMA already offers a
48 comprehensive educational resource on E/M downcoding; however, the policy directive suggests
49 that physicians are not aware of this tool. Therefore, the AMA could more widely promote this
50 resource, including communication of any updates or additional downcoding materials. Finally,

1 reaffirmation of Policy H-70.294 recommits the AMA to supporting lawsuits that seek redress from
2 insurers engaging in inappropriate or inaccurate downcoding practices.

3
4 RECOMMENDATIONS

5
6 The Board of Trustees recommends that the following be adopted, and the remainder of the report
7 be filed:

8 1. That our American Medical Association (AMA), in collaboration with state medical
9 associations, communicate legislative guardrails on health plans' downcoding policies to
10 physician practices and provide guidance on how any payer noncompliance can be reported to
11 the appropriate regulatory body for enforcement. (New HOD Policy)

12
13 2. That our AMA amend Policy D-70.940[3] to read as follows:

14
15 Our AMA will develop, regularly update, ~~and disseminate~~, and widely promote guidance and
16 educational materials for physicians regarding insurer downcoding and recoding practices,
17 including how to document, appeal, and report inappropriate payer conduct to regulators and
18 AMA advocacy channels. (Modify Current HOD Policy)

19
20 3. That our AMA reaffirm Policy H-70.924, which states that the AMA Litigation Center will
21 support lawsuits that seek redress from insurers engaging in inappropriate or inaccurate
22 downcoding practices. (Reaffirm HOD Policy)

23
24 4. That our AMA rescind Policy D-70.940[2] as it has been fulfilled by this report. (Modify
25 Current HOD Policy)

Fiscal Note: Minimal.

Policy Appendix

Policy D-70.940, “Opposing Unilateral Downcoding of Physician Services by Insurance Companies”

(1) Our American Medical Association will work with state medical associations, specialty societies, and regulatory authorities to challenge payer-initiated downcoding policies through regulatory, legislative, and when appropriate, legal channels. (2) Our AMA will report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Interim Meeting. (3) Our AMA will develop and disseminate guidance and educational materials for physicians regarding insurer downcoding and recoding practices, including how to document, appeal, and report inappropriate payer conduct to regulators and AMA advocacy channels. Res. 810, I-25

Policy D-320.972, “Automatic Downcoding of Claims”

(1) Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim. (2) Our AMA supports that, after review of the patient's medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes. (3) Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim. (4) Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims. Res. 714, A-24; Reaffirmed: Res. 810, I-25

Policy D-320.995, “Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans”

(1) Our American Medical Association will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization. (2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims. (b) seek information on a regular basis from those associations that collect such information. (c) respond with appropriate legislation, advocacy, and communication initiatives. CMS Rep. 5, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation: A-18; Reaffirmation: A-22

Policy H-70.924, “Litigation Center Cases to Combat Automatic Downcoding and/or Recoding”

The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22

Policy H-70.937, “Bundling and Downcoding of CPT Codes”

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers; (2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and (4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

Policy H-320.948, “Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans”

It is the policy of our American Medical Association, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) The principal reason(s) for the determination. (2) The clinical rationale used in making the determination. (3) A statement describing the process for appeal. CMS Rep. 5, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-08; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21

Policy H-335.984, “Medicare Regulatory Relief Legislation”

It is the policy of our American Medical Association to initiate modifications to the Regulatory Relief Amendments or introduce additional legislation to address further areas where unwieldy or inequitable federal regulations or legislation place unrealistic or unfair demands on physicians and their office staff to: (1) Abolish the A/B Data Link in which physician services provided during inpatient treatment, where payment to the hospital has been denied, are reviewed and can be denied as medically unnecessary years after the treatment has been provided. (2) Abolish the practice of downcoding claims where Medicare carriers arbitrarily alter physician claims so that physicians are paid for a lower level of service than the one actually provided. (3) Further clarify Section 6109 of OBRA 1989 that nullified the recoupment of funds from Texas physicians and patients so that the original intent of the legislation would be realized through repayment of funds to those physicians and beneficiaries who had already repaid funds to the government. (4) Include provisions that relieve patients and physicians of responsibility for implementation of the Medicare as a Secondary Payer provisions and that the Medicare carrier be charged with responsibility for obtaining payment from the proper insurer rather than from physicians or beneficiaries for any errors that may be made in the determination of a beneficiary's insurance status. (5) Include provisions that would nullify Section 6102(g)(4) of OBRA 1989 that all Medicare claims be filed by physicians so that physicians who have large numbers of claims for small amounts would not be burdened with the transaction costs of meeting the mandatory claims filing provision, particularly since the OBRA 1989 provisions explicitly forbid physicians from requesting or receiving any additional payment

for this costly and time-consuming service. Res. 213, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21

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REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Transparency with the Term “Emergency Department”
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, Resolution 226-I-25, Transparency with the Term “Emergency Department,” was referred. It asked the following:

RESOLVED, that our American Medical Association (AMA) advocates for the designation of “emergency department” or “emergency room” to be restricted to facilities with the presence of at least one physician on site and on-duty, who is responsible for the emergency department at all times; and be it further

RESOLVED, that our AMA recommends that facilities without physician staffing use alternative terminology, such as Acute Care Unit, as a matter of truth and transparency for patients, so that patients are not expecting care by a physician; and be it further

RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV), and other authorities/regulators to educate them about this issue, and to encourage them to implement correct “emergency department” terminology designations to ensure truth and transparency at all times for our patients.

This report discusses emergency department staffing requirements, the Emergency Medical Treatment and Labor Act (EMTALA), emergency service payment, Critical Access Hospitals, Rural Emergency Hospitals, emergency department signage and advertising requirements, the American College of Emergency Physicians’ accreditation program, the emergence of Urgent Care Centers, and includes several policy recommendations.

The Council on Medical Service recommends new policy supporting the development of standardized emergency department descriptors that clearly identify each facility’s level of on-site physician coverage and available services; and recommends that facilities dedicated to emergency care without an on-site physician use standardized, real-time language that allows a prudent layperson to readily understand the level of physician presence and services available, thereby promoting truth and transparency for patients. The Council also recommends limiting the designations “emergency department” and “emergency room” to facilities that meet EMTALA requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. Furthermore, the Council recommends requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines and community engagement to improve the education of patients. The Council also recommends reaffirming Policy H-130.929, which identifies an on-site physician whose primary duty is emergency department care as the AMA’s preferred model; Policy D-35.976, which states that only physicians should supervise emergency care services in an emergency department; Policy D-130.958, which recognizes that staffing arrangements that do not allow physicians to properly provide emergency services are insufficient; Policy H-160.949, which opposes legislation allowing nonphysician groups to practice medicine without physician training or appropriate physician supervision; and Policy H-240.958, which recognizes the vital role of smaller, financially challenged facilities that provide emergency services.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-26

Subject: Transparency with the Term “Emergency Department”

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, Resolution 226-I-25, Transparency with the Term “Emergency Department,” was referred. It asked the following:

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This report discusses emergency department staffing requirements, the Emergency Medical Treatment and Labor Act, emergency service payment, Critical Access Hospitals, Rural Emergency Hospitals, emergency department signage and advertising requirements, the American College of Emergency Physicians’ accreditation program, the emergence of Urgent Care Centers, and includes several policy recommendations.

BACKGROUND

Emergency departments (EDs) are a critical—and increasingly strained—gateway to care in the United States (US). In 2025, there were 155.4 million visits to the 5,751 EDs in the US with 17.8 million resulting in hospital admission, and 3.1 million resulting in admission to a critical care unit.^{1,2} Nearly 1 in 4 patients aged 18-64 use the ED for non-urgent issues, which could otherwise be treated in an urgent care center (UCC) or primary care setting.³ A small percentage of patients (4.5 percent to 8 percent) utilize the ED at least four times per year, but account for 21 percent to 28 percent of all ED visits.⁴ Regional disparities for ED visits are significant, driven largely by healthcare access, the density of rural populations, and the prevalence of chronic health conditions.⁵ For instance, in rural states healthcare providers are overwhelmingly concentrated in a few urban centers which leave geographic stretches with limited local primary care or UCCs.⁶ Hospital deserts are widespread in the US: 691 of the nation’s 3,142 counties (22 percent) lack a hospital, including 258 counties in highly vulnerable states where residents also face socioeconomic, housing, and transportation barriers to care.⁷

1 Patient expectations for physician-led emergency care often collide with staffing realities, particularly in
 2 rural and low-volume hospitals. According to an American College of Emergency Physicians (ACEP)
 3 poll from 2021, 80 percent of patients state they most trust a physician to lead their ED medical care
 4 compared with a nurse, physician assistant (PA), or nurse practitioner (NP).⁸ However, one in 13 EDs did
 5 not have one or more on-duty attending physicians at all times.⁹ In several states, more than 30 percent of
 6 the EDs lacked constant physician leadership and, among them, 92 percent had low annual visit volumes,
 7 89 percent were in critical access hospitals (CAHs), and 72 percent were rural.¹⁰

8
 9 Gaps in round-the-clock emergency physician coverage vary significantly across states and reflect more
 10 than rural geography alone. Several factors are associated with the absence of continuous physician
 11 coverage, including annual visit volume under 10,000, workplace shortages, permissive state-level scope
 12 of practice laws, challenging hospital economics, and rural location.¹¹ Fifteen states—including many
 13 largely rural states—reported no EDs operating without a physician on-site 24 hours per day/7days per
 14 week (24/7).¹² Some of these states (e.g., Nevada, New Mexico, and West Virginia) are adjacent to states
 15 with comparatively high numbers of EDs without continuous physician coverage. In the Dakotas, for
 16 example, more than half of EDs operated without an attending physician, and in Montana, 43 percent
 17 lacked 24/7 attending physician coverage.¹³ Nine states reported that at least 20 percent of EDs did not
 18 have 24/7 attending-physician coverage; these states are disproportionately located in the central US.¹⁴
 19 Most EDs (89 percent) without 24/7 physician coverage are designated as CAHs, 72 percent were rural,
 20 and 2 percent were freestanding.¹⁵ However, more than a quarter (28 percent) of these EDs are located in
 21 metropolitan areas and the vast majority of which represent specialized freestanding emergency
 22 departments rather than traditional main hospital campuses.¹⁶

23
 24 US hospital closures have risen sharply since the early 2000s. From 2017 through 2023, rural closures
 25 outnumbered openings 61 to 11, yielding a net loss of 50 hospitals; from 2005 through 2024, 193 rural
 26 hospitals closed.¹⁷ Urban hospitals also close frequently, often because of financial pressures. In both
 27 settings, closures force residents to travel farther for care. Rural residents, for example, have preventable
 28 ED visit rates up to 45 percent higher than urban residents, largely because primary care shortages, longer
 29 travel distances for primary and specialty care, and geographic isolation allow conditions to worsen.¹⁸ At
 30 the same time, annual visits to remaining EDs have increased by about 30 percent, worsening wait times
 31 and overcrowding. Closures are driven primarily by unsustainable financial losses and operational
 32 challenges; nearly half of rural hospitals operate at a negative margin. Major contributors include
 33 uncompensated care, low patient volume, billing and administrative burdens, regulatory requirements,
 34 and staffing shortages, with rural and socioeconomically disadvantaged communities facing the greatest
 35 effects.¹⁹

36 37 EMERGENCY MEDICAL TREATMENT AND LABOR ACT

38
 39 Ninety eight percent of EDs are subject to the Emergency Medical Treatment and Labor Act (EMTALA).
 40 EMTALA requires Medicare-participating hospitals with EDs to screen and treat emergency medical
 41 conditions regardless of a patient's insurance status or ability to pay.²⁰ EMTALA obligations are triggered
 42 when an individual "comes to the emergency department," including by arrival via Emergency Medical
 43 Services, is present anywhere on hospital property within 250 yards of the main building, or is sent via a
 44 transfer request from another hospital's ED.²¹ Federal law requires hospitals to maintain an on-call list of
 45 physicians available to provide stabilizing treatment for emergency medical conditions, but it does not
 46 require ED care to be physician-led.²² When an individual presents at a hospital ED for examination or
 47 treatment, the hospital must provide an appropriate medical screening examination (MSE) by qualified
 48 medical personnel (QMP), which may include a physician, PA, or NP.²³ Physicians may be on call for
 49 multiple hospitals at once, but hospitals must have policies to manage that arrangement, including backup
 50 community call plans when a physician is unavailable.²⁴

Regulations define a “hospital with an emergency room” as a hospital with a dedicated ED, whether located on or off the main campus.²⁵ A dedicated ED is one that meets any one of the following three criteria: (1) it is licensed by the state as an emergency room (ER) or ED; (2) it is presented to the public—through its name, signage, advertising, or other means—as providing urgent care for emergency medical conditions without a scheduled appointment; or (3) during the prior calendar year, at least one-third of its visits were for urgent treatment of emergency medical conditions without a scheduled appointment, based on a representative sample.²⁶ This definition also includes units, such as labor and delivery or psychiatric intake or assessment units, where unscheduled ambulatory patients are routinely evaluated and treated for emergency medical conditions.²⁷

Hospital policies must specify when a QMP must consult an on-site or on-call physician. If a QMP cannot confidently rule out an emergency medical condition, a physician must be involved.²⁸ The Centers for Medicare & Medicaid Services (CMS) also permits the required MSE be performed via telehealth, even when the physician is elsewhere on campus or off-site, so long as the remote examination is clinically sufficient to determine whether an emergency medical condition exists.²⁹ Under EMTALA, a telehealth provider performing a MSE does not have to be a physician as long as they qualify as a QMP.³⁰ If video or other remote data are inadequate, an in-person examination is required. Any remote provider performing MSEs must be fully credentialed and privileged by the hospital, and hospitals may use proxy credentialing to streamline telemedicine services.³¹ If the treating ED physician determines that an in-person specialist assessment is needed to stabilize the patient, the on-call specialist must come to the hospital.³²

Although uncommon, some ED-like settings are not subject to EMTALA. Facilities that do not accept Medicare or Medicaid payments may fall outside the scope of EMTALA. Military and Veterans Affairs hospitals are also exempt and operate under separate federal requirements. UCCs that are not owned or operated by a hospital typically are not covered, and off-campus hospital departments that do not primarily provide emergency services may not qualify as dedicated EDs. Once a patient is formally admitted as an inpatient, EMTALA obligations generally end and other CMS Conditions of Participation apply.

EMERGENCY SERVICE PAYMENT

Emergency service payment typically uses the Current Procedural Terminology (CPT®) codes 99281–99285 evaluation and management (E/M) codes (five levels based on complexity), supplemented by critical care CPT codes 99291–99292 and facility revenue codes 0450, 0451, or 0456.³³ Additional CPT codes include observation (99221–99223) for patients placed in observation status and common procedure codes such as laceration repair (12001–12011) and splint application (29125–29515).^{34,35} For hospital inpatient or observation care services (including admission and discharge services) CPT codes 99234–99236 are used.³⁶ A modifier may be used to indicate a significant, separately identifiable E/M service performed by the same physician on the same day as a procedure.³⁷ Ambulance services are billed with Healthcare Common Procedure Coding System codes A0021–A0999 (e.g., Basic Life Support or Advanced Life Support).³⁸ Payment for these services does not depend on whether the care is delivered in a facility labeled an “emergency department” or “emergency room.”

Place of Service (POS) codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided. While there are numerous codes, POS 23 is designated for, “a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.”³⁹ For emergency services provided via telehealth, POS 23 should be paired with -95 to indicate remote care.⁴⁰ There is no regulation, directive, or guidance by CMS that POS code 23 must be within a location called an “emergency room” or “emergency department.”⁴¹

EMERGENCY DEPARTMENT STAFFING REQUIREMENTS

Staffing requirements vary by state and are set by state regulations and hospital licensing standards. State differences in ED physician-led care are driven, in part, by varying state regulations on the corporate practice of medicine, differing scope-of-practice laws, and the availability of local residency programs. While some states require continuous on-site physician coverage, most do not. Indiana, Virginia, and South Carolina require a physician to be on site and on duty 24/7, and several other states have considered similar legislation. Although this approach may serve as a model for other states, its success may depend upon most EDs in those states already being staffed in this way. In Virginia, for example, there was no ED without a physician present.⁴² It is unclear whether South Carolina and Indiana were staffed similarly. California and New Jersey have long had comparable mandates. California requires a qualified physician to oversee a hospital's emergency services and ensure they are staffed by an experienced physician.⁴³ New Jersey requires at least one licensed physician to be present in the ED to manage emergencies.⁴⁴

Most states, however, mandate flexible physician staffing requirements. Illinois, for example, classifies EDs as Comprehensive, Basic, or Standby. Comprehensive and Basic emergency treatment services require a physician on site 24/7, while standby services require a physician to be on call.⁴⁵ In Florida, state law requires every hospital offering emergency services to have its ED directed by a physician who is a member of the organized medical staff.⁴⁶ At least one physician must be available within 30 minutes through a required call roster, and two-way voice communication may be used for the initial consultation.⁴⁷ In New York, regulations provide that hospitals with fewer than 15,000 unscheduled ED visits per year do not need a supervising or attending physician on site, so long as one is available within 30 minutes of the patient's arrival.⁴⁸ States, however, universally require every licensed ED to appoint an explicit, state-licensed physician to serve as the Emergency Department Medical Director.⁴⁹ This individual is legally responsible for quality control, protocols, and provider credentialing.

Several factors can explain why a physician may not be present in an ED, including recruitment and retention challenges. Hospital administrators report difficulty attracting and retaining physicians to staff EDs, and workforce data support this concern. A 2020 study found that only eight percent of emergency physicians practiced in rural areas, and only two percent practiced in small rural areas.⁵⁰ Rural physicians also were, on average, significantly older than their urban counterparts and near retirement age, with most having completed training at least 20 years before 2020.⁵¹ Although rural EDs may be more likely to employ physicians who are not specialty trained in emergency medicine, workforce research shows that fewer than one-quarter of clinically active family medicine-trained emergency physicians practice in rural areas.⁵² Staffing challenges can also reinforce themselves; for example, rural hospitals may require new physicians to cover ED shifts multiple nights per week as a condition of employment, which may deter physicians who do not want to provide emergency services or work overnight hours.

EDs without an on-site physician often use alternative staffing models centered on advanced practice providers (APPs), such as PAs and NPs, to perform MSEs and stabilize patients. These models commonly pair APP staffing with remote physician oversight and rapid transfer protocols for higher-acuity cases. One approach is 24/7 APP coverage with an emergency physician continuously available off-site through real-time audiovisual technology to guide assessments, interpret diagnostics, and support critical decisions.⁵³ Another is autonomous APP staffing, in which PAs and NPs operate the ED with remote or on-call supervision from an off-site collaborating physician.⁵⁴ Some facilities use hybrid inpatient/ED models, with one experienced provider covering both the ED and inpatient unit during low-acuity or overnight periods.⁵⁵ A less common model uses specialized emergency paramedics, working under the attending APP's direct supervision, to support care through tasks such as IV placement, protocol-directed medication administration, and continuous vital-sign monitoring.⁵⁶

The capabilities of EDs with and without continuous physician leadership differ significantly. With an attending physician, there is usually the capability to independently perform complex procedures like intubation, chest tube insertion, and emergency surgeries while immediate, autonomous decision-making is possible with an interpretation of imaging and lab results.⁵⁷ Furthermore, specialty coverage is a possibility with direct, on-site management of acute trauma, severe strokes, and multi-system organ failure and procedural sedation with full capacity to manage deep sedation for acute fracture reductions or cardioversion on-site.⁵⁸ Without a physician present, an initial assessment and triage is likely to occur with basic stabilization, telehealth consultation for lab results and treatment of complex conditions, basic diagnostics (e.g., lab work), and emergency transfer if trauma is severe.⁵⁹

The practice requirements for APPs vary by state. All PAs must graduate from an accredited program, pass the national certification exam, obtain state licensure, and complete 100 continuing medical education hours every two years. Most states require physician supervision or collaboration, although eight—Iowa, Montana, New Hampshire, North Dakota, South Dakota, Maine, Utah, and Wyoming—allow eligible PAs to practice without a formal agreement.⁶⁰ PAs may prescribe in all states, Washington, D.C., and Guam, subject to local registration or delegation rules. Advanced practice registered nurses (APRNs), including NPs, clinical nurse specialists, nurse anesthetists, and nurse-midwives, practice under full, reduced, or restricted authority. Full practice permits independent evaluation, diagnosis, testing, treatment, and prescribing; reduced or restricted practice limits at least one function and may require collaboration, supervision, or delegation.⁶¹ APRNs generally must hold an accredited graduate degree, national certification for their role and population focus, and state licensure.

Trauma capabilities also vary by facility. Every trauma center has an ED, but not every hospital with an ED is a trauma center. Trauma centers provide specialized care for critical injuries, with trauma surgeons, neurosurgeons, orthopedic specialists, and other teams available around the clock for emergency surgery.⁶² State or regional authorities, not healthcare organizations, designate trauma centers using criteria that vary by state. Levels I through V reflect the resources available to treat traumatic injuries: Level I centers offer the most comprehensive care for severe injuries, while Level IV and V centers stabilize patients for transfer to higher-level facilities.⁶³ Adult and pediatric trauma centers receive separate designations. The American College of Surgeons (ACS) conducts a separate verification process to improve trauma care.⁶⁴ Whereas designation establishes a facility's trauma-center status, ACS verification confirms that it meets defined standards for preparedness, policies, resources, operations, and quality improvement.⁶⁵ Verification remains valid for three years.

CRITICAL ACCESS HOSPITALS & RURAL EMERGENCY HOSPITALS

Congress created the CAH designation in the Balanced Budget Act of 1997 after many rural hospitals closed in the 1980s and early 1990s.⁶⁶ The program is intended to preserve access to care in rural communities, reduce financial vulnerability, and keep essential services available.⁶⁷ Congress later established the Rural Emergency Hospital (REH) designation to help struggling rural hospitals avoid closure by converting to facilities that provide 24/7 emergency and outpatient services without inpatient care.⁶⁸ CAHs and REHs receive enhanced Medicare payments for certain outpatient services and, for REHs, additional monthly facility payments.⁶⁹ CAHs, rural acute care hospitals, tribally operated hospitals, and Indian Health Service hospitals with 50 or fewer beds that were open on December 27, 2020, may apply for REH status. To qualify, a hospital must be in a rural area or have an active rural classification under the Office of Management and Budget's Core Based Statistical Areas.⁷⁰

REHs must provide 24-hour emergency and observation services and may choose to offer other outpatient services.⁷¹ As with CAHs, an MD or DO physician, PA, NP, or clinical nurse specialist with emergency care training or expertise must be on-site or on-call and able to arrive within 30 minutes, or within 60 minutes if the facility meets certain frontier or remote-area criteria.⁷² States may impose stricter

requirements, including minimum staffing hours or specific personnel standards.⁷³ CAHs also must meet federal Conditions of Participation and comply with applicable state and local laws.⁷⁴ If state law is more stringent—such as California’s nurse-to-patient ratio standards or Indiana’s on-site physician staffing requirement—the facility must follow the stricter state standard.⁷⁵ CAH and REH eligibility rules do not mandate use of the terms “emergency department” or “emergency room.”

EMERGENCY DEPARTMENT SIGNAGE

No federal regulation requires facilities that provide immediate, unscheduled care, diagnostic services, and stabilization for seriously ill or injured patients to be labeled “emergency departments.” There is also no financial barrier preventing an “emergency department” from adopting alternative names (e.g., “unscheduled care center” or “rural immediate care center”). EMTALA does require conspicuous signage that is easily visible to all individuals entering the ED, including at entrances, waiting rooms, registration, and treatment areas.⁷⁶ Hospitals with dedicated EDs that do not have a physician present 24/7 must post clear public signage disclosing that fact under Medicare Conditions of Participation and EMTALA-related requirements.⁷⁷ Hospitals with continuous, on-site, qualified physicians are not required to post a physician-absence notice. When an MD or DO is not present on-site 24/7, the sign must state that the hospital does not have a physician present 24/7, and explain how the hospital will meet the immediate needs of patients with emergency medical conditions when a physician is not physically present, such as calling on-call physicians, using telehealth, or transferring the patient.⁷⁸ The notice must be posted conspicuously where patients and visitors are likely to see it, including emergency department entrances, waiting rooms, admitting areas, and patient treatment or examination areas, readable from 20 feet away, and written in clear, simple, and accessible language.⁷⁹

Furthermore, hospitals must post notices explaining patients’ rights to emergency treatment and to file complaints.⁸⁰ Signs must also state that the hospital provides an appropriate MSE, necessary stabilizing treatment (including for stabilization of the fetus), and whether the hospital participates in Medicaid.⁸¹ Posted information must be in the language(s) understood by the population served, written in clear, simple terms, and readable from 20 feet away.⁸² Updated model signage includes a QR code for additional information to meet 42 CFR § 489.20(q) requirements.⁸³ In addition, public ED entrances must be clearly marked from outside and from surrounding roads, readily distinguishable from ambulance entrances, and illuminated for visibility at night or in poor weather.⁸⁴

Some states impose additional ED signage requirements. For example, Massachusetts requires highly visible, illuminated—and in some cases reflective—signage directing patients to 24/7 care and clearly marking emergency entrances as “EMERGENCY.”⁸⁵ Illinois requires additional ED notices, including information on Affordable Care Act exchange enrollment, human trafficking, and charges for services such as x-rays, ER services, and room fees.⁸⁶ Some cities also have added requirements; Chicago, for instance, mandates approved emergency lighting and exit signage that may differ from national codes and requires local inspections.⁸⁷

EMERGENCY DEPARTMENT ADVERTISING

Although EDs without 24/7 on-site physician coverage must post clear public signage disclosing that fact under Medicare Conditions of Participation and EMTALA-related requirements, they are not required to include the same disclosure in advertising. Healthcare advertising is governed by federal law, state licensing boards, and healthcare marketing standards intended to protect patient safety, promote transparency about pricing and facility capabilities, and prevent deceptive practices. The Food and Drug Administration regulates pharmaceutical and medical device marketing to ensure information is accurate and not misleading.⁸⁸ State medical boards enforce jurisdiction-specific advertising rules, while the Federal Trade Commission (FTC) broadly regulates healthcare advertising by requiring claims to be

truthful, evidence-based, and not misleading.⁸⁹ For example, claims about wait times, equipment, or staff qualifications must be accurate. FTC enforcement focuses on deceptive practices under a three-part standard: the representation, omission, or practice must mislead or be likely to mislead consumers; the consumer's interpretation must be reasonable under the circumstances; and the misleading representation, omission, or practice must be material.⁹⁰ States (e.g., California, Georgia, and Indiana) increasingly restrict or penalize non-physician clinicians from using the title "doctor" in clinical and advertising settings if it misleads patients into believing they are physicians.^{91,92}

FTC guidance on claim substantiation and consumer endorsements is particularly relevant to healthcare marketing. Advertisers must have support for all express and implied claims an advertisement is likely to convey to reasonable consumers before the advertisement runs.⁹³ For example, ED wait-time claims must be substantiated before publication. If the comparison relies on a national standard for certain trauma or condition-specific care, such as heart attacks or strokes, the advertisement should clearly disclose that qualification. Healthcare providers that advertise treatment outcomes must also be able to support those claims.⁹⁴ Comparisons to regional or national averages should be clearly stated, and advertisers should avoid success-rate claims when the data may be distorted by an unusual patient population, small case volume, or another statistical anomaly. Healthcare marketing should also consider how prospective patients are likely to interpret an advertisement.⁹⁵ A patient who sees a facility claims a much higher success rate than the national average may reasonably assume the difference reflects better care at that facility, rather than differences in patient population or case volume.

State medical boards oversee ED advertising primarily to protect public health by preventing false, deceptive, or misleading claims.⁹⁶ Because emergency care is time-sensitive, boards scrutinize advertisements that could manipulate vulnerable patients or delay lifesaving treatment. Key compliance concerns include misrepresenting a facility's services, capabilities, licensing, or staff credentials.⁹⁷ For example, a practice or freestanding facility should not advertise itself as an "emergency room" or "emergency department" unless it has the required state license, trauma designation, and 24/7 capabilities.⁹⁸ Similarly, an ED should not claim to be "fully staffed by emergency specialists" if shifts are routinely covered by clinicians who lack the stated qualifications or required supervision.⁹⁹ Advertised wait times—whether displayed on billboards, websites, or apps—also must be based on legitimate, reliable data.¹⁰⁰ A board may investigate a hospital that presents door-to-triage time as total wait time rather than measuring the time until evaluation by a qualified medical professional. The ACEP advises prominent disclaimers explaining that published wait times do not apply to life-threatening emergencies, which receive immediate priority.¹⁰¹ If a patient with a serious condition, such as a heart attack, delays care because of a posted wait time, a board may assess whether the advertisement created a public health risk.¹⁰² State licensing boards also restrict fear-based or high-pressure marketing that exaggerates health threats or exploits patient panic to steer individuals toward a particular hospital network.¹⁰³ Although medical boards regulate individual professional licenses, they often coordinate with other agencies on ED advertising violations. Misleading, inaccurate, or unsafe marketing can result in public reprimands, financial penalties, practice restrictions, or suspension or revocation of the licenses of responsible physicians or medical directors.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS' ACCREDITATION PROGRAM

The ACEP Emergency Department Accreditation Program (EDAc) is a voluntary national program recognizing EDs that meet defined standards for quality, safety, and clinical excellence and could be a roadmap to evaluate and distinguish EDs with and without continuous physician coverage. Its 33 multidisciplinary benchmarks address quality improvement, boarding policies, pediatric readiness, workplace fairness, performance monitoring, and resources such as ultrasound, interpreter services, and staff safety protocols.¹⁰⁴ EDAc evaluates facilities across four levels based on capabilities such as advanced imaging, social services, and, most importantly, staffing models. Gold Level I, the highest

1 designation, requires comprehensive staffing, a qualified emergency or pediatric emergency physician be
 2 physically on-site 24/7 365 days per year, advanced imaging, and on-site social services.¹⁰⁵ Silver Level II
 3 applies strong but less stringent staffing with integrated physician-led care and advanced diagnostic
 4 access but permits flexible on-call scheduling or slightly altered supervisor-to-midlevel (APP) staffing
 5 ratios.¹⁰⁶ Bronze Level III reflects compliance with the 33 foundational standards and focuses heavily on
 6 the structural administrative baseline and requires foundational advanced imaging and strict physician-led
 7 supervision frameworks but mandates fewer dedicated ancillary staff lines like standalone ED social
 8 workers.¹⁰⁷ Lastly, the Rural and Critical Access designation uses streamlined criteria for federally
 9 designated Rural Emergency Hospitals and Critical Access Hospitals.¹⁰⁸ Participating hospitals use EDAC
 10 to show they follow evidence-based policies and provide high-quality emergency care.

11 URGENT CARE CENTERS

13 While EDs address immediate, life-threatening emergencies, UCCs are free-standing same-day clinics for
 14 patients who need expedient, non-critical care. UCCs emerged in the 1970s as a convenient alternative to
 15 EDs for noncritical, acute illnesses.¹⁰⁹ In the 1980s, there was skepticism of their role due to a perceived
 16 lack of quality control which led to a decline in popularity.¹¹⁰ However, they are now seen as an essential
 17 part of the healthcare system. Over the past two decades, they have expanded due to the high cost of ED
 18 visits, insurance company encouragement, and the need for immediate, non-scheduled care.^{111, 112} From
 19 2016 to 2025, UCCs have grown from 9,000 to 15,398 with 89.4 percent of the US population within a
 20 20-minute drive.¹¹³ Approximately, 185 million patients were cared for in an UCC setting in 2025.¹¹⁴

22 UCCs are largely physician-led with 94 percent of facilities employing at least one full-time physician.¹¹⁵
 23 Most UCCs legally require a physician for medical oversight, with a physician employed or contracted by
 24 the facility even if they are not physically in the building. Approximately 80 percent of UCCs employ a
 25 combination of physicians, PAs, and NPs.¹¹⁶ The remaining 20 percent employ only physicians.¹¹⁷ Sixty
 26 percent of UCCs are independent/private while 30 percent are hospital-owned.¹¹⁸ Of the physicians
 27 practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine
 28 physicians, and 8 percent are internal medicine physicians.¹¹⁹ In 22 states and the District of Columbia,
 29 NPs have full practice authority and can practice without direct physician supervision. However, even in
 30 states with relaxed rules, corporate practice of medicine laws and insurance enrollment policies often
 31 require a physician on the business or licensing framework, making completely physician-free corporate
 32 urgent care structures extremely rare. Physician employment tends to attract physicians wishing to work
 33 part-time hours and those looking to transition into retirement.

35 There is a diverse, rapidly growing variability in the care, services, and staffing between UCCs and
 36 EDs.¹²⁰ While designed for immediate, non-life-threatening needs, UCC capabilities range from basic,
 37 NP-led care to advanced, hospital-affiliated facilities with specialized diagnostics.¹²¹ Services vary, but
 38 they often include on-site x-rays, casting, and suturing.¹²² However, only 14 percent had computed
 39 tomography scanners and 18.6 percent had ultrasound on site.¹²³ There also might be potential for high
 40 rates of discordant diagnoses compared to EDs, with some studies finding that 64 percent of patients
 41 transferred from a UCC to the ED had a discordant diagnosis.¹²⁴ This discrepancy may reflect limited
 42 services at some UCCs, less experience with advanced diagnostic interpretation, and care provided by
 43 APPs rather than physicians specializing in emergency medicine.¹²⁵ Some UCCs focus on primary care or
 44 occupational medicine, while others prioritize acute, low-acuity cases and increasing patient volume.¹²⁶
 45 UCCs in cities with hospitals may have different patient demographics (younger) and shorter wait times,
 46 while corporate-owned or hospital-affiliated centers may offer different service menus than independent
 47 ones.¹²⁷

RECENT REGULATORY ACTIVITY

Several states have mandated that a physician be present in the ED 24/7. Signed into law on May 4, 2023, [Indiana's Senate Bill 400 \(SB 400\)](#) requires that all hospital EDs in the state have a licensed physician on-site, on-duty, and responsible for the ED at all times. This legislation aims to ensure physician-led care in emergency settings. The law was driven by efforts to standardize care quality and ensure high-level training is available, particularly following concerns about solely staffing EDs with non-physician practitioners. Starting July 1st, 2025, Virginia law ([Senate Bill 392](#)) requires all hospital EDs to have a physician physically on site, on-duty, and responsible for the ED 24/7. Passed by the Virginia General Assembly and signed into law, the mandate ensures physician-led care for emergency patients, specifically enhancing care in rural locations. Previously, the law mandated there must be a physician on-call, but not physically present. South Carolina passed legislation in May 2025 ([H. 4067](#)) that requires all hospitals with EDs to always have at least one physician physically on-site while the department is open. This applies to all hospitals with EDs, regardless of their classification – rural, urban, public, or private.

AMA POLICY

[Policy H-130.929](#) recognizes that the preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement.

[Policy D-35.976](#) advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED.

[Policy H-160.949](#) opposes legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision, and vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.

[Policy H-130.976](#) reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services and asserts that physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

[Policy H-35.973](#) supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

[Policy H-35.989](#) broadly outlines that the PA should function under the direction of and supervision by a duly qualified licensed physician and that the care provided by the PA be in concert and guidance by the physician.

[Policy H-160.947](#) presents the guidelines developed by the AMA for guiding an appropriately developed physician/PA practice and that the AMA will develop a plan for identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

[Policy H-160.888](#) supports any individual, company, or other entity that establishes and/or operates UCCs adhere to principles which, in part, suggests that UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided.

[Policy D-130.958](#) seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all ED be staffed 24/7 by a qualified physician.

[Policy D-35.985](#) outlines the advocacy of the AMA for physician led team-based care.

DISCUSSION

The Council recognizes that physician-led emergency care differs in scope, complexity, and depth from care provided by non-physician practitioners such as PAs and NPs. It also acknowledges that a growing number of EDs are not physician-led or lack on-site physician coverage around the clock. Rural and under-resourced facilities often face financial, recruitment, and retention challenges that make continuous physician coverage difficult. These pressures are contributing to facility closures, further limiting patients’ access to care. Nonetheless, transparency remains essential. Patients seeking care at an ED should be clearly informed when a physician is not providing their care and when transfer to another hospital may be necessary for more complex treatment. Accordingly, the Council supports standardized ED descriptors that clearly identify each facility’s level of on-site physician coverage and available services. It also recommends that facilities dedicated to emergency care without an on-site physician use standardized, real-time language that enables a prudent layperson to readily understand the physician coverage and services available. To further promote transparency, the Council supports requiring facilities without continuous on-site physician staffing to prominently disclose this fact through physical and online signage and in advertisements, consistent with FTC guidelines. The Council also supports community engagement and patient education to improve understanding of ED coverage and services and to help healthcare teams promote efficient, site-appropriate care. Finally, the Council recognizes the complexities of site-of-service payment, including the risk that emergency care may be improperly paid regardless of a facility’s level of on-site physician coverage, and that facility terminology may confuse patients. To address these concerns, the Council supports limiting the terms “emergency department” and “emergency room” to facilities that meet EMTALA requirements and classifying any qualifying EMTALA-covered facility as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage.

The AMA has longstanding policy on key aspects of this issue, and the Council recommends reaffirming several policies to reassert its position. Because emergency medicine is complex, the preferred model is full-time, on-site physician presence, which should be pursued whenever possible and feasible. However, the Council recognizes that workforce shortages and financial constraints may warrant limited rural exceptions, and that alternative models may be necessary to meet some communities’ needs. Accordingly, the Council recommends reaffirming Policy H-130.929, which recognizes the AMA’s preferred model of on-site physician presence in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing appropriate limited rural exceptions. Additionally, the Council recognizes that an increasing number of facilities, including EDs, are substituting physicians with non-physician practitioners. The Council views this trend as concerning because physician-led care provides a level of training, scope, and clinical judgment that differs from care provided by non-physicians. As such, the Council recommends reaffirming Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-

physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers.

Furthermore, the Council recognizes the important role of physicians in the supervision of emergency care. Therefore, the Council recommends reaffirming Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED, and Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED. Lastly, the Council recognizes the vital role of smaller, financially challenged facilities that provide emergency services and does not seek to undermine their viability. Accordingly, the Council recommends reaffirming Policy H-240.958, which advocates prohibiting insurers from denying or reducing payment for medically necessary procedures based solely on the site of service, provided the procedure can be safely performed in that location.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support the development of standardized emergency department (ED) descriptors that reflect a facility's level of on-site physician coverage and available services, easily discernible by the prudent layperson. (New HOD Policy)
2. That our AMA recommend that emergency care facilities without a dedicated on-site physician utilize these standardized ED descriptors to promote truth and transparency for patients. (New HOD Policy)
3. That our AMA support limiting the designations "emergency department" and "emergency room" to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. (New HOD Policy)
4. That our AMA support requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on-site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines. (New HOD Policy)
5. That our AMA support community engagement to improve the education of patients and allow other healthcare team members to promote efficient and site appropriate care. (New HOD Policy)
6. That our AMA reaffirm Policy [H-130.929](#), which recognizes that the AMA's preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing limited appropriate rural exceptions. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy [D-35.976](#), which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy [H-160.949](#), which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers. (Reaffirm HOD Policy)
9. That our AMA reaffirm Policy [D-130.958](#), which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all EDs be staffed 24 hours per day/7days per week by a qualified physician. (Reaffirm HOD Policy)
10. That our AMA reaffirm Policy [H-240.958](#), which advocates to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which it was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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¹¹⁸ Mireles-Romo C, Hernandez E, Choi I, Roh J, Saadat S, Toohey S. Exploring Factors That Drive Nonurgent Emergency Department Use. *J Patient Exp*. 2025 Jul 23;12:23743735251362529. doi: 10.1177/23743735251362529. PMID: 40718463; PMCID: PMC12290403.

¹¹⁹ *Ibid*.

¹²⁰ *Supra* 109.

¹²¹ Nicole W. Carter, Judith Finn, Janie A. Brown, Urgent care centres and their role in metropolitan healthcare systems in high-income countries: A scoping review, *Australasian Emergency Care*, 2026, ISSN 2588-994X, <https://doi.org/10.1016/j.auec.2026.03.003>.

¹²² *Supra* 109.

¹²³ *Supra* 109.

¹²⁴ Poyorena C, Patel S, Keim A, Monas J, Urumov A, Lindor R, Girardo M, Rappaport D. Evaluating urgent care center referrals to the emergency department. *J Am Coll Emerg Physicians Open*. 2022 Dec 7;3(6):e12838. doi: 10.1002/emp2.12838. PMID: 36504881; PMCID: PMC9728618.

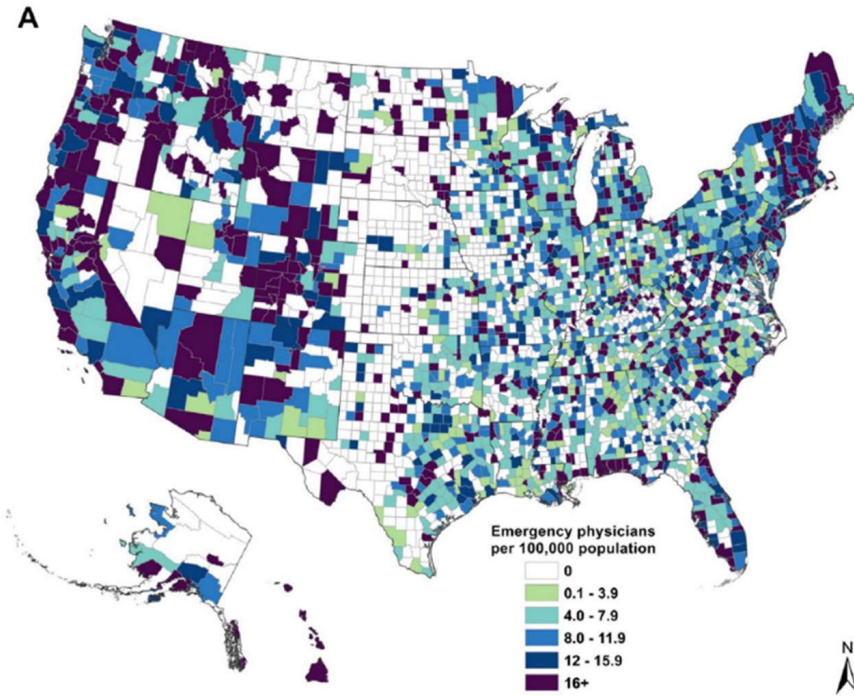
¹²⁵ *Ibid*.

¹²⁶ *Supra* 118.

¹²⁷ The Essential Nature of Urgent Care in the Healthcare Ecosystem Post-COVID-19. August 2023. Urgent Care Industry White Paper. Urgent Care Association. <https://urgentcareassociation.org/wp-content/uploads/2023-Urgent-Care-Industry-White-Paper.pdf>

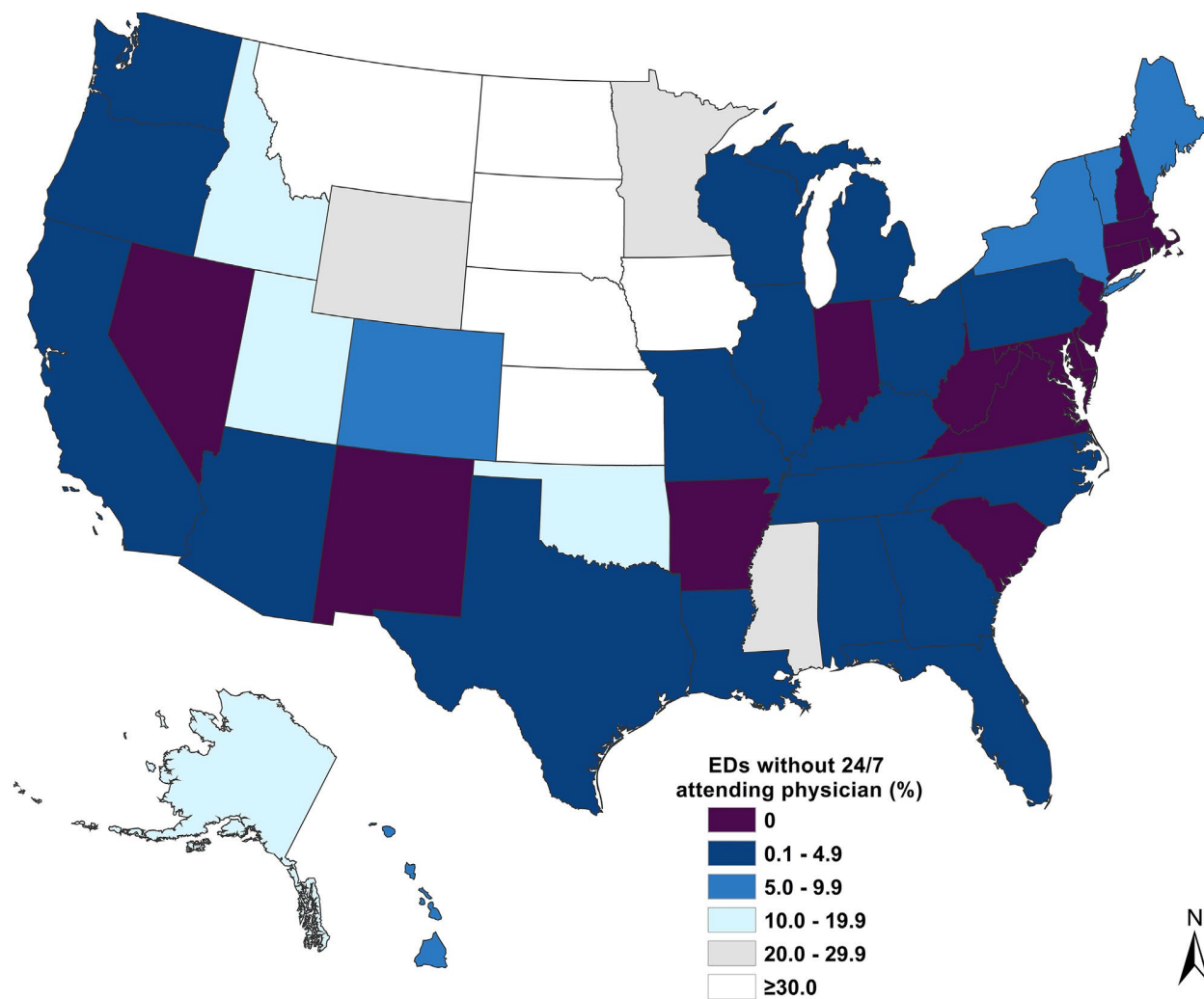
Appendix A

Density of emergency physicians across the country—emergency physicians per 100,000 population—includes physicians who are residency-trained or certified in emergency medicine and physicians trained in a nonemergency specialty. (*Supra* 47)



Appendix B

Percentage of US emergency departments without 24/7 attending physician coverage by state, 2022.
(Supra 8)



**Council on Medical Service Report 1-I-26
Transparency with the Term “Emergency Department”
Policy Appendix**

On site Physician Requirements for Emergency Departments H-130.929

1. Our American Medical Association recognizes that the preferred model of emergency care is the on site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.
2. Our AMA, in the pursuit of any legislation or regulation requiring the on site presence of a physician who is primarily responsible for care in the emergency department (ED), supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on site care.

(BOT Rep. 02, I-24; Reaffirmed in lieu of: Res. 213, A-25)

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976

Our American Medical Association will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department.

(Res. 218, A-23; Reaffirmed in lieu of: Res. 213, A-25)

Practicing Medicine by Non-Physicians H-160.949

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

(Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-

11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21; Reaffirmed in lieu of: Res. 213, A-25)

On site Emergency Care H-130.976

(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

(BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

Scopes of Practice of Physician Extenders H-35.973

Our American Medical Association supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

(Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: BOT Rep. 7, A-21)

Physician Assistants H-35.989

1. Our American Medical Association opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which:
 - a. would unreasonably expand the professional scope of practice of the supervising physician;
 - b. cannot be performed safely and effectively by the physician assistant, or
 - c. would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal

presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to their physician assistant.
5. Our AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice. (BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17; Reaffirmed: BOT Rep. 12, A-23; Reaffirmed: Res. 208, I-23; Modified: Speakers Rep. 02, I-24)

Physician Assistants and Nurse Practitioners H-160.947

Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

(BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22; Reaffirmed: CMS Rep. 09, A-23; Modified: Speakers Rep. 02, I-24; Reaffirmed in lieu of: Res. 213, A-25)

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our American Medical Association endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: BOT Rep. 09, A-23)

Support for Physician Led, Team Based Care D-35.985

1. Our American Medical Association reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-

35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Our AMA will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Our AMA will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Our AMA will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Our AMA will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Our AMA will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Our AMA will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

(BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21)

Staffing Ratios in the Emergency Department D-130.958

1. Our American Medical Association will seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the Emergency Department.
2. Our AMA supports that all Emergency Departments be staffed 24-7 by a qualified physician.
(Res. 204, A-24; Reaffirmed in lieu of: Res. 213, A-25)

Urgent Care Centers H-160.888

1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
 - a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community.
 - b. UCCs must transfer a patient's medical records to their primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
 - c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.
 - d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made.
 - e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted.
 - f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on site health care providers.

- g. UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided.
- 2. Our AMA will work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending.
- 3. Our AMA supports patient education including notifying patients if their physicians are providing extended hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, asking for their patients to notify their physician or usual source of care before seeking UCC services, and encouraging patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services.

(CMS Rep. 6, A-21; Modified: Speakers Rep. 02, I-24)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
The Impact of the Inflation Reduction Act on Physician Practices
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the House of Delegates adopted Policy D-110.980, which asks that the American Medical Association (AMA) study the impact of the Inflation Reduction Act (IRA) drug price negotiation on physician-owned practices, with a focus on oncologic practices, and patient access.

The Council reviewed data related to drug pricing and payment in the United States, including the impact of drug affordability on patients and physicians. The Council discussed different drug payment models and how these models may, or may not, benefit patients and physicians. Among these payment models, the Council reviewed the commonly used Average Sales Price-based reimbursement payment model used for many physician-administered drugs, including those covered under Medicare Part B. This report highlights the challenges that this payment model can cause for physicians and physician practices, especially smaller/community-based practices, such as lagging and inadequate payments. Further, the Council reviewed information regarding updates to the IRA drug price negotiation and its initial implementation. The Council reviewed the potential impacts of these negotiated Maximum Fair Prices (MFPs) and how payment structures would change for physician practices, highlighting the potential revenue loss for practices that utilized a high number of Part B/physician-administered drugs. However, the report also outlines the uncertainty of this area as the IRA negotiated MFPs for Part D drugs have just begun to be implemented and the initial round of Part B negotiated MFPs are yet to be released. The Council highlights information on how these negotiated prices could affect physician practices, particularly in the specialties of oncology and hematology, as they are most likely to see the largest financial impact. Finally, the Council reviewed AMA advocacy efforts and existing policy which highlight the need for transparency, affordability, and fair payment for prescription drugs.

The Council firmly believes in the importance of ensuring that physician practices are able to remain financially viable, while also acknowledging that it will take time to realize the full impact of the IRA Medicare negotiated prices. The Council recommends adoption of new policy to advocate for Medicare prescription drug price negotiation and price effectuation toward ensuring that: 1) actual acquisition costs decrease in a manner commensurate with reductions in drug prices; and 2) all payments cover the cost of acquisition, storage, inventory, administration, and other necessary clinical services, highlight administrative simplicity, and are timely, affordable, and transparent for patients and physicians. The Council believes that this policy allows support for alternatives to the traditional payment models while also ensuring that the IRA negotiation does not have a negative impact on patients or physicians. Additionally, the Council recommends amendments to Policy D- 110.980 to support continued monitoring, reporting, and advocacy on Medicare drug price negotiation. Finally, the Council recommends the reaffirmation of Policy H-110.956, which works to safeguard fair and timely payment for physicians and practices for biologic/biosimilar drugs. The Council believes that the combination of the new policy, amended policy, and reaffirmed policy builds on a strong foundation to ensure not only patient access to affordable medications, but also to financially health physician-owned practices.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-26

Subject: The Impact of the Inflation Reduction Act on Physician Practices

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates adopted Policy D-110.980, “Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices,” which asks that:

1. Our American Medical Association (AMA) will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act’s (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA’s potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is.
2. Our AMA will specifically evaluate the potential impact on the sustainability of community-based physician practices, with a particular focus on oncology practices.
3. Our AMA will consider using the findings of this study to inform its advocacy efforts to ensure that any future drug pricing policies balance patient affordability with the stability of physician practices, patient access, and the continued advancement of drug innovation.

This report provides an overview of drug pricing in the United States, drug payment models, and the IRA drug price negotiation provisions. Further, although the data are limited and preliminary, this report outlines potential impacts of IRA drug price negotiation on physicians, practices, and patients.

BACKGROUND

In the United States, prescription drug spending represents a major portion of overall health costs, leading to serious concern for many Americans. Prescription drug spending makes up approximately 10 percent of all national health dollars, and as much as 20 percent of spending for large employers and Medicare.^{1,2} This is a major point of concern for many patients as 60 percent of adults report worrying about being able to afford prescription drugs, approximately 40 percent report rationing or skipping doses as a result of cost, and over two-thirds report that prescription drug price affordability is getting worse.^{2,3} Further, this can also be a major obstacle for physician practices, especially when dealing with high-cost physician-administered drugs.

The American prescription drug pricing system is both complicated and opaque, with drug manufacturers, payers, and pharmacy benefit managers (PBMs) setting prices, and requiring physicians and patients to navigate the system.⁴ Within employer sponsored plans, drug price

1 negotiations are typically handled by PBMs who act as middlemen between the payer and the
2 manufacturer, negotiating lower prices for the payers. Manufacturers often incentivize PBMs to
3 place their drugs favorably on the formulary via rebates and discounts. Cost savings are often
4 calculated based on a list price, which serves as the starting point for future negotiations and is
5 commonly inflated to allow for larger rebates and/or discounts.⁴ While these savings should be
6 passed on to patients, they often are not, and as a result, patients often pay more out-of-pocket for
7 higher-priced drugs.⁴ To further exacerbate the issues around opacity and expensive drug prices,
8 many PBMs are vertically integrated with payers and/or pharmacies, thereby enabling practices
9 which may limit competition, often driving prices up further and limiting patient choice.⁵

10 11 DRUG PAYMENT MODELS

12
13 Under the commonly used buy-and-bill model, the purchasing entity, typically a physician office,
14 hospital, or outpatient infusion center, will buy and store the medication, administer it to the
15 patient, and bill the payer. The purchaser is then paid for the medication at a rate that is pre-set
16 either by legislation with public payers or contractual agreement with private payers.^{6,7} Drugs
17 covered under Medicare Part B are typically administered in a healthcare setting and have a more
18 complicated payment system, with the administering entity, often a physician's office, hospital, or
19 infusion center, entering into this buy-and-bill system. In contrast to Medicare Part D drugs, which
20 include mostly traditional, non-physician administered prescription medications, Part B drugs are
21 typically those that require administration by a healthcare professional. These injectable/infused
22 drugs often include chemotherapy, immunosuppressives, and certain vaccines such as influenza
23 and COVID-19. Under Part B, reimbursement is set at the Average Sales Price (ASP) plus six
24 percent, often referred to as ASP+6, with 20 percent cost-sharing paid by the patient. This is
25 slightly modified for qualifying biosimilar medications in that these medications are paid at an ASP
26 plus eight percent rate to incentivize their use over the typically more expensive reference
27 biologic.^{6,7} However, due to Medicare sequestration on Part B drugs, the actual payment rate is as
28 low as ASP+4.3. This means that if the ASP of a medication is \$100, the purchasing entity would
29 be paid \$104.30, or \$106.30 if the drug is a qualifying biosimilar.

30
31 While this system seems to be straightforward, it does pose a number of distinct challenges for
32 purchasing entities, especially smaller and community-based physician practices, as payment rate
33 updates often lag, making them inadequate to cover actual costs. Since payment rates are updated
34 quarterly, purchasing entities are paid based on the ASP rate from two quarters prior instead of the
35 current rate.⁸ Even when rates are updated accurately, research shows that in just over a third of
36 cases, clinics are inadequately reimbursed.⁹ Since the medications are typically administered in
37 office settings, there are associated fixed costs such as complex drug storage, staffing, shipping,
38 inventory management, compliance with drug compounding protocols, drug preparation,
39 acquisition, and administration. These costs are unique to physician administered drugs and add to
40 the typical costs associated with running a physician practice such as information technology,
41 patient debt, prior authorization, and other administrative burdens.¹⁰ As a result, physician practices
42 that utilize these drugs, commonly oncology practices, struggle to remain financially viable.^{6,10}
43 Because larger health systems have more patients, the fixed cost per patient is lower which allows
44 the ASP plus payment system to cover the costs. Further, larger health systems are often able to
45 negotiate lower initial drug prices. However, for smaller community-based practices, the
46 combination of the lower patient load with a less powerful negotiation position often leads to the
47 ASP plus payment being inadequate to cover the actual costs of delivering medication therapy.⁹
48 This system also places the financial risk on the purchasing entity instead of the pharmacy or payer
49 as is more common with non-physician-administered drugs, such as Part D drugs.¹⁰
50 In response to criticisms of the buy-and-bill model, some experts suggest moving toward value-
51 based payment models, which are sometimes referred to as "financial risk-based" or "outcomes-

based,” but rely on associating a drug’s performance with its cost.¹¹ For example, if a drug performs well and treats a disease effectively, the price may go up, but if a drug does not effectively treat the disease, then the price may decrease. Historically, this model has been challenging, as the collection of data faces many obstacles. While technology enables real-time patient data collection, making data more readily available, there are concerns around reliability, accessibility, operations, and data privacy that must be addressed before this pricing model can be successfully implemented.¹¹ These types of models are especially attractive to entities that purchase larger quantities of drugs, where contractual agreements include full or partial reimbursement to the purchaser if predetermined outcomes are not met.¹¹ For example, the University of Pittsburgh Medical Center (UPMC) entered a contract with AstraZeneca for the drug Brilinta, a blood thinner used to lower the risk of heart attack and stroke, in which payment depended on outcome and the health system was able to reduce the monthly cost for UPMC patients from \$40 per month to just \$10.¹²

Although outcomes-based payment models are relatively rare, with only a quarter of pharmaceutical executives reporting usage, reports have shown that a majority of pharmaceutical company and PBM directors seem to be open to entering into these types of models.¹¹ However, research suggests that while cost savings for consumers can result from these types of models, value-based drug pricing is often tied to significant price instability, which can result in less effective and/or lower long-term cost savings.¹³ Further, there is often debate as to how “value” should best be defined with concerns about equity, especially for those with a disability or chronic illness. When drugs are not curative, the maximum health utility formula for patients who take it can be lessened and as a result the value of the drug can be artificially lowered.¹⁴ Further, this type of drug pricing model may place smaller clinics and offices at a disadvantage as they may have less resources to track patient outcomes and lower bargaining power when negotiating with manufacturers.

While not applicable for all types of drugs, the so-called “mortgage” payment model could be utilized when the quantity and cost of a drug is appropriate. When a drug is extremely high cost, does not have direct competition, and is not widespread in its usage, purchasers may be able to utilize a mortgage buying model.^{14,15} This model allows for the upfront costs to be spread over time and is relatively common with about half of surveyed pharmaceutical leaders reporting that they used this model at least once. Within this model the drug purchaser and drug manufacturer enter into an agreed upon payment schedule and/or financial payments when a treatment milestone is reached.¹⁵ Proponents of this type of model argue that its implementation allows the payer to spread costs and potentially reduce downstream costs. However, critics of the mortgage model argue that it may not actually reduce any costs and that the tracking of milestones to trigger payment may place additional administrative burdens on physicians and their offices or practices.¹⁵

IRA NEGOTIATION

While none of these payment models are a perfect fit, research has shown that drug payment and reductions in cost are top issues for the majority of Americans. Polls show that 77 percent of Americans across political party affiliation support an increased focus on drug pricing affordability. Further, nine out of ten Americans support the need for federal legislative action to reduce the cost of drugs, with three-quarters supporting legislation limiting pharmaceutical company influence. Although many voters currently report a worsening in drug price affordability, the issue itself is not new. The IRA was enacted in 2022, and targeted a number of affordability issues, including drug pricing. The law included out-of-pocket spending caps, vaccine coverage for Medicare and/or Medicaid beneficiaries, and a requirement that if the price of a selected medication rises faster than the overall rate of inflation, the manufacturer is required to pay rebates to the Federal government.

A particularly impactful change included in the law was the allowance for the Centers for Medicare & Medicaid Services (CMS) to directly negotiate the prices of high expenditure drugs.¹⁶ To be eligible for CMS selection for negotiation, drugs must be single source and not have a biosimilar/generic alternative. Negotiated prices are set as the Maximum Fair Price (MFP), and the medication must be available to all Medicare beneficiaries at, or below, the set MFP. Further, each year CMS is required to publish explanations of MFPs, called initial price applicability year (IPAY), which allows for greater insight to the negotiation process and what data points CMS is using.¹⁷ IPAY summaries have been released for the first two rounds of negotiations and demonstrate that CMS seems to be relying on manufacturer-provided data, clinical evidence, and public comment to complete structured and evidence-heavy reviews.^{17,18}

Currently, private payers are not required to match these prices for their beneficiaries, with experts divided on whether they will. Although some experts posit that MFPs may eventually serve as a benchmark for private payers which could lower the prices of those drugs, others advocate that the MFPs should be legislatively required to be honored by private payers as well.¹⁹ While it will take time to see if private payers choose to incorporate Medicare negotiated MFPs, there may be some level of impact as research shows that around two percent of those with private plans are currently taking at least one of the drugs included in the initial round of negotiations.¹⁹

The initial list of 10 Part D drugs selected for negotiation was released in late 2023 with negotiations occurring in 2024 and the negotiated MFPs taking effect January 1, 2026. Negotiation for these 10 initial drugs resulted in an average savings of about 60 percent and largely targeted drugs that treated conditions such as diabetes, cancer, and heart diseases.^{16,17} For example, Imbruvica, a drug used to treat blood cancers, saw a 38 percent reduction in cost while Januvia, a drug used to treat diabetes, heart failure, and kidney disease, saw a 79 percent cost reduction.²⁰ The second round of negotiations occurred in 2025 and included 15 Part D drugs, with the prices scheduled to go into effect at the start of 2027. Negotiated prices for the second round of 15 Part D drugs boasted savings as high as 85 percent for consumers.^{16,17} For example, Janumet, a medication used in the treatment of Type 2 Diabetes, saw the greatest cost reduction with a negotiated price of \$80 for a 30-day supply, down from a list price of \$526. Further, although the smallest cost reduction was seen by the drug Calquence, which is used to treat types of blood cancer, this drug still had a cost decrease of 40 percent.¹⁶ Notably, this round of negotiations also targeted popular GLP-1 medications Ozempic, Rybelsus, and Wegovy, resulting in a 71 percent decrease from the previous list prices.¹⁷ The third cycle of drugs, currently being negotiated, includes for the first time Medicare Part B drugs. These prices will go into effect in January 2028 and include six drugs covered under Part B along with nine Part D covered drugs.¹⁷ While MFPs have not been released for the drugs currently under negotiation, the first two cycles have resulted in an average cost reduction just over 60 percent. Although higher cost drugs, often those covered in Part B, have seen slightly lower cost reductions, if the current round of negotiation follows suit of the first two, selected Part B drugs may see a reduction between 40 and 60 percent. Full details on the drugs included in all rounds of negotiation can be found in Appendix A.

IMPACT OF IRA NEGOTIATION

Although the initial round of negotiated prices has only been in effect since the start of 2026, and Part B medications were not included in the first two rounds, some physicians and experts have begun to voice concerns about the potential impact of the negotiated MFP, especially on smaller/community-based physician practices. While the negotiated Part D prices are unlikely to have any major impact on physicians or practices, it is possible that the forthcoming Part B negotiated prices may.¹⁰ For Part B drugs selected as a part of Medicare negotiation, physician payment will shift from ASP+6 to MFP+6, or 106 percent of the MFP. As a result of this shift, it is

likely that physician payment for the drugs will decrease. For example, should a drug's ASP be \$1,000, the ASP+6 reimbursement for the physician would be \$1,060. If the drug's negotiated MFP were to be set at the average cost reduction, 62 percent, the new price would be \$380. Based on the updated physician payment model of MFP+6, the physician/practice would receive about \$403. While the acquisition cost for the practice should also decrease, this drop in payment could be significantly problematic, especially for smaller community-based practices that do not have as much overhead capital to cover costs associated with elements like storage, staffing, or administration or if physician offices are required to pay the non-MFP cost for the drug upfront and be reimbursed later.¹⁰ While these changes are only guaranteed to occur for medications selected for negotiation and only for Medicare beneficiaries, it is possible that private payers will seek to negotiate drug prices based on the publicly available IRA negotiated MFPs, potentially leading to further issues for physicians related to private payer rates.¹⁹

While many experts do believe that the lower negotiated MFPs will benefit physician practices that purchase the drugs as they may lead to lower costs, physicians who practice in these settings, especially smaller community-based practices, have voiced significant concern. Estimates anticipate reductions of approximately 64 percent, or as much as \$19 billion, in Medicare add-on payments and an anticipated a 13-21 percent reduction in Medicare Advantage (MA) add-on payments for physicians/providers who administer negotiated oncology/hematology drugs. This means that if an oncology/hematology practice currently receives \$100,000 in payment for these high-cost drugs, after the implementation, assuming the average 64 percent reduction, this could be reduced to as little as \$19,000 from Medicare and MA. As previously mentioned, larger hospitals and health systems are likely better suited to be able to manage these payment and cost changes, however it is anticipated that smaller practices and/or hospitals may struggle significantly. The closures of these community clinics, hospitals, or physician practices are likely to exacerbate health disparities and create or expand care deserts for patients.¹⁰

Although the impacts of these negotiations on patients have yet to be seen, some experts believe that the negotiations have the potential to save patients money and may improve coverage. Some research has begun to show, however, that patient out-of-pocket (OOP) savings are marginal, if they are present at all. Differences in Part D plans will likely impact how much, or if, patients save money. Beneficiaries whose OOP cost is a set copayment will likely not save money, or not as much money, as beneficiaries whose OOP costs are calculated as a percentage of the cost.²¹ While the Medicare plan would save money by paying the MFP instead of the non-negotiated price, the savings may not reach the patient. Further, since the IRA MFP prices are only required to be honored for Medicare beneficiaries, it is unknown if these prices would carry over to those with other forms of health insurance. Should payers choose to continue to use non-negotiated prices, it is possible that beneficiaries of non-Medicare plans may see no net benefit to the IRA negotiated prices. However, it is also possible that public payers will choose to rely on the negotiated MFPs, which could result in significant cost savings for both companies and patients. While initial research does support this prediction that patients may have reduced OOP spending, the full impact of the IRA on patient costs has yet to be seen as only 10 drug MFPs have been implemented. Further, since the IRA requires Part D plans to cover all the drugs selected for negotiation, preliminary results suggest that coverage has improved among Part D plans.

While some findings anticipate improvements for patients, others voice substantial concern regarding the potential for unintended consequences. Research shows that overall pharmaceutical gross margins have decreased as a result of the IRA negotiations. Since these funds are the primary source of funding for research and development (R&D), some studies have shown a link between decreases in gross margins and overall innovation, with one study projecting internal rates of return on negotiated drugs dropping between three and five percent. While this may not seem like a

substantial decrease, the authors argue that over the long-term drug companies may redirect funding away from R&D for products that are more likely be negotiated, potentially limiting innovation in this area.²² However, since these reductions in internal revenue are still relatively small, there is no guarantee that R&D will be limited in practice given that experts posit that there is not a direct correlation between successful innovation and R&D dollars.²³ Further, there is concern that payers and/or PBMs may increase utilization management as a method to control costs and maintain formularies.²⁴ This could result in not only delays in patient access, but also to increased cost and time for physicians to combat the utilization management.

AMA POLICY AND ADVOCACY

The AMA has a relatively large body of policy related to ensuring that prescription medications are available and accessible to patients in a manner that is economically sustainable for physician practices. Policies [H-110.980](#) and [H-110.987](#) outline efforts to ensure that medications are affordable for patients through process transparency, limits on patents, legislative/regulatory changes, and limits on anticompetitive practices. Policy H-110.980 also ensures that price indexes should be multifaceted and ensure for patient access and limited burdens on physician practices. Policy H-110.956 works to ensure that payment to physician practices for biosimilars and biologic drugs is fair and timely. Policies [D-110.987](#), [D-120.988](#), and [D-120.934](#) target PBM practices that negatively impact patients and physicians. Finally, Policy D-110.987 supports active PBM regulation and efforts to ensure transparency throughout PBMs and their coverage determinations.

To address Medicare drug price negotiation specifically, Policy [D-330.954](#) indicates AMA support for federal legislation that allows the Department of Health and Human Services to negotiate contractual agreements with manufacturers for covered Part D medications. This policy also supports the elimination of Medicare prohibition on drug price negotiation, which was accomplished by the IRA, and directs the AMA to prioritize support for CMS negotiation of all applicable and covered medications. Policy [D-110.980](#), the motivating policy for this report, outlines the need for study of the IRA negotiation on physician practices in order to guide future advocacy efforts.

The AMA also has pursued robust advocacy efforts to lower drug costs and ensure payment to physicians is reasonable. The AMA has an ongoing grassroots campaign, [TruthinRx](#), designed to support patients and physicians in understanding and fighting the lack of transparency and subsequent high drug prices. In addition to this campaign, the AMA has continually supported PBM and drug pricing reform to [legislators](#) as well as provided guidance regarding regulation of drug pricing in Medicare to both [CMS](#) and the [Department of Health and Human Services](#). The AMA has provided testimony to the House of Representatives [Energy and Commerce Subcommittee on Health](#) and [Ways and Means Subcommittee on Health](#) related to lowering health care pricing for Americans. Finally, the AMA has voiced concern to [Congress](#) and [CMS](#) related to issues surrounding physician drug reimbursement and the need for improvement to payment rates.

DISCUSSION

The cost of prescription medications, especially those administered in-office, is a major issue in American healthcare and one that the IRA was designed in part to address. The opacity of the current drug pricing system, paired with increasing drug prices, has further complicated the issue. Historically, a combination of PBMs, payers, and drug manufactures have negotiated the price of prescription drugs. However, with passage of the IRA and its Medicare drug price negotiation, this system now also includes the federal government. The IRA allows for CMS to negotiate with drug manufacturers to set an MFP for each of the selected drugs. In 2024, this included 10 Part D drugs,

1 in 2025 negotiations included 15 Part D drugs, and in 2026 includes six Part B drugs. Since the
2 negotiated prices have not been released, it is still to be seen if Part B drugs see similar price
3 reductions to the previously negotiated Part D drugs.

4
5 Currently, Part B drugs are paid based on a “buy-and-bill” model, meaning the purchasing entity
6 buys and administers the drug and then is later paid for the cost. For Medicare, the payment rate for
7 these physician-administered medications is ASP+6, or ASP+8 for some biosimilars. However,
8 after sequestration, these payment rates can be as low as ASP+4.3. This payment system can be
9 particularly problematic for smaller physician-owned/community practices as the payment rates do
10 not cover the full cost of necessary fixed costs like staffing, administration, and procurement.
11 While the aforementioned reductions in cost from the IRA may help in reducing patient costs, there
12 is significant concern that practices, patient access, and/or drug innovation may be negatively
13 impacted.

14
15 When the IRA negotiated Part B drug MFPs go into effect, the payment system will transition from
16 ASP+6 to MFP+6. Estimates suggest that this could have significant impacts on the payments
17 made to practices, especially those that administer the oncology/hematology drugs included in the
18 negotiation schedule. While the cost of purchasing the drug should decrease, the aforementioned
19 fixed costs for these practices may not dissipate at the same rate. Since payment is calculated as a
20 percentage of MFP, the cushion designed to cover fixed costs will decrease at a rate that may not
21 be sustainable for practices. While larger hospitals and health systems may be able to cover these
22 costs and often face lower fixed costs due to higher patient volume, smaller community
23 based/physician-owned practices are less likely to be able to. Experts voice concern that this
24 change in payment may result in the closure of these smaller practices which would have
25 detrimental impacts on patient access.

26
27 Due to the recency of its implementation, the full impact of the IRA Medicare drug price
28 negotiation has yet to be seen; however, some initial steps can be taken now to maintain physician
29 practice viability and patient access. In order to ensure that physician practices are able to acquire
30 medications needed for patients, it will be essential to ensure that any drug price negotiation, and
31 related price caps, should be set and implemented in a manner that does not require physicians or
32 practices to “front” the related costs. Supporting alternatives to the traditional buy-and-bill model
33 that ensures payment covers all associated costs, including acquisition, inventory, storage,
34 administration, and associated clinical services, while also maintaining administrative simplicity
35 and patient access and affordability will be essential. As the IRA Medicare negotiation MFPs are
36 put into place the full impact will become clearer and additional, more specific action steps may be
37 identifiable, thus ongoing monitoring is also important.

38
39 To address these potential concerns, the Council recommends the adoption of new policy that will
40 ensure practice viability, administrative simplicity, timely access, transparency for negotiated drug
41 prices, and that decreases in price are commiserate with acquisition cost. The Council notes that
42 this policy advocates for adequate payment based on actual acquisition cost, and thus
43 physicians/physician practices would be protected during a transition period between ASP and
44 MFP calculated reimbursements. Further, the Council recommends amendments to Policy
45 D-110.980 to reflect the completion of this report as well as ensure continued monitoring of this
46 issue. The amendments also retain the portion of the policy that ensure advocacy efforts will
47 balance sustainability of practices and drug innovation with patient access and affordability, and
48 guarantee that the policy is applicable to any Medicare drug price negotiation, not just the
49 negotiation related to the IRA specifically. Finally, to work to secure fair and timely physician
50 payment the Council recommends the reaffirmation of Policy H-110.956 which focuses on fair and
51 timely biosimilar and biologic drug payment.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) advocate that Medicare prescription drug price negotiation and associated maximum fair price effectuation, for all Medicare-covered drugs, are implemented in a manner that minimizes financial risk and cash-flow burdens for physicians or community practices to front costs and supports the following:
 - a. Practices' actual acquisition costs decrease commensurate with reductions in drug prices;
 - b. Any drug payment covers the cost of acquisition, storage, inventory, drug administration, and any other necessary related clinical service(s);
 - c. Administrative simplicity for physicians and their practices;
 - d. Timely and affordable patient access to medications prescribed by their physician; and
 - e. Drug price transparency for patients, physicians, and non-physician providers (New HOD Policy)

2. That our AMA amend Policy D-110.980 to read as follows:

~~Study on Impact of Inflation Reduction Act~~ Medicare Drug Price Negotiation on Oncology, Other Physician-Owned Practices

~~1. Our American Medical Association will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician-administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA's potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is provided.~~

~~2. 1. Our AMA will specifically evaluate the potential~~ continue to monitor and, when relevant, report on the impact of the Inflation Reduction Act Medicare drug price negotiation on the sustainability of community-based physician practices, with a particular focus on oncology practices.

~~3. 2. Our AMA encourages will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiation provisions on the sustainability of community-based practices to inform its advocacy efforts to ensure that any future drug pricing policies to balance patient affordability and access, with the stability of physician practices, patient access, and the continued advancement of drug innovation. (Modify Current HOD Policy)~~

3. That our AMA reaffirm policy H-110.956 which ensures fair and timely payment for physicians and physician practices for biologic and biosimilar drugs. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 2-I-26
The Impact of the Inflation Reduction Act on Physician Practices
Policy Appendix

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
 - a. The arbitration process should be overseen by objective, independent entities.
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
 - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
 - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
 - a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
 - b. The use of any international drug price index or average should preserve patient access to necessary medications.
 - c. The use of any international drug price index or average should limit burdens on physician practices.
 - d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing

pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

10. Our AMA supports:

- a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;
- b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
- c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

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

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.

2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.

3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.

4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.

5. Our AMA supports improved transparency of PBM operations, including disclosing:

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

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

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

Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988

Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care D-120.934

1. Our American Medical Association will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)

Prescription Drug Prices and Medicare D-330.954

1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices D-110.980

1. Our American Medical Association will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician-administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA's potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is provided.
2. Our AMA will specifically evaluate the potential impact of the Inflation Reduction Act on the sustainability of community-based physician practices, with a particular focus on oncology practices.
3. Our AMA will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiation provisions on the sustainability of community based practices to inform its advocacy efforts to ensure that any future drug pricing policies balance patient affordability with the stability of physician practices, patient access, and the continued advancement of drug innovation. (Res. 234, I-25)

Payment for Biosimilars H-110.956

1. Our American Medical Association supports the revision of the Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent the cost of drugs for the physician practice.
2. Our AMA encourages public and private payers to implement comprehensive payment structures that allow for fair and timely payment for biologic/biosimilar drugs that:
 - a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician consistent with AMA Policy H-100.940;
 - b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug through a payment rate that covers these costs;
 - c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician; and
 - d. Ensure that patient out-of-pocket costs are affordable. (CMS Rep. 04, I-25)

Appendix A
Medicare Negotiation Drugs

Drug Name	Manufacturer	Common Uses	Negotiated MFP	List Price	Percent Discount	Start Date
Januvia	Merck & Co., Inc.	Type 2 Diabetes	\$113	\$527	79%	2026
NovoLog/ Fiasp	Novo Nordisk	Diabetes	\$119	\$495	76%	2026
Farxiga	AstraZeneca	Type 2 Diabetes, Heart Failure Chronic Kidney Disease	\$178	\$556	68%	2026
Enbrel	Amgen Inc.	Rheumatoid & Psoriatic Arthritis, Plaque Psoriasis, Ankylosing Spondylitis	\$2,355	\$7,106	67%	2026
Jardiance	Boehringer Ingelheim & Eli Lilly	Type 2 Diabetes, Heart Failure Chronic Kidney Disease	\$197	\$573	66%	2026
Stelara	Janssen Biotech Inc.	Plaque Psoriasis, Psoriatic Arthritis, Chron's Disease, Ulcerative Colitis	\$4,695	\$13,836	66%	2026
Xarelto	Bayer and Johnson & Johnson's Janssen	Blood Clots (DVT, PE, and AFib stroke prevention)	\$197	\$517	62%	2026
Eliquis	Bristol Myers Squibb & Pfizer	Blood Clots (DVT, PE, and AFib stroke prevention)	\$231	\$521	56%	2026
Entresto	Novartis Pharmaceuticals	Heart Failure	\$295	\$628	53%	2026
Imbruvica	Pharmacyclics LLC & Janssen Biotech Inc.	Blood Cancers and Autoimmune Conditions (CLL, SLL, WM, cGVHD)	\$9,319	\$14,934	38%	2026
Ozempic, Rybelsus, Wegovy	Novo Nordisk Inc.	Type 2 diabetes, Cardiovascular disease and obesity/ overweight	\$274	\$959	71%	2027
Trelegy Ellipta	GlaxoSmithKline Intellectual Property Development Ltd.	Asthma; Chronic obstructive pulmonary disease	\$175	\$654	73%	2027
Xtandi	Astellas Pharma US, Inc.	Prostate Cancer	\$7,004	\$13,480	48%	2027
Pomalyst	Bristol-Myers Squibb Company	Kaposi sarcoma; Multiple myeloma	\$8,650	\$21,744	60%	2027
Ofev	Boehringer Ingelheim Pharmaceuticals	Idiopathic pulmonary fibrosis	\$6,350	\$12,622	50%	2027
Ibrance	Pfizer	Breast Cancer	\$7,871	\$15,741	50%	2027
Linzess	AbbVie	Chronic idiopathic constipation; Irritable bowel syndrome	\$136	\$539	75%	2027
Calquence	AstraZeneca UK Limited	Chronic lymphocytic leukemia/small lymphocytic lymphoma; Mantle cell lymphoma	\$8,600	\$14,228	40%	2027
Austedo; XR	Teva Branded Pharmaceutical Products R&D LLC	Chorea in Huntington's disease; Tardive dyskinesia	\$4,093	\$6,623	38%	2027

Drug Name	Manufacturer	Common Uses	Negotiated MFP	List Price	Percent Discount	Start Date
Breo Ellipta	GlaxoSmithKline Intellectual Property Development Ltd.	Asthma; Chronic obstructive pulmonary disease	\$67	\$397	83%	2027
Xifaxan	Salix Pharmaceuticals Inc	Hepatic encephalopathy; irritable bowel syndrome	\$1,000	\$2,696	63%	2027
Vraylar	AbbVie	Bipolar I; Major depressive disorder; Schizophrenia	\$770	\$1,376	44%	2027
Tradjenta	Boehringer Ingelheim Pharmaceuticals	Type 2 Diabetes	\$78	\$488	84%	2027
Janumet; XR	Merck Sharp & Dohme LLC	Type 2 Diabetes	\$80	\$526	85%	2027
Otezla; Otezla XR	Amgen	Oral ulcers in Behçet's Disease; Plaque psoriasis; Psoriatic arthritis	\$1,650	\$4,722	65%	2027
Trulicity	Amgen	Type 2 diabetes; cardiovascular disease	Currently under negotiation			2028
Biktarvy	Gilead Sciences	HIV type 1 infection	Currently under negotiation			2028
Orencia*	Bristol Myers Squibb	Psoriatic & Rheumatoid arthritis;	Currently under negotiation			2028
Cosentyx*	Novartis	Plaque psoriasis; Psoriatic arthritis	Currently under negotiation			2028
Erleada	Janssen Biotech Inc. (Johnson & Johnson)	Prostate Cancer	Currently under negotiation			2028
Kisqali	Novartis	Breast Cancer	Currently under negotiation			2028
Entyvio*	Takeda Pharmaceutical Company Limited	Chron's Disease, Ulcerative Colitis	Currently under negotiation			2028
Verzenio	Eli Lilly	Breast Cancer	Currently under negotiation			2028
Botox*	Allergan Aesthetics (AbbVie)	Chronic migraine; Overactive bladder; Spasticity; movement disorders	Currently under negotiation			2028
Lenvima	Eisai Co. and Merck & Co	Thyroid cancer; Endometrial cancer; Liver cancer; Kidney cancer	Currently under negotiation			2028
Xolair*	Genentech & Novartis Pharmaceuticals	Asthma; Chronic spontaneous urticaria	Currently under negotiation			2028
Rexulti	Otsuka Pharmaceutical and Lundbeck	Major depressive disorder; Schizophrenia; Agitation associated with dementia due to Alzheimer's disease	Currently under negotiation			2028
Xeljanz; Xeljanz XR	Pfizer	Psoriatic arthritis; Rheumatoid arthritis; Ulcerative colitis	Currently under negotiation			2028
Anoro Ellipta	GlaxoSmithKline	Chronic obstructive pulmonary disease	Currently under negotiation			2028
Cimzia*	UCB, Inc. (Union Chimique Belge)	Crohn's disease; Plaque psoriasis; Psoriatic & Rheumatoid arthritis;	Currently under negotiation			2028

List price is based on the previous calendar year's price | Start date begins on the first day of the year

*Indicates the medication may be covered under Medicare Part B (all other medications covered under Medicare Part D)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-26

Subject: Non-Medical Switching of Prescription Drugs

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates adopted Policy [H-125.971](#), “Non-Medical Switching,” which states:

1. Our American Medical Association (AMA) opposes the practice of non-medical switching by pharmacy benefit managers (PBMs) and health insurers, except when clinically justified and approved by the prescribing physician.
2. Our AMA study and report back at I-26 on the clinical and economic impact of non-medical switching on patient outcomes, medication adherence, and overall healthcare utilization, and disseminate these findings to policymakers and the public.

This report provides an overview of non-medical switching of prescription drugs and its impact on patients, physicians, and the healthcare system overall; related AMA policies; and offers recommendations to amend and reaffirm AMA policy.

BACKGROUND

While there are valid medical reasons for a medication to be changed, such as treatment efficacy and adherence or if a patient is experiencing concerning side effects, these choices should be made collaboratively between the patient and physician, not by insurance companies or PBMs. When a drug is switched for reasons outside of medical necessity, often driven by payment or coverage changes, it is referred to as non-medical switching.¹ Typically, payers and PBMs force these switches in order to reduce their own costs.¹ Non-medical switches are generally done through direct changes in drug formularies, the negotiated list of covered drugs, or coverage structures and driven either by the PBM, payer, or a combination of each entity. However, on occasion, switches can be strongly encouraged or forced on patients through pharmacy changes or limitations imposed by patient assistance programs.^{2,3} While similar, non-medical switching is distinct from a change from a brand name drug to its biosimilar/generic drug. Non-medical switching occurs when the payer or PBM requires that the patient switch to a different drug altogether instead of a generic, but identical, version.¹

Estimates show that non-medical switching is a relatively frequent occurrence, with over 50 percent of physicians reporting their patients experienced it on a regular basis. Surveyed psychiatrists reported that over 60 percent of their patients prescribed psychoactive medications experienced non-medical switching “frequently or very frequently.”⁴ Further, physicians practicing in specialties that utilize higher cost drugs, such as dermatology, oncology, rheumatology, and cardiology, reported as many as 80 percent of patients prescribed certain classes of drugs experienced frequent non-medical switching.⁴ As an example, in 2025 anti-obesity medication

(AOM) tirzepatide Zepbound was replaced on CVS Caremark's formulary with AOM semaglutide Wegovy, resulting in approximately nine percent of all patients prescribed Zepbound switched from that medication.⁵ This illustrates the impact that these switches can have not only on individual patients, but also on the overall prescription drug landscape.

IMPACTS OF NON-MEDICAL SWITCHING

While the most frequent justification for non-medical switching is cost reduction, research suggests that in the majority of cases, the switch ends up costing more. As biologics and other expensive specialty drugs are a frequent target for non-medical switching, payers and PBMs force patients to switch from the more expensive drug to a less expensive alternative, potentially saving the payer up to 90 percent.⁶ Yet these savings are often not seen by the patient and if savings are passed on to the patient, savings are much less than the amount seen by payers or PBMs.⁶ Research also shows that in the long-term these savings are not maintained,⁶ with over 86 percent of patients reporting higher out-of-pocket spending for the medication they were switched to compared to the original medication.⁷ Compared to patients whose medication was not non-medically switched, patients who experienced non-medical switching had significantly higher total costs, resulting in an average increase in spending of about \$4,500 per person.^{6,8} These costs largely stem from greater utilization of the healthcare system after the switch.⁹ Research has shown that non-medically switched patients have higher rates of surgery, hospitalization, emergency department visits, and medication intake either through dose escalation or the addition of other medications after a non-medical switch occurs.^{9,10} Further, these negative impacts can have disproportionate consequences for those in minority communities as barriers to care, such as economic inequalities and systemic biases, compound the issues related directly to non-medical switching.¹¹

Beyond the potential for increased costs and health system utilization, patients often face significant negative consequences to their health and well-being from non-medical switching. Nearly 40 percent of patients report that the medication they were switched to was less effective and with more disruptive side effects than the medication they were previously taking.¹² Further, over half of patients reported medical complications as a result of the new medication.^{12,13} Of those patients reporting adverse impacts of the new medication, over half reported impacts on work and regular hobbies/activities, with about 40 percent also reporting impacts on their ability to provide care for children or other family members.¹² As a result of higher cost and poorer outcomes, patients often abandon treatment plans, which regularly leads to detrimental impacts on the patient's health.^{12,14} Beyond physical health, patients report significant decreases in their overall mental health and well-being. After experiencing a non-medical switch, a majority of patients reported experiencing significantly higher levels of frustration, confusion, anxiety, and depression as well as a lower quality of life.^{10,12,14}

Not only does non-medical switching cost more and harm patients, but research suggests that non-medical switching may adversely impact the patient-physician relationship. While patients reported that they eventually felt aligned with their physician in fighting the switch, a majority reported initial negative feelings that had an undermining effect on the patient-physician relationship.¹² Further, physicians consistently report that non-medical switching is a significant administrative burden to their practice, as it requires additional time and effort to find new, effective medication for the patient. Physicians reported significant increases in non-visit patient interactions, staffing needs, and contact with payers/PBMs and pharmacies after a non-medical switch.^{12,15} Many physicians report increases in job stress related to non-medical switching as a result of ethical concerns and being forced to take responsibility for the decision of the payer/PBM. Physicians also report significant increases in stress and frustration, especially related to a lack of practice autonomy and poorer patient health outcomes.^{12,15}

LEGISLATIVE ACTIVITY

Advocates suggest that a federal non-medical switching law could be a factor in ensuring long-term prescription drug affordability for patients.¹⁶ At a basic level, advocates suggest that legislation preventing non-medical switching should include assurances that patients will continue to be able to access a medication that is prescribed by their physician/non-physician provider for at least the duration of the plan's coverage as plans are typically reevaluated at renewal.¹⁶ Further, it is argued that such legislation should be distinct from anti-step therapy legislation as the two issues are distinct. Non-medical switching occurs *after* a patient has a stable medication routine, whereas step therapy typically occurs *while* a patient is attempting to establish a medication routine.¹⁶

While there has been no federal legislation successfully passed to prevent non-medical switching, 18 states have enacted some type of legislative protection against non-medical switching. Of these states, 12 have laws that prohibit all non-medical switching and six have laws that prohibit non-medical switching provided the prescriber can demonstrate the switch is likely to be harmful or an ineffective treatment.^{17,18} Illinois law requires that payers provide 60-day notice of any formulary change to patients and provide a clear exception process. Further, if the prescribing physicians or non-physician providers provide a certification that the prescribed medication is medically necessary, the payer must cover it without any cost change to the patient through the remainder of the plan year.¹⁹ Similarly, Texas law has established specific guidelines that require formulary changes to occur only at plan renewal and ensures that if a drug was covered, the patient will continue to be able to access coverage through the term of their plan year and requires allowance for physician appeal of any change in coverage if medically necessary.²⁰ It is important to note that application of such state laws to self-funded/employer-sponsored health plans varies, meaning that in some cases legal protections may not extend to beneficiaries of these plans.

AMA POLICY AND ADVOCACY

The AMA has a robust body of policy designed to ensure that patients are able to receive the medication prescribed by their physician without interference from payers, pharmacies, or PBMs. Policy [H-125.971](#) details AMA opposition to non-medical switching, unless the switch is approved by the prescribing physician and clinically justified. Policy [H-125.995](#), states AMA opposition to any changes by pharmacies/pharmacists to medications and outlines advocacy efforts to ensure that physician prescriptions cannot be substituted without physician approval. Policies [H-115.974](#) and [H-120.918](#) outline AMA support for the development and implementation of guidelines that detail the physician's ability to ensure that a prescription be dispensed exactly as written. Similarly, Policy [D-120.923](#) outlines AMA advocacy to ensure that physicians are notified of any changes to a prescription and the origin of the change. To address biosimilar substitution, Policy [D-125.989](#) outlines advocacy to ensure that any switches from biologic to biosimilar drugs will be done with express authorization of the physician and agreement of the patient. Further, Policy [H-125.991](#) works to ensure that formularies meet a basic standard and that substitutions are not made without physician and patient approval. Finally, [Policy D-125.992](#) outlines AMA opposition to administrative burden in prescription medication prior authorization and urges payers to minimize its usage.

The AMA Advocacy Resource Center (ARC) has worked extensively to prevent [pharmacy interference](#) in prescribing and altering drugs when dispensing. Additionally, to fight opaque practices in drug pricing, the AMA has developed a grassroots campaign, [Truth in Rx](#). This campaign advocates for drug pricing transparency through public education and grassroots advocacy to legislators and regulators. Additionally, the AMA has submitted several comment letters and provided testimony on the importance of maintaining physician autonomy in prescribing

and increased transparency in drug pricing and formulary creation. Finally, the AMA has advocated to [regulators](#), [legislators](#), and [payers](#), to urge patient access to the prescribed medication and support [increased transparency](#) in drug pricing and PBM practices.

DISCUSSION

Non-medical switching occurs when a medication is switched, often by a payer or PBM decision, without medical justification. Although these changes are common and typically done to save money, the savings generally begin and end with the payer and/or PBM. Not only do patients not share in the savings, but research also suggests they may actually end up paying more in out-of-pocket expenses for the new drug. Patients are more likely to experience adverse health events, such as side effects, hospitalization, or surgery, and report poorer mental health and quality of life after a non-medical switch occurs. Further, patients report that the switch may harm their relationship with their physician as patients are commonly confused as to the source of the switch. Additionally, physicians report significant increases in administrative burden and increases in stress and frustration after a patient's non-medical switch.

Currently, legislation to limit non-medical switching has been enacted in a number of states, but there is no federal restriction on the practice. Since the AMA has strong policy opposing the practice of non-medical switching, the Council recommends three amendments to strengthen and update the policy. First, the Council recommends the removal of the second clause of Policy H-125.971 as it is completed by this report. Second, it is recommended that a new second clause be added that outlines AMA advocacy to ensure that payers and PBMs honor coverage and prior authorization determinations through the duration of the most recent prior authorization approval. This will work to ensure that payers and PBMs cannot force a switch through extra utilization management requirements in order to skirt non-medical switching prohibitions. Third, the Council recommends a new third clause to advocate for payers to continue coverage for a medication while internal and external appeals processes are being adjudicated, thus ensuring patients are not left without their medication due to insurance company procedures. Finally, to ensure that physicians are not met with undue administrative burdens around prescription drug prior authorization, the Council recommends the reaffirmation of Policy D-125.992 which opposes prescription drug prior authorization and advocates for reduced administrative burdens for physicians.

RECOMMENDATIONS

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

1. That our American Medical Association amend Policy H-125.971, "Non-Medical Switching," to read as follows:

1. Our AMA opposes the practice of non-medical switching by pharmacy benefit managers and health insurers, except when clinically justified and approved by the prescribing physician.

- ~~2. Our AMA will study and report back at I-26 on the clinical and economic impact of non-medical switching on patient outcomes, medication adherence, and overall healthcare utilization, and disseminate these findings to policymakers and the public.~~

2. Our AMA advocate that all payers and pharmacy benefit managers honor coverage and prior authorization determinations for a prescription drug through the term determined in the most recent prior authorization approval or the plan year, whichever is longer.

1 3. Our AMA advocate that coverage be continued for a medication that is to be switched until
2 all appeals regarding the prescription are adjudicated. (Modify Current HOD Policy)

3

4 2. That our AMA reaffirm Policy D-125.992, which outlines opposition to administrative burden in
5 prescription medication prior authorization. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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**Council on Medical Service Report 3-I-26
Non-Medical Switching of Prescription Drugs
Policy Appendix**

Non-Medical Switching H-125.971

1. Our American Medical Association opposes the practice of non-medical switching by pharmacy benefit managers and health insurers, except when clinically justified and approved by the prescribing physician.
2. Our AMA will study and report back at I-26 on the clinical and economic impact of non-medical switching on patient outcomes, medication adherence, and overall healthcare utilization, and disseminate these findings to policymakers and the public. (Res. 811, I-25)

Opposition to Prescription Prior Approval D-125.992

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

Therapeutic and Pharmaceutical Alternatives by Pharmacists H-125.995

The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician's directions cannot be overruled or substituted without prior physician approval. (Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18)

Prescription Labeling H-115.974

1. Our American Medical Association recommends that when a physician desires to prescribe a brand name drug product, they do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, they do so by designating the USAN-assigned generic name of the drug on the prescription.
2. Our AMA recommends that, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.
3. Our AMA recommends that when generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".
4. Our AMA recommends that when a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug

manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed. (BOT Rep. 1, A-95; Amended: CSA Rep. 2, I-99; Modified Res. 512, I-00; Reaffirmed: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmed: Sub. Res. 509, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Reaffirmation: A-19; Modified: Speakers Rep. 02, I-24)

Prescription Drug Dispensing Policies H-120.918

1. Our American Medical Association supports the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as "dispense quantity as written" or "no change in quantity;"
2. Our AMA supports the development, implementation and/or use of electronic or other means of communication to provide cost and coverage information of various prescribing quantities at the point of care allowing physicians to make the best decisions with their patients regarding prescribed medication quantities. (CMS Rep. 05, A-23)

Automatic Pharmacy-Generated Prescription Requests D-120.923

Our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient's surrogates, or automatically by the pharmacy. (Res. 706, A-24)

Substitution of Biosimilar Medicines and Related Medical Products D-125.989

Our American Medical Association urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena:

1. Preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients;
2. Allow substitution when physicians expressly authorize substitution of a biologic or biosimilar product; and
3. In the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when;
 - a. the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and
 - b. there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and (c) the prescribing physician has been adequately notified by the pharmacist. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14; Modified: CSAPH Rep. 05, A-24; Reaffirmed: CMS Rep. 04, I-24)

Drug Formularies and Therapeutic Interchange H-125.991

It is the policy of the AMA:

(1) That the following terms be defined as indicated:

- (a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
- (b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
- (c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
- (d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
- (e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously

established and approved written guidelines or protocols within a formulary system; and

(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:

(i) have the concurrence of the organized medical staff;

(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;

(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;

(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;

(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;

(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;

(vii) provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;

(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;

(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and

(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:

(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);

(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;

(iii) conduct drug utilization review (DUR) activities;

(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;

(v) analyze adverse results of drug therapy;

(vi) make recommendations to ensure safe drug use and storage; and

(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.

(c) The P&T Committee's recommendations must be approved by the medical staff;

(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and

(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.

(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition

(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;

(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and

(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.

(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Determining Fair Market Value when Contracting with Physician Practices
(Reference Committee J)

EXECUTIVE SUMMARY

This report was self-initiated by the Council on Medical Service to address the need for further policy guidelines for physicians, especially independent physicians, in determining fair market value (FMV) under the Physician Self-Referral law, otherwise known as the Stark law, when contracting with a hospital or health system. The report examines the Stark law and its exceptions, various data sources for determining FMV, and the impact the law has on physician practices.

The Stark law was originally enacted in 1989 and applied only to physician referrals for clinical laboratory services. It has since undergone several revisions and expansions. As currently written, the law prohibits physicians from referring patients to receive “designated health services” payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

Designated health services include: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Some of the most common Stark law exceptions include In-office Ancillary Services, Personal Service Arrangements, Fair Market Value Compensation, Group Practice Compensation Methods, and the Professional Courtesy Exception.

Burdensome regulatory and administrative requirements, including those associated with the Stark law, are some of the drivers that are leading independent physician practices to being sold to hospitals, health systems, and private equity companies which increases consolidation in already consolidated markets. Employment preferences vary across the profession, and while employment by a hospital system or a hospital-owned practice are attractive options to some, it is also important to maintain the sustainability of independent practice. In order to reduce administrative burden related to Stark law compliance, this report highlights several ways physician practices can mitigate risk and ensure compliance.

The Council offers a series of recommendations to empower physicians during contract negotiations and encourage transparency in FMV compensation calculations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-26

Subject: Determining Fair Market Value when Contracting with Physician Practices

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

The Physician Self-Referral law, otherwise known as the Stark law (42 U.S.C. §1395nn), prohibits physicians from referring patients to receive “designated health services” (DHS) payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships must align with fair market value (FMV) definitions and can include both ownership/investment interests and compensation arrangements. Ownership or investment interests can include equity (stock or partnership shares) or debt interests (loans tied to an entity’s revenue). The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required.

This report was self-initiated by the Council on Medical Service to address the need for further policy guidelines for physicians, especially independent physicians, in determining FMV under the Stark law when contracting with a hospital or health system. The American Medical Association’s (AMA) position on the Stark law and physician compensation is clear. However, the Council sees a policy gap regarding the definition of FMV, guidelines for independent physicians when negotiating contracts with hospitals, and best practices to avoid a Stark law violation. As such, this report examines the Stark law and its exceptions, various data sources for determining FMV, the impact the Stark law has on physician practices, and makes policy recommendations.

BACKGROUND

The Stark Law, Anti-Kickback Statute, and False Claims Act

The Stark law was originally enacted in 1989 and applied only to physician referrals for clinical laboratory services. In 1993-94, Congress expanded the law to include additional DHS and applied certain aspects of physician self-referral laws to Medicaid. In 1997, Congress added a provision to permit the Secretary of Health and Human Services (HHS) to issue written advisory opinions concerning whether a referral relating to DHS (other than clinical laboratory services) is prohibited under Section 1877.

Designated health services include: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Related statutes include the False Claims Act (FCA) and Anti-Kickback Statute (AKS). The FCA makes it illegal to submit claims for payment to Medicare or Medicaid that a physician knows to be

false or fraudulent. “Knowing” is defined to include not only actual knowledge but also encompasses cases when an individual acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. AKS is a criminal law that prohibits the knowing and willful payment or remuneration (which includes anything of value, in any form) to induce or reward patient referrals or the generation of business involving any item or service payable by federal healthcare programs. AKS has broader coverage than the Stark law, requires intent, and is not limited to certain services. While there is often overlap between these three laws, this report will focus specifically on the impact of the Stark law, the definition of FMV, and the impacts on independent physicians.¹

Exceptions to the Stark Law

Most physician practices rely on one or more of the exceptions to the Stark law to maintain clinical operations. Many of the exceptions are complicated and can impose significant administrative burdens on physicians and their practices.² Common exceptions include:

1. In-office Ancillary Services Exception. This exception is widely used in group medical practices and allows physicians to refer Medicare patients for DHS within their own practice, if certain conditions are met. For example, the referring physician must be part of a qualifying group practice, the DHS must be provided either in the same building where the group provides non-DHS services or in a centralized building used by the group for diagnostic or clinical services, and the physician or the practice of the physician performing the service must submit the bill.³
2. Personal Service Arrangement Exceptions. This exception allows physicians to be paid FMV for services when there is a written, signed agreement in place that does not tie compensation to referral volume or value.
3. Fair Market Value Compensation Exception. This exception protects arrangements where compensation reflects market rates and does not depend on referrals.
4. Group Practice Compensation Methods Exception. This exception allows group practices to compensate physician employees using productivity and profit-sharing methods as long as the formulas used to calculate salary do not tie compensation to the volume or value of that physician’s own DHS referrals.
5. Professional Courtesy Exception. This exception allows practices to extend courtesy discounts or free services as long as these benefits are available to all staff or community members and are not tied to referrals. The benefits must be in writing and approved in advance by the practice’s governing body. They cannot be extended to federal program beneficiaries unless based on demonstrated financial need and they cannot violate AKS.

Impact of Regulatory Changes

Following the original enactment, the Stark law has undergone several additional expansions and changes. In 2003, Congress authorized the Secretary of HHS to promulgate an exception to the physician self-referral prohibition for certain arrangements in which the physician receives non-monetary remuneration that is necessary and used solely to receive and transmit electronic prescription information and established a moratorium on physician referrals to certain specialty hospitals in which the referring physician has an ownership or investment interest. In 2010, the Centers for Medicare & Medicaid Services (CMS) published the Voluntary Self-Referral Disclosure Protocol pursuant to Section 6409(a) of the Affordable Care Act, which sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral law.⁴

1 More recently, in 2020, CMS issued “Modernizing and Clarifying the Physician Self-Referral
2 Regulations.” Established here were three new exceptions to the physician self-referral law
3 applicable to compensation arrangements that qualify as “value-based arrangements.” Notably,
4 CMS defined “commercial reasonableness” in the regulation, which established an objective test
5 for evaluating whether compensation takes into account the volume or value of referrals or other
6 business generated between the parties. The definitions of “fair market value” and “indirect
7 compensation agreement” were also revised.⁵

8
9 Also in 2020, HHS Office of the Inspector General (OIG) published the final rule “Revisions to the
10 Safe Harbors under Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding
11 Beneficiary Inducements.” The two rules create a dual regulatory environment where a value-based
12 arrangement could meet the requirement for protection under one law but not the other. This could
13 hinder transitions to value-based healthcare delivery and payment systems. The AMA [submitted a](#)
14 [letter](#) in response the proposed rules.⁶ Finally, CMS finalized clarifications to the regulations
15 defining a “group practice” for the purposes of the Stark law.⁷

16 17 *The Stark Law, Independent Physicians, and Increasing Market Consolidation*

18
19 Burdensome regulatory and administrative requirements, including the Stark law requirements,
20 may be some of the drivers that are leading independent physician practices to be sold to hospitals,
21 health systems, and private equity companies. This in turn increases consolidation in already
22 consolidated markets. According to AMA analysis, a substantial majority of hospital markets are
23 highly concentrated, and concentration continues to increase over time. Between 2012 and 2024,
24 the share of physicians who work in private practice dropped 18 percentage points from 60.1
25 percent to 42.2 percent.⁸ Research has found that mergers in concentrated markets can lead to price
26 increases and concerns about physician autonomy and leadership. The AMA is an advocate for
27 competitive healthcare markets and antitrust relief for physicians and maintains that healthcare
28 markets should be sufficiently competitive to allow physicians to have adequate choices and
29 practice options.⁹

30
31 Employment preferences vary among physicians and employment by large hospital systems or
32 hospital-owned practices remains an attractive practice option for some physicians. It is also
33 important to maintain the sustainability of independent practice for physicians who wish to pursue
34 this career path. An alternative to direct employment by a hospital or health system would be for
35 independent physicians to contract with hospitals or other groups to provide certain services (either
36 clinical, administrative, or quality-based). However, many facilities and physicians are concerned
37 about inadvertent violations of the Stark Law and thus utilize FMV to set proposed payments lower
38 than the value of services or assume that an employment relationship is required to provide more
39 coordinated or integrated care. While some of these relationships may fit under exceptions to the
40 Stark law, the fear of prosecution can lead to a failure of these relationships to be developed in a
41 way that would support both patient care and the success of an independent physician practice.

42
43 The Stark law has the potential to negatively impact private practice by imposing strict liability for
44 often unintentional financial relationship violations, leading to large financial penalties, forced
45 repayment of all Medicare revenue for the impacted service, and high compliance costs. The law
46 also requires rigorous, signed documentation for all financial relationships. Failure to maintain,
47 sign, or update these arrangements can invalidate them and the cost of hiring legal counsel to
48 ensure compliance with FMV and commercial reasonableness can be high.

Calculating Fair Market Value and Sources of Physician Compensation Data

CMS provides a broad definition of FMV in Section 1877 of the Social Security Act, describing it as “the value in arm’s length transactions, consistent with general market value, and, with respect to rentals or leases, the value of a rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.”¹⁰ FMV protections are not solely a regulatory burden on physicians. Properly applied, they can protect patients and the healthcare system from fraud and abuse when compensation arrangements are being used to influence referrals.

CMS has acknowledged that there is a desire for a “clear bright line” for how FMV should be defined but argues that the definition is intentionally kept broad to account for nuances of different specialties, geographic locations, and practice types across the country. Because there is no specific definition, physicians, practices, and hospitals must rely on outside data sources, namely physician salary surveys and databases, to calculate FMV for individual employment scenarios. Some examples of arrangements that may warrant FMV negotiations include a radiologist contracting to provide medical director services, an independent physician group contracting for hospital coverage, including call and weekend hours, a specialist with clinical work and administrative obligations, or a physician practicing in a geographically underserved area where average salary may exceed the national survey average.

There are several prominent data sources for this information, each with benefits and limitations. It is best practice to consult several of these resources to determine FMV. Many of the most utilized sources are accompanied by high price tags (often annual subscriptions) that may be costly for independent physicians to access. The following are a list of some of the most utilized:

- Medical Group Management Association (MGMA) has been the default source for salary data for decades, providing national provider compensation and production data, often broken down by specialty, geographic region, and practice setting. Data are collected from healthcare organizations (employers) and not directly from physicians, meaning the compensation figures reflect what organizations report paying, which can differ from the payment actually received by physicians. The cost of accessing the dataset is also a limitation, as access starts at \$3,000/year, requiring annual renewals. Premium access costs are even higher.
- Sullivan Cotter provides comprehensive datasets tailored for hospitals, health systems, and larger clinical networks. These data focus on executive, physician, and non-physician provider compensation. Sullivan Cotter provides 30 years of survey history, but access can also be cost prohibitive and is reported from the employer perspective, which could report data that is different than physician take-home pay.
- American Medical Group Association publishes robust medical group compensation and financial survey metrics, reflecting data from over 200 specialties, with a particular strength in reporting multi-specialty group practice data. This dataset includes region breakdowns and organizational size segmentation. Membership to the Association and data access could be cost prohibitive for smaller organizations.
- The Association of American Medical Colleges (AAMC) provides a Faculty Salary Report that displays total compensation statistics for full-time medical school faculty broken out by degree, rank, department/specialty, medical school type, region, gender, and race/ethnicity. The reported total compensation is the sum of fixed/contractual salary,

- 1 medical practice supplement, and bonus or incentive pay. The survey is fielded annually
 2 and can be purchased for \$75 or \$1,500, depending on AAMC membership status.¹¹
- 3 • Bureau of Labor Statistics Occupational and Wage Statistics offers free physician
 4 compensation data organized by Standard Occupational Classification codes. While costs
 5 are friendly, the data provides only very broad specialty groupings (i.e., Physicians &
 6 Surgeons, All Others), limited percentile granularity, and a publication lag of 12-18
 7 months. As such, these data are best used as a cross-validation source rather than a primary
 8 benchmark measure.
 - 9 • Other sources that can be used include SalaryDr (provides physician-reported on-demand
 10 reports for a fraction of the costs), Doximity (provides self-reported physician data from its
 11 physician social network), and proprietary datasets from independent, third-party valuation
 12 firms which can vary in cost, access, and reliability.¹²

13

14 When utilizing these resources to calculate FMV, there are a few best practices to keep in mind.
 15 First, the data should be used as a guide, and multiple sources should be referenced. Second, both
 16 median and percentile data should be used as reference points as this is more accurate than using
 17 the mean in these circumstances. This allows for the consideration of various aspects of
 18 compensation, such as a shortage of services, the qualifications of the physician, and the non-
 19 clinical work being requested in determining an appropriate percentile. For example, only looking
 20 at the median as a ceiling for FMV could be inaccurate, as those earning at the 90th percentile can
 21 also be receiving a FMV salary based on their individual circumstances and qualifications. Third,
 22 current practice realities should be examined and leveled with physician salary expectations before
 23 applying necessary filters to specific scenarios.¹³

24

25 *Recent Legal Activity*

26

27 The following are a few examples of recent cases that focus on hospital compensation practices and
 28 that highlight either an alleged lack of sufficient safeguards to ensure that physicians are paid
 29 within the range of FMV or a calculated plan to capture and retain referrals through excessive
 30 compensation. Each of these entities have been defendants in Stark law-based FCA lawsuits, whose
 31 allegations focus on above FMV compensation to referring physicians:¹⁴

- 32 • Community Health Network (Indiana) allegedly engaged in a scheme to recruit a variety of
 33 specialists by offering them significantly higher salaries than they received in private
 34 practice, in order to capture these specialists' lucrative downstream referrals.
- 35 • The University of Pittsburgh Medical Center (UPMC) settled a lawsuit after a
 36 neurosurgeon and two other UPMC clinicians filed suit, alleging that UPMC incentivized
 37 its neurosurgeons to perform unnecessary and overly complex procedures at UPMC
 38 facilities by providing base pay and productivity bonuses that far exceeded FMV.
- 39 • The Department of Justice (DOJ) intervened in a case against Steward Health Network
 40 (Massachusetts) that alleged that the hospital paid a \$5 million incentive compensation to
 41 the Chief of Cardiac Surgery for increasing the number of surgical cardiovascular cases
 42 performed at the hospital and that resulted in the hospital's submission of more than 1,000
 43 claims to Medicare in violation of the Stark law, equaling tens of millions of dollars in
 44 improper Medicare payments. Steward has since filed for Chapter 11 bankruptcy.
- 45 • There is an ongoing case against Erlanger Health System (Tennessee) that alleges that
 46 Erlanger violated both the Stark law and AKS by paying physicians above FMV for
 47 referrals. The DOJ has partially intervened and the settlement is expected to exceed \$60
 48 million.^{15,16}

These examples highlight real and alleged abuses that need to be prevented and show the importance of the Stark law in protecting patients, physicians, and the healthcare system as a whole from fraud and abuse. As a goal, the Stark law should be modernized to ensure fair payment for physicians in a variety of contractual relationships without increasing administrative or regulatory burdens rather than weakening meaningful protections.

Compliance Concerns and Risk Management

The above cases highlight the importance of proper risk management. There are several ways that physician practices can mitigate risk of violating the Stark law and related statutes, although it is important to note that the administrative costs of keeping up with these requirements can be expensive for independent physicians:

- Make sure all compensation agreements are in writing and signed by all relevant parties. Revisit the agreements on a regular basis to ensure continued compliance.
- Document all financial relationships and referral patterns clearly.
- Verify compliance with Stark law exceptions and AKS safe harbors.
- Have a consistent valuation process in place and ensure that physician compensation is consistently evaluated and documented as falling within the range of FMV and does not rely on the volume or value of referrals.
- Make compliance programs a priority and integrate them into operations through measures such as compensation policies, training, audits, and evaluations.
- Conduct regular internal audits and monitor regulatory arrangements for changes.
- Take whistleblower complaints seriously.
- Seek legal guidance when necessary, including for complex or novel arrangements.
- Monitor regulatory updates and OIG advisory opinions.^{17,18,19}

AMA POLICY

[Policy D-385.940](#) states that the AMA recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral," and supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

[Policy H-385.914](#) states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

[Policy H-225.973\(3\)](#) states that the AMA opposes financial arrangements between hospitals and physicians that: a) either require physicians to compensate hospitals in excess of the fair market value of the services or resources that hospitals provide to physicians; b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request; and c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals.

[Policy D-405.988](#) states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients.

[Policy E-9.6.9](#) addresses ethical challenges for self-referral in which patients' medical interests can be in tension with physicians' financial interests.

DISCUSSION

The Stark law prohibits physicians from referring patients to receive DHS payable to Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Most physician practices rely on complicated exceptions to the Stark law to maintain clinical operations. The Stark law is not meant to solely be an administrative burden on physicians, but when applied properly, these guidelines can protect the healthcare system from fraud and abuse.

In recent years, CMS has attempted to more clearly define FMV with regulatory updates; however, it has not gone far enough, and the definitions continue to be vague. In its recommendations, the Council encourages further specificity in the definition of FMV and offers suggestions for factors that should be included in the calculation.

Transparency in how FMV is calculated, including specific factors and data sources used, can empower physicians entering into contracts with hospitals or health systems to best advocate for themselves and their practices. To this end, the Council recommends supporting transparency in the disclosure of financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities, as well as encouraging physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide methodology, data sources, and calculations used in determining FMV.

Burdensome regulatory and administrative requirements, including those associated with the Stark law, are some of the drivers that are leading independent physician practices to being sold to hospitals, health systems, and private equity companies which increases consolidation in already consolidated markets. Employment preferences vary across the profession, and while employment by a hospital system or a hospital-owned practice are attractive options to some, it is also important to maintain the sustainability of independent practice. In order to reduce administrative burden related to Stark law compliance, there are several ways physician practices can mitigate risk and ensure compliance. The Council recommends encouraging physicians to seek independent valuation or legal counsel when negotiating compensation and contractual agreements where FMV is an issue as well as recommends supporting policies that ensure contractual integrity in physician-health system relationships.

Finally, the Council recommends reaffirmation of Policies D-405.988, D-385.940 and H-385.914, which support preserving the value of the private practice of medicine, recognize the substantial impact of the Stark law's unequal restrictions on independent physicians, and oppose and continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support modernization of federal regulatory frameworks, including the Stark law and Anti-Kickback Statute, to reduce unnecessary administrative burden, mitigate penalties for technical or non-substantive violations, and better

- 1 enable value-based, patient-centered care while maintaining appropriate safeguards against
2 fraud and abuse and protecting patients from conflicts of interest and inappropriate utilization.
3 (New HOD Policy)
- 4 2. That our AMA support the Centers for Medicare & Medicaid Services (CMS) explicitly
5 defining factors that can be utilized to calculate “fair market value” (FMV) as it relates to
6 physician compensation including, but not limited to, the following factors:
7
 - Physician specialty, subspecialty, or physician services to be provided;
 - 8 • Geographic location;
 - 9 • Supervision of non-physician providers or trainees;
 - 10 • Whether a restrictive covenant is in place and its level of restrictiveness;
 - 11 • Additional roles and responsibilities (e.g., education, quality improvement duties,
12 alternative payment model or value-based care participation, serving as licensed directors
13 of hospital departments or laboratories);
 - 14 • Restrictions on outside activities or income opportunities (e.g. work at a Veterans Affairs
15 facility, work at an academic institution, moonlighting, consulting, development of
16 intellectual property owned by the physician, or other outside professional activities);
 - 17 • Specialty or subspecialty shortages, either locally or nationally; and/or
 - 18 • Other factors that impact value to the health system. (New HOD Policy)
19
- 20 3. That our AMA support CMS providing additional guidance on exceptions and/or safe harbors
21 that physicians and employers can rely upon to adjust physician compensation, either through
22 direct compensation, or through value-sharing of other payments that are based on the
23 physician’s contribution to the institution. (New HOD Policy)
24
- 25 4. That our AMA encourage physicians to ask for transparency when negotiating an employment
26 contract and ask for employers to disclose and provide the methodology, data sources, and
27 calculations used in determining FMV as it relates to the compensation of independent
28 physicians contracting with the hospital whenever FMV is cited as a reason for the selected
29 compensation level. (New HOD Policy)
30
- 31 5. That our AMA support transparency of ongoing and future proposed physician financial
32 relationships, compensation models, and ownership structures between physicians, hospitals,
33 and other healthcare entities during any negotiation to provide healthcare or administrative
34 services between all parties. (New HOD Policy)
35
- 36 6. That our AMA encourage physicians, particularly those in independent practice that are
37 entering contracting arrangements, to seek independent valuation, legal counsel, and third-
38 party review when negotiating compensation and contractual agreements where FMV is an
39 issue. (New HOD Policy)
40
- 41 7. That our AMA support policies that ensure fair and transparent integrity in physician-health
42 system contractual relationships, including written, transparent, and time-limited agreements,
43 appropriate limitations on restrictive covenants to protect patient access and continuity of care,
44 and preservation of physician advocacy on behalf of patients. (New HOD Policy)
45
- 46 8. That our AMA reaffirm Policy D-405.988, which states that the AMA supports preserving the
47 value of the private practice of medicine and its benefit to patients. (Reaffirm HOD Policy)
48
- 49 9. That our AMA reaffirm Policy D-385.940, which states that the AMA recognizes the
50 substantial impact of Stark law’s unequal restrictions on independent physicians, contributing

- 1 to the growing trend of hospital consolidation, which has led to negative consequences of
- 2 restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at
- 3 rectifying the disparities that disadvantage independent physician practices while preserving
- 4 the intent of AMA Code of Ethics Policy 9.6.9, “Physician Self-Referral,” and supports
- 5 equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation,
- 6 and facilitates the delivery of high-quality, patient-centered care. (Reaffirm HOD Policy)
- 7
- 8 10. That our AMA reaffirm Policy H-385.914, which states that the AMA opposes and continues
- 9 to advocate against the misuse of the Stark law and regulations to cap or control physician
- 10 compensation. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 4-I-26
Determining Fair Market Value when Contracting with Physician Practices
Policy Appendix

Stark Law Self-Referral Ban, D-385.940

1. Our American Medical Association recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs.
 2. Our AMA supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral."
 3. Our AMA supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.
- (BOT Rep. 03, I-25)

Stark Law and Physician Compensation, H-385.914

Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

(BOT Rep. 6, I-15; Reaffirmed: BOT Rep. 09, A-25)

Financial Arrangements Between Hospitals and Physicians, H-225.973

1. Our American Medical Association opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time, skill, education and professional expertise of the physician.
2. Our AMA opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges.
3. Our AMA opposes financial arrangements between hospitals and physicians that
 - a. either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians.
 - b. require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request.
 - c. require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals.
4. Our AMA opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories.
5. Our AMA urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy.

(CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22)

The Preservation of the Private Practice of Medicine, D-405.988

1. Our American Medical Association supports preserving the value of the private practice of medicine and its benefit to patients.
2. Our AMA will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care.

3. Our AMA will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians.
4. Our AMA will work through the appropriate channels to preserve choice and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt.
5. Our AMA will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine.
6. Our AMA will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice.
7. Our AMA will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
8. Our AMA will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.

(Res. 224, I-10; Appended: Res. 604, A-12; Reaffirmation: I-13; Appended: Res. 735, A-14; Reaffirmed in lieu of Res. 223, I-14; Modified: Speakers Rep. 01, A-17; Reaffirmed: Res. 724, A-22; Reaffirmation: A-22; Appended: Res. 602, A-22; Reaffirmed: BOT Rep. 14, A-23; Reaffirmed: CMS Rep. 08, A-24; Reaffirmed: BOT Rep. 19, A-26)

Vertical Consolidation in Healthcare – Markets or Monopolies, D-160.908

1. Our American Medical Association advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians.
2. Our AMA supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the healthcare industry.
3. Our AMA will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the healthcare sector.

(Res. 723, A-23; Reaffirmed: Res. 813, I-25)

AMA Principles for Physician Employment, H-225.950

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

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

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

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

the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

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

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

4. Hospital Medical Staff Relations

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

- d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

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

5. Peer Review and Performance Evaluations

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

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

6. Payment Agreements

- a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
- b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
- c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary.

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

(BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24; Appended: Res. 712, A-25)

E-9.6.9 Physician Self-Referral

Business arrangements among physicians in the healthcare marketplace have the potential to benefit patients by enhancing quality of care and access to healthcare services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a healthcare facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

- (a) Ensure that referrals are based on objective, medically relevant criteria.
- (b) Ensure that the arrangement:
 - (i) is structured to enhance access to appropriate, high quality healthcare services or products; and
 - (ii) within the constraints of applicable law:
 - a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
 - b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
 - c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
- (c) Take steps to mitigate conflicts of interest, including:
 - (i) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
 - (ii) establishing mechanisms for utilization review to monitor referral practices; and
 - (iii) identifying or if possible, making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
- (d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

AMA Principles of Medical Ethics: II, III, VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

E-11.2.3 Contracts to Deliver Healthcare Services

Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the healthcare system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver healthcare services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

Ongoing evolution in the healthcare system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for healthcare delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in healthcare, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver healthcare services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

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

- (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
 - (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
 - (ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
 - (iii) ensures the physician can appropriately exercise professional judgment;
 - (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
 - (v) is transparent and permits disclosure to patients;
 - (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
 - (vii) prohibits the corporate practice of medicine.
- (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

- (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.
- (d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.
- (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.
- (f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of healthcare services, physicians should:

- (g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

AMA Principles of Medical Ethics: I, II, III, V, VI, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Improving Marketplace Affordability through Premium Tax Credits
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the House of Delegates referred a clause proposed as an additional recommendation to [Council on Medical Service Report 1, Health Savings Account Reform](#). The clause asked the American Medical Association to advocate using the expanded Affordable Care Act (ACA) premium tax credits (PTCs) as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts (HSA) or other cash savings accounts. This report describes ACA PTCs, the enhanced subsidies available from 2021 through 2025, and the potential impacts of redirecting PTCs into HSAs.

The expiration of the enhanced PTCs at the end of 2025 contributed to sharp premium increases and precipitous enrollment declines this year, raising concerns about less stable ACA marketplaces and more financial stress on patients, hospitals, and physicians. To address affordability concerns, some healthcare proposals have promoted redirecting federal marketplace premium subsidies through HSAs or HSA-type accounts. Although the Council has heard support in the House of Delegates for the flexible use of HSAs when they are voluntary, we understand that HSAs are regressive and could worsen economic and racial disparities if policies require that marketplace subsidies be placed into such accounts. Notably, most marketplace enrollment growth between 2021 and 2025 stemmed from lower-income enrollees, who the enhanced PTCs helped the most but who would be least likely to benefit from an HSA. The Council is also concerned that HSA-focused ACA reforms could incentivize greater enrollment shifts into cheaper but less comprehensive plans, including catastrophic plans that have deductibles this year of \$10,600 for individual and \$21,200 for family coverage. Although the Council maintains that HSAs should be available to individuals purchasing qualified marketplace plans on a voluntary basis, we believe that increased premium assistance within the existing ACA PTC structure will be critical as healthcare costs, and the cost of coverage, continue to rise. Therefore, the Council recommends supporting enhancements to ACA marketplace subsidies, including PTCs, without redirecting subsidies into HSAs.

Of note, in a year of significant declines in marketplace enrollment, a few states opted to use state funds to help subsidize coverage for residents who had lost federal premium support. Although the Council recognizes that states face serious fiscal challenges and difficult funding choices, we hope that many states will at least consider investing in marketplace subsidies for their residents with lower incomes. Therefore, the Council recommends encouraging states, when possible, to consider supplementing federal premium subsidies.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-26

Subject: Improving Marketplace Affordability through Premium Tax Credits

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates referred a clause proposed as an additional recommendation to [Council on Medical Service Report 1, Health Savings Account Reform](#). It states the following:

Our American Medical Association (AMA) advocates for using the expanded Affordable Care Act (ACA) premium tax credits (PTC) as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts (HSA) or other cash savings accounts.

This report describes ACA PTCs, the enhanced subsidies available from 2021 through 2025, and the potential impacts of redirecting PTCs into HSAs; summarizes relevant AMA policy; and makes policy recommendations. The purview of this report is limited to PTCs and HSAs, and does not make recommendations for broader improvements to ACA affordability, which the Council continues to monitor.

BACKGROUND

Enrollment in the ACA marketplaces reached a record high of 24.3 million people in early 2025, more than double the 12 million individuals who were enrolled in 2021¹ when Congress increased the generosity of the ACA's PTCs as part of the American Rescue Plan Act (Public Law 117-2). The enhanced PTCs, which decreased the maximum required contribution for previously eligible enrollees and extended eligibility to people with incomes exceeding 400 percent of the federal poverty level (FPL), also led many enrollees to choose higher actuarial value plans that helped decrease their out-of-pocket expenses.²

As highlighted in a 2025 [AMA Federation sign-on letter](#) to congressional leadership, the enhanced PTCs increased the affordability of marketplace plans and drew in healthier people, thereby improving the risk pool and lowering premiums overall. Originally set to expire in 2022, the more generous subsidies were extended through 2025 by the Inflation Reduction Act (Public Law 117-169), and sunsetted at the end of that year when Congress did not extend them. Notably, both the American Rescue Plan Act and the Inflation Reduction Act were partisan bills that were enacted via the federal budget reconciliation process. The expiration of the enhanced PTCs, along with [marketplace changes made by H.R. 1 \(Public Law 119-21\) and relevant rulemaking](#), have contributed to sharp premium increases and precipitous enrollment declines in 2026, raising concerns about less stable marketplaces and more financial stress on patients, hospitals, and physicians whose practice revenues could be negatively impacted.

Healthcare proposals from the Trump Administration and Congress have promoted an expanded role for HSA-type accounts to address affordability concerns stemming from the expiration of the enhanced PTCs. An HSA is a tax-advantaged savings account that consumers enrolled in high-deductible health plans (HDHP) can use to set aside money, without paying taxes, for qualified medical expenses. Of note, HSAs do not constitute health coverage and, under current law, funds generally cannot be used to pay health plan premiums.

PREMIUM TAX CREDITS AND AFFORDABILITY

In addition to creating federally-regulated health insurance marketplaces, the ACA established federal subsidies, including PTCs that were intended to lower the cost of marketplace premiums for individuals with incomes up to 400 percent of the federal poverty level (FPL).³ These credits can either be claimed at the end of the year when filing federal taxes, and then reconciled, or be paid in advance based on an enrollee's estimated income. Advance PTCs are paid directly to the insurer and applied to an enrollee's monthly premium.⁴

The ACA's eligibility limit around PTCs created a "subsidy cliff" by excluding people whose incomes exceeded 400 percent FPL by even a small amount from receiving federal subsidies. In 2021, as the costs of health coverage across markets continued to rise amid the COVID-19 pandemic, Congress enacted temporary federal ACA subsidy enhancements that were subsequently extended through 2025. These enhancements increased the value of subsidies, decreased the maximum required premium contribution for previously eligible enrollees, and extended eligibility for PTCs to people with incomes above 400 percent FPL. Because the PTCs effectively cap an eligible individual's premium liability at a percentage of household income, expanding PTC eligibility improved affordability for most people who depend on the ACA, including small business owners, self-employed people, gig workers, farmers, and early retirees. In 2025, for example, 92 percent of marketplace enrollees received advanced PTCs.⁵

After the enhanced PTCs expired at the end of 2025, the average marketplace premium more than doubled for a formerly subsidized individual who was no longer eligible for PTCs. As many consumers faced substantial premium increases in 2026 (average net premiums increased 58 percent from 2025),⁶ marketplace coverage became less affordable and less attractive to some as an insurance option. During open enrollment for the 2026 plan year, initial sign-ups fell across a majority of states, and by 1.2 million people nationally.⁷ Moreover, as premiums became due at the beginning of this year, a substantial number of enrollees dropped coverage instead of absorbing such large premium increases. By February 2026, effectuated enrollment in the ACA marketplaces—meaning those people who signed up for plans and maintained their coverage by making premium payments—had declined to 19.2 million individuals, down considerably from 2025 but still higher than pre-Covid era enrollment figures.⁸ Fifty-state survey data from Manatt Health similarly highlighted enrollment declines and "buy-downs" to lower-value plans, especially in states using the federal platform (healthcare.gov). For example, silver plan selection, which allows lower-income people to qualify for cost-sharing assistance that is not available to individuals enrolled in other metal tiers, fell by 28 percent as many consumers switched to bronze and catastrophic plans.⁹ Although every state except New Mexico experienced marketplace enrollment declines this year, some states (e.g., California, Colorado, Connecticut, Maryland, Massachusetts, and New Jersey) were able to mitigate the severity of the decreases by using state resources to at least partially make up for the loss of the enhanced federal subsidies.¹⁰

The full extent of attrition from ACA marketplaces had not yet been reported at the time this report was written; however, early estimates projected that enrollment would drop by 17 to 26 percent in 2026.¹¹ Such sizeable attrition, if it materializes, will negatively impact the risk pool if the people

dropping coverage tend to be younger and healthier. Changes to the risk pool could in turn destabilize the marketplaces in some states, causing further rate increases and less competition if insurers choose to exit the market. Early rate filings from plan issuers quickly signaled the potential for double-digit rate increases next year, on top of the significant increases in effect this year.¹² An analysis of preliminary rate filings in 16 states and DC found that insurers in most states had requested 10 to 20 percent premium increases for the 2027 plan year, on top of this year's rate increases. KFF estimates that between 2025 and 2027, marketplace premiums will increase by more than one-third, citing the expiration of the enhanced PTCs, Centers for Medicare & Medicaid Services (CMS) regulatory changes, and the rising cost of healthcare as contributing factors.¹³

The AMA has [advocated against CMS marketplace changes](#) that expanded less comprehensive coverage options and removed important network adequacy standards, among other provisions affecting marketplace affordability. In July 2026, a Federal District Court in Maryland issued a preliminary ruling and opinion in *City of Columbus v. Kennedy* (2026) that granted a stay of eight provisions in CMS rulemaking that were set to take effect for plan year 2027. Last year, the AMA also urged Congress not to allow the enhanced PTCs to expire, highlighting in an [AMA Federation sign-on letter](#) that extending the more generous subsidies would have continued to lower premiums across income levels, mitigated financial barriers to care, and sustained enrollment in the marketplaces. In addition to affordability concerns, the AMA argued that allowing the more generous subsidies to expire would reverse enrollment gains, increase the uninsured rate, and raise uncompensated care costs for hospitals and physician practices.

HEALTH SAVINGS ACCOUNTS (HSAs)

HSAs are closely tied to United States tax code and therefore must follow a complex web of guidelines and regulations governing their use. Pre-tax dollars can be saved in an HSA and the funds can be used at any time in a person's life to pay for co-pays, prescriptions, dental care, contacts and eyeglasses, bandages, x-rays, and other qualified medical expenses as defined by the Internal Revenue Service. Under current law, insurance premiums are generally not considered a qualified medical expense. Of note, once individuals turn 65, HSAs are treated similar to traditional retirement accounts.

The rationale behind the creation of HSAs in 2003 was that the accounts would incentivize people to choose HDHPs and therefore reduce health spending. In the years since, the use of these accounts has increased significantly, as has the number of goods and services that can be purchased using HSA funds, many of which are not typically covered by health plans.¹⁴ [Council on Medical Service Report 1-I-25](#) established new AMA policy ([Policy H-165.818](#)) intended to improve usability and flexibility for individuals who have HSAs. Importantly, this policy also decisively affirms that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability, such as PTCs. As highlighted in the [Council's report](#), HSAs provide account owners with several tax advantages but are considered regressive because higher income people are more likely to use such accounts, exempt larger amounts, and navigate complex tax rules to maximum advantage.¹⁵ Research also shows that HSAs are distributed unevenly across race and ethnicity, with Latino and Black individuals about half as likely to have HSAs as white and Asian individuals.¹⁶ Finally, HSAs also tend to benefit patients who are healthy compared to those that have chronic care needs or substantial medical expenses.

High-Deductible Health Plans (HDHP)

Several Council reports have discussed HDHPs, which HSAs must be paired with and which typically have higher deductibles and lower premiums when compared to traditional health plans.

High-deductible plans generally require patients to pay the full cost of health services and medications until the high deductibles are met. Although an HDHP's lower premium may be attractive to some consumers, the responsibility for out-of-pocket expenses can become problematic when deductibles are too high for enrollees to afford and patients are unable to cover the cost of needed care. Not surprisingly, studies have found that reductions in health spending achieved through HDHPs are primarily due to patients simply receiving less medical care.¹⁷

An H.R. 1 (Public Law 119-21) provision allows ACA marketplace bronze and catastrophic plans to be treated as HSA-eligible HDHPs so that individuals who opt for these higher-deductible plans can take advantage of HSA tax and savings benefits. Regardless of actual deductible amounts, [Policy H-165.828](#) supports bronze and silver plans being treated as HSA-qualified HDHPs, as long as appropriate guardrails are in place to ensure lower-income enrollees do not suffer financial hardships. As the Council noted in its [2025 report](#), HSAs can benefit some individuals but should not be considered a one size fits all approach, nor should they be considered a replacement for health insurance.

Proposals to Redirect ACA Subsidies into HSAs

In the months leading up to the expiration of enhanced PTCs at the end of last year, some Republicans in Congress proposed funneling subsidy amounts through HSAs or HSA-type accounts for eligible marketplace enrollees. For example, the Health Care Freedom for Patients Act ([S. 3386](#)), introduced by Senators Mike Crapo and Bill Cassidy, called for placement of enhanced subsidy amounts (but not baseline PTCs) into HSAs paired with bronze or catastrophic plans. Under this legislation, eligible individuals earning less than 700 percent FPL would receive \$1,000 in an HSA if aged 18 to 49, and \$1,500 if aged 50 to 64. Legislation introduced by Senator Rick Scott (R-FL) ([S. 3264](#)) would allow states to apply for waivers to place PTC and cost-sharing reduction amounts into HSA-type accounts called Trump Health Freedom Accounts. This bill would allow money in these accounts to be used for health plan premiums for any type of plan, including short-term limited duration policies, thus broadening the rules regarding qualifying medical expenses.¹⁸ In January 2026, the Trump Administration announced the Great Healthcare Plan, which broadly proposes to “stop sending big insurance companies billions in extra taxpayer-funded subsidy payments and instead send that money directly to eligible Americans to allow them to buy the health insurance of their choice.”¹⁹ Although details of that plan were not yet available at the time this report was written, it may signal continued debate about using HSA-type accounts as a substitute for federal premium subsidies.

Channeling federal subsidies through HSAs in the ACA market could benefit both the healthiest enrollees whose spending on healthcare is relatively low, and those with the highest incomes who can afford high deductibles and out-of-pocket expenses. Presumably, these enrollees would be better able to set aside and roll over federal HSA contributions, allowing funds to grow tax free for future use. The availability of comprehensive coverage (e.g., bronze or silver plans) paired with HSAs could potentially incentivize such enrollees to keep marketplace coverage, which would improve the overall risk pool, although only catastrophic and bronze plans currently qualify as HDHPs. Proponents of HSA-focused options also argue that the accounts give patients more choice and control over their healthcare, incentivize consumers to price-shop and seek more value, and help HSA owners plan for future healthcare expenses.²⁰

Under current law, plans that redirect federal premium subsidies into HSAs would reduce the total amount of federal premium assistance because HSA funds cannot be used to pay premiums. Since both the original and enhanced PTCs were designed to make marketplace premiums more affordable, plans substituting HSAs for PTCs may be viewed as pivoting away from the intended

purpose of direct premium assistance while shifting financial risk away from insurers and onto patients.

Redirecting subsidies into HSAs would also incentivize more consumers to choose cheaper, less comprehensive plans with deductibles so high that an unexpected illness could put them in financial straits. Notably, average bronze plan deductibles in 2026 are nearly \$7,500; for catastrophic plans, deductibles are \$10,600 for individuals and \$21,200 for family coverage, the maximum allowed by the ACA,²¹ sums that far exceed proposed federal contribution amounts for HSAs. Although such plans may work well for healthier and wealthier consumers, most marketplace enrollees are from lower- and middle-income households and are less likely to have sufficient disposable income to benefit from HSAs.²² Thus, concerns have been raised that consumers incentivized to sign up for these plans may ultimately choose to delay or forego needed care if they cannot afford to pay for medical services before their high deductibles are met. Some enrollees in less comprehensive high-deductible plans may also incur increased medical debt. Furthermore, enrollment growth in bronze and especially catastrophic plans, even when paired with HSAs, could also make it more difficult for physician practices and other providers to be paid for services rendered, potentially increasing uncompensated care costs. Analysts have also expressed concern that, under a broad plan like Senator Scott's, healthier people could opt into less comprehensive plans (e.g., catastrophic or short-term limited duration plans) or not enroll at all, harming the risk pool and potentially destabilizing some marketplaces.²³

AMA POLICY

Numerous AMA policies address the issues raised in the referred proposed recommendation, including policies supporting original and enhanced PTCs, and policies addressing HSAs and HDHPs.

PTCs, Enhanced PTCs: AMA policy supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage ([Policy H-180.951](#)). [Policy H-165.865](#) maintains that tax credits should be refundable and advanceable, and large enough to ensure that health insurance is affordable for most people. Under [Policy H-165.824](#), the AMA supports improving affordability in health insurance exchanges by expanding eligibility for PTCs beyond 400 percent of the FPL (up to 500 percent of the FPL); increasing the generosity of PTCs; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. This policy also encourages state innovation, including consideration of state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize premiums without undercutting existing patient protections. [Policy H-165.820](#) supports extending the enhanced PTCs established under the American Rescue Plan Act and the Inflation Reduction Act.

HSAs: Policy adopted by the House of Delegates in 2025 ([Policy H-165.818](#)) supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. [Policy H-165.818](#) also supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans as well as some HSA flexibilities.

The AMA also has policy on how HSAs fit into the larger health insurance landscape. For example, [Policy H-165.852\(3\)](#) states that advocacy of HSAs continues to be incorporated prominently in AMA's campaign for health insurance reform, indicating the organization's commitment to improving HSAs, while [Policy H-165.833](#) states that as part of the AMA's organizational goal of improving the ACA, the AMA will advocate to expand the use of HSAs.

[Policy H-165.828](#) supports individual market bronze and silver plans being treated as HSA-qualified HDHPs, with appropriate guardrails in place to ensure low-income enrollees in these plans do not suffer financial hardships. This policy also encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. [Policy H-165.865](#) states that tax credits should be applicable only for the purchase of health insurance, including all components of a qualified HSA, and not for out-of-pocket health expenditures.

[Policy H-165.852](#) supports legislation promoting the establishment and the use of HSAs and allowing the tax-free use of such accounts for healthcare expenses, including health, dental, vision, hearing, and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. This policy also supports enhancing activities to educate patients about HSAs. Under [Policy H-385.912](#), consumers should be able to use HSAs to access direct primary care.

[Policy H-290.972](#) outlines principles for states to consider when deciding whether to offer HSA programs to Medicaid beneficiaries. These guidelines include, amongst other standards, making beneficiary participation voluntary, providing first-dollar coverage for preventive care, and allowing payments to non-Medicaid providers by beneficiaries to count towards deductibles and out-of-pocket spending limits. Under [Policy D-165.962](#) the AMA will monitor pending regulations and take appropriate steps to ensure access to HSAs by all Medicare eligible individuals. [Policy D-165.954](#) states that the AMA will monitor and support rigorous research on the impact of HSAs and health reimbursement arrangements on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

HDHPs: [Policy H-165.852](#) states that deductible limits for families should be the lower of either the individual or family combined deductible. [Policy H-185.918](#) encourages strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. [Policy D-180.979](#) encourages states and other stakeholders to monitor the growth of HDHPs to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. This policy also advocates for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing obligations at the time of service. [Policy H-165.849](#) similarly opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. Accordingly, the AMA has supported the right of individuals to choose the type of health coverage that best meets their needs, with an HDHP paired with an HSA being one such option. While supporting the use of HSAs for those who want them, AMA policy ([Policy H-165.818](#)) also underscores that HSAs should be complementary to—and not replace—health insurance coverage or other efforts to improve affordability, such as ACA PTCs.

In the ACA market, AMA policy supports treating bronze and silver plans as HSA-qualified HDHPs, with appropriate guardrails in place to ensure that lower-income enrollees do not suffer financial hardships ([Policy H-165.828](#)). Existing policy also supports tax credits that are large

1 enough to ensure that insurance is affordable for most people ([Policy H-165.865](#)), and expanding
2 eligibility for PTCs beyond 400 percent FPL ([Policy H-165.824](#)).
3

4 The Council has heard support in the House of Delegates over the years for the flexible use of
5 HSAs when they are voluntary. At the same time, we understand that HSAs can be regressive and
6 could worsen economic and racial disparities if policies require that marketplace subsidies be
7 placed into such accounts. Most marketplace enrollment growth between 2021 and 2025 stemmed
8 from lower-income enrollees,²⁴ who the enhanced PTCs helped the most but who would be least
9 likely to benefit from an HSA. The Council is also concerned that HSA-focused ACA reforms
10 could incentivize even greater enrollment shifts into less comprehensive plans—including
11 catastrophic and short-term limited duration plans—that provide less coverage, worsen healthcare
12 affordability challenges, and cause patients to forego needed healthcare if they cannot afford their
13 high deductibles. Furthermore, enrollment growth in marketplace high-deductible plans, even when
14 paired with HSAs, could in turn increase physician’s uncompensated care costs and/or add to
15 patients’ medical debt. Although the Council maintains that HSAs should be available to
16 individuals purchasing qualified marketplace plans on a voluntary basis, we believe that increased
17 premium assistance within the existing ACA PTC structure will be critical as healthcare costs, and
18 the cost of coverage, continue to rise.
19

20 Although redirecting baseline or enhanced PTCs into HSAs or HSA-type accounts could benefit
21 healthier marketplace enrollees and those with higher disposable incomes, the Council does not
22 believe such policies would offset the loss of enhanced PTCs, lower costs for most marketplace
23 consumers, or adequately mitigate affordability concerns. As previously noted, HSAs shift
24 financial risk onto patients and should not be viewed as a replacement for federal premium
25 assistance. Accordingly, the Council recommends that the AMA support enhancements to ACA
26 marketplace subsidies, including PTCs, without redirecting subsidies into HSAs.
27

28 During the development of this report, the Council learned that a few states (e.g., California,
29 Colorado, Connecticut, Maryland, Massachusetts, and New Jersey) used their own funds this year
30 to help subsidize coverage in order to stabilize enrollment and improve affordability for residents
31 who had lost federal premium support. In a time of general enrollment downturn, New Mexico
32 actually increased enrollment in its marketplace by 17 percent by fully backfilling the lost federal
33 enhanced subsidies, though it was the only state to fully make up for the expired enhanced PTCs.²⁵
34 Other states amended existing state subsidy programs to address a growing need for premium
35 assistance, including Massachusetts, where an additional \$250 million was invested and
36 Connecticut, which spent an additional \$51 million.²⁶ The Council recognizes that states cannot be
37 expected to offset the loss of the enhanced federal PTCs, and that states face serious fiscal
38 challenges and difficult funding choices due to federal cuts to Medicaid, SNAP, and other
39 programs. However, since some states funded marketplace subsidies this year, we also believe that
40 states should at least consider investing in marketplace subsidies, particularly for residents with the
41 lowest incomes. Therefore, the Council recommends encouraging states, when possible, to consider
42 supplementing federal ACA premium subsidies using state funds in order to stabilize enrollment
43 and improve affordability. In addition, the Council recommends that the AMA reaffirm Policy H-
44 165.818, which supports the principle that HSAs are complementary to and do not replace health
45 insurance coverage or other efforts to improve affordability of health insurance, such as ACA
46 premium tax credits. Finally, the Council continues to study marketplace affordability and will
47 present future policy recommendations to the House of Delegates as needed.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support enhancements to Affordable Care Act (ACA) marketplace subsidies, including premium tax credits, without redirecting subsidies into health savings accounts (HSAs). (New HOD Policy)
2. That our AMA encourage states, when possible, to supplement federal ACA premium subsidies using state resources in order to stabilize enrollment and improve affordability. (New HOD Policy)
3. That our AMA reaffirm Policy H-165.818, which supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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²³ Leavitt L and Cox C. The New ACA Repeal and Replace: Health Savings Accounts. KFF. November 21, 2025. Available at: <https://www.kff.org/affordable-care-act/the-new-aca-repeal-and-replace-health-savings-accounts/>

²⁴ KFF. Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire? July 26, 2024. Available at: <https://www.kff.org/affordable-care-act/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/>

²⁵ Pogue *supra* note 10.

²⁶ *Ibid.*

**Council on Medical Service Report 5-I-26
Improving Marketplace Affordability through Premium Tax Credits
Policy Appendix**

Health Savings Account Reform H-165.818

1. Our American Medical Association (AMA) supports permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded.
2. Our AMA supports contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees.
3. Our AMA supports external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members.
4. Our AMA supports Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts.
5. Our AMA supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies.
6. Our AMA supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits. (CMS Rep. 01, I-25)

Health Insurance Affordability H-165.828

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA
 - i. encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and
 - ii. supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans, with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer financial hardships.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
9. Our AMA supports that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan.
10. Our AMA supports incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families.
11. Our AMA supports any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected.
12. Our AMA advocates that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay fair and equitable rates. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21; Reaffirmed: Res. 826, I-24; Appended: CMS Rep. 02, A-25; Modified: CMS Rep. 01, I-25)

Principles for Structuring a Health Insurance Tax Credit H-165.865

- (1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
- (2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
- (3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. (CMS

Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24)

Improving Affordability in the Health Insurance Exchanges H-165.824

1. Our American Medical Association will:
 - a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
 - b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
 - c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
 - d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
 - a. eliminating the subsidy “cliff”, thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
 - b. increasing the generosity of premium tax credits.
 - c. expanding eligibility for cost-sharing reductions.
 - d. increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 826, I-24)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-26

Subject: Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

Council on Medical Service Report 6, “Study of Practice Models for Physicians Performing Procedures Across State Lines,” was introduced at the 2026 Annual Meeting and was referred. Council on Medical Service Report 6-A-26 initially addressed referred Resolution 711-A-25. This report focuses on physicians traveling out of state or to another area distant from their primary practice location, performing a procedure in an ambulatory surgical center (ASC), office-based laboratory (OBL), or office-based surgical (OBS) suite and subsequently leaving the area or state. The report recommends the adoption of a new set of related policy principles.

BACKGROUND

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

ASCs are regulated health care facilities providing outpatient surgical care for patients who do not require an overnight stay, including preventive and diagnostic treatments. ASC procedures are often paid at rates 35-50 percent lower than those for comparable procedures performed at hospital outpatient departments and thus may be considered more cost efficient.¹ OBLs are similar non-hospital outpatient facilities, typically offering less complex procedures. Recently, OBS has become increasingly prevalent. In this arrangement, a physician will build a surgical suite within their practice to perform procedures, often with the same layout and standards as an ASC. As with other licensed surgical facilities, office-based surgical suites can utilize either Class A (oral sedation) or Class B (IV sedation) anesthesia.

ASCs account for over 60 percent of outpatient procedural care and represent a \$30 billion market.² In recent years, ASCs have become an attractive target for private equity investment. The shift to outpatient surgical procedures presents investment opportunities for investors without having to directly acquire a hospital facility. Empirical evidence on quality of care in ASCs after private

equity acquisition is still limited and relies on a small number of studies, which to date have not found significant changes in short-term quality metrics though they do show substantial changes in charges and payer mix.³ A recent study found that private equity-owned ASCs do not increase surgical volume but do raise prices significantly – charging nearly 50 percent more per case within four to five years.⁴

RELEVANT POLICY

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

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

The American College of Surgeons (ACS) has its own policy and ethics statements regarding itinerant surgeons and surgical co-management.⁶ Other surgical specialty societies such as the American Academy of Ophthalmology, American Society of Plastic Surgeons, and American Academy of Otolaryngology-Head and Neck Surgery also have policies or statements that outline situations where itinerant surgery may be permissible. While these vary, they all generally indicate that the ultimate responsibility for arranging an appropriate level of continuity of care falls upon the operating surgeon.^{7,8,9}

DISCUSSION

The lack of available data on patient outcomes and physician medical liability make it difficult to accurately gauge the impact of itinerant surgeons and their work at ASCs, OBLs, or OBS suites across state lines. There are plausible concerns regarding follow-up care or burdens on local physicians, although available data do not establish the extent of these effects.

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

continue caring for the patient, as long as this arrangement is agreed to ahead of the procedure by all parties, including the patient.

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

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

When presented at the 2026 Annual Meeting, there was feedback shared on CMS Report 6-A-26 that indicated there could be unintended consequences with the recommendations as written, particularly related to reproductive health care. The report was referred to the Council for further consideration. The Council appreciated this feedback and has amended the recommendations to address these concerns. Specifically, the Council has deleted the original recommendations 1a and 1b from CMS Report 6-A-26. The Council believes the intent of this language is captured in AMA Ethical Opinions 2.3.6, 1.1.3, and 11.2.3, as well as Policy H-475.984. The Council has also incorporated amendments proposed at the 2026 Annual Meeting to what are now clauses 1a, 1a(iii), and 1b. Finally, the Council has added a recommendation to reaffirm [Policy D-5.999](#) which states that the AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.

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

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) supports the following principles for physicians utilizing ambulatory surgical centers (ASC), office-based laboratories (OBL), or office-based surgery (OBS) suites who may travel from their primary practice location to provide patient care, while asserting that regulatory requirements applicable to ASCs, OBLs,

- 1 and OBS should be evidence-based, proportional to patient risk, and should not create
2 unnecessary barriers to medically appropriate care:
- 3 a. When applicable, transfer agreements and backup plans should be coordinated between
4 physicians.
 - 5 i. In the event an institution coordinates these arrangements (i.e., a hospital system,
6 an ASC, or an OBL), a physician who would be designated to be among those
7 receiving and caring for the patient must give explicit consent to the agreement to
8 provide follow-up care.
 - 9 ii. When patient transfer is required, an appropriate and timely handoff of the patient
10 and the transfer of relevant patient records should be completed.
 - 11 iii. Transfer agreements should be evidence-based, proportional to patient risk, and
12 should not create unnecessary barriers to patient access to medically appropriate
13 care.
 - 14 b. Protocols and agreements for ensuring continuity of care with physicians in the local
15 community should be established when clinically indicated and feasible. Such
16 protocols should be proportionate to patient risk and the services provided.
 - 17 c. Consent from the patient regarding preoperative assessment and postoperative care
18 should be obtained prior to the provision of any procedure, with clarity on which
19 physician will be providing care during each step of the process.
 - 20 d. Physicians entering into these arrangements should ensure that they are in keeping with
21 ethical standards and legal requirements.
22 (New HOD Policy)
23
- 24 2. That our AMA reaffirm Policy D-5.999, which states that the AMA will advocate for legal
25 protections for patients who cross state lines to receive reproductive health services, including
26 contraception and abortion, or who receive medications for contraception and abortion from
27 across state lines, and legal protections for those that provide, support, or refer patients to
28 these services, and that the AMA will advocate for legal protections for medical students and
29 physicians who cross state lines to receive education in order to deliver reproductive health
30 services, including contraception and abortion. (Reaffirm HOD Policy)

Fiscal Note: Minimal.

REFERENCES

¹Bruch, JD, et. al. Private Equity Acquisitions of Ambulatory Surgical Centers Were Not Associated with Quality, Cost, or Volume Changes. Health Affairs. 2022.

<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2021.01904>

²Fenne, M. Private Equity in ambulatory surgical centers. Private Equity Stakeholder Project. October 2025.

https://pestakeholder.org/wp-content/uploads/2025/10/PESP_Report_Ambulatory-Surgical-Centers_2025-compressed.pdf

³*Supra*. Note 1.

⁴*Supra*. Note 2.

⁵*Supra*. Note 1.

⁶American College of Surgeons. Statements on Principles. April 12, 2016. <https://www.facs.org/about-acs/statements/statements-on-principles/>

⁷American Academy of Ophthalmology. Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care. Accessed: March 24, 2026. <https://www.aao.org/Assets/075e64c4-dd0e-4e6d-b9a4-d35ed78f4027/636088512564430000/comprehensive-guidelines-for-the-co-management-of-ophthalmic-postoperative-care-08262016-final-pdf?inline=1>

⁸American Society of Plastic Surgeons. Position Statement on Itinerant Surgery. Issued: September 19, 2024.

<https://www.plasticsurgery.org/documents/health-policy/positions/2025-itinerant-surgery.pdf>

⁹American Academy of Otolaryngology – Head and Neck Surgery. AAO-HNS Itinerant Surgery Policy.

Revised: September 2013. https://www.entnet.org/wp-content/uploads/files/Itinerant%20Surgery%20Policy_0.pdf

Council on Medical Service Report 6-I-26
Study of Itinerant Surgeons Practicing at Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries
Policy Appendix

Preserving Access to Reproductive Health Services, D-5.999

1. Our American Medical Association (AMA) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

(Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A023; Appended: Res. 711, A-23; Reaffirmed: Res. 014, A-25)

Office-Based Surgery Regulation, H-475.984

Our American Medical Association supports the following Core Principles on Office-Based Surgery:

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

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

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

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

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

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

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

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

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

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

E-2.3.6 Surgical Co Management

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

When engaging in this practice, physicians should:

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

AMA Principles of Medical Ethics: I, II, IV, V, VI

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

(Issued: 2016)

E-1.1.3 Patient Rights

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

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

- (a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
- (b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
- (c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
- (d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
- (e) To have the physician and other staff respect the patient's privacy and confidentiality.
- (f) To obtain copies or summaries of their medical records.
- (g) To obtain a second opinion.

- (h) To be advised of any conflicts of interest their physician may have in respect to their care.
- (i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I, IV, V, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

(Issued: 2016)

E-11.2.3 Contracts to Deliver Health Care Services

Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

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

- (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
 - (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
 - (ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

- (iii) ensures the physician can appropriately exercise professional judgment;
 - (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
 - (v) is transparent and permits disclosure to patients;
 - (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
 - (vii) prohibits the corporate practice of medicine.
- (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

- (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.
- (d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.
- (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.
- (f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

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

- (g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

AMA Principles of Medical Ethics: I, II, III, V, VI, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

(Issued: 2016)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-26)

Introduced by: Medical Student Section, Oklahoma, Mississippi, Florida, South Carolina

Subject: Improving the External Appeals Process for Denied Claims

Referred to: Reference Committee J

1 Whereas, insurers of qualified health plans (QHPs) sold on HealthCare.gov denied 19% of in-
2 network claims in 2023 and 37% of out-of-network claims for a combined average of 20% of all
3 claims, with some insurers denying up to 54% of in-network claims¹; and
4

5 Whereas, the most common reason (34%) for claims denial cited by insurers was “Other”,
6 followed by “Administrative reason” (18%), with only 6% based on lack of medical necessity¹;
7 and
8

9 Whereas, 58% of insured adults encountered issues with their health insurance in the past 12
10 months as of 2023, including claim denials, and 39% of those who struggled to pay medical bills
11 indicated that denied claims contributed to their financial challenges²; and
12

13 Whereas, while insurers are required to allow for an internal appeals process, less 1% of all
14 denials are appealed, with a majority of internal appeals ending with insurers upholding their
15 initial decision, and while individuals are also allowed an independent *external* appeals process
16 for denied claims, marketplace enrollees approximately filed only 5,000 external appeals in
17 2023¹; and
18

19 Whereas, the low number of appeals are attributed to difficulty in obtaining accurate information,
20 lack of provider and patient knowledge regarding the appeals process, and excessive
21 administrative burden and extended timelines³⁻⁶; and
22

23 Whereas, in some states, up to 80% of external appeals are successful after the initial denial of
24 a claim and failure of an internal appeal, and have allowed for lifesaving care that was otherwise
25 denied^{7,8}; and
26

27 Whereas, the external appeals process is severely hampered by the cessation of federal ACA
28 funding for external review programs, ‘labyrinthine’ processes for filing for an external appeal,
29 strict eligibility requirements, and lack of patient and physician education regarding external
30 appeals processes^{4,5,9}; and
31

32 Whereas, the insurer has between 30 to 60 days to respond to an initial internal appeal,
33 depending on category, and the cumulative timeframes of the many levels to the appeals
34 process delays crucial health care interventions^{6,10}; and
35

36 Whereas, some UnitedHealthcare plans have appeal packets as long as 14 single-spaced
37 pages, detailing three levels of standard and three levels of expedited appeals, all of which
38 delay the start of an independent external appeal⁶; and

Whereas, only certain denials are eligible for external appeal, which primarily involve medical judgment, surprise medical bills, or an insurer deciding to retroactively cancel coverage or determining that a treatment was experimental, and the insurer must agree that a given denial meets the eligibility criteria for such an appeal, setting up a conflict of interest¹¹; therefore be it

RESOLVED, that AMA Policy H-320.952, External Grievance Review Procedures, be amended by addition and deletion to read as follows:

Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components:

- (1) It should apply to all health carriers and Accountable Care Organizations;
- (2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician;
- (3) ~~Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational;~~
Issues eligible for external grievance review should include, at a minimum, adverse benefit determinations that materially affect an enrollee's coverage of, access to, or financial responsibility for health care items or services, including, but not limited to: determinations based on medical necessity or other medical judgment, experimental or investigational status, plan terms or benefit classification, network status, coding or other administrative grounds, surprise billing protections, or rescission of coverage; provided that external review need not encompass disputes solely concerning practitioner payment that do not affect the enrollee's coverage, access, or financial responsibility;
- (4) ~~Internal grievance procedures should generally be exhausted before requesting external review;~~
Internal grievance procedures should remain available, but an enrollee, the enrollee's authorized representative, or treating physician should be permitted to seek independent external review of an adverse benefit determination without first exhausting internal grievance procedures. A health plan may conduct internal review concurrently, provided that independent external review is not delayed;
- (5) An expedited review mechanism should be created for urgent medical conditions;
- (6) Independent reviewers practicing in the same state should be used whenever possible;
- (7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review;
- (8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information;
- (9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Date Received: 9/3/26

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11. Eldeib D, Blesener S. "Just Let Me die": after insurance repeatedly denied a couple's claims, one psychiatrist was their last hope. ProPublica. Published November 7, 2025.

RELEVANT [AMA POLICY](#)

Medicare Advantage Plans Double Standard H-330.863

Our AMA will seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor.

External Grievance Review Procedures H-320.952

Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components:

(1) It should apply to all health carriers and Accountable Care Organizations; (2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician; (3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational; (4) Internal grievance procedures should generally be exhausted before requesting external review; (5) An expedited review mechanism should be created for urgent medical conditions; (6) Independent reviewers practicing in the same state should be used whenever possible; (7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review; (8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information; (9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

Full transparency - Explanation of Benefits D-320.973

Our American Medical Association advocates that the minimum information included in an explanation of benefits,..., what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal...

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-26)

Introduced by: American College of Lifestyle Medicine

Subject: Payer Coverage and Tax-Advantaged Access for Physical Activity
Professionals, Services, and Programs

Referred to: Reference Committee J

1 Whereas, existing American Medical Association policy supports the use of exercise for health
2 promotion and rehabilitation, encourages payer and employer coverage for fitness club
3 memberships and other physical activity programs, and supports evidence-based lifestyle
4 interventions addressing physical activity and nutrition for chronic disease prevention and
5 management (H-470.997; H-425.972); and
6

7 Whereas, the 2018 Physical Activity Guidelines Advisory Committee Scientific Report found
8 substantial health benefits from regular physical activity across the life course, and the Physical
9 Activity Guidelines for Americans recommend both aerobic and muscle-strengthening physical
10 activity;^{1, 2} and
11

12 Whereas, inadequate aerobic physical activity is associated with substantial health care
13 expenditures, with a 2025 analysis estimating approximately \$192 billion in annual United
14 States health care expenditures associated with inadequate aerobic physical activity during the
15 study period;³ and
16

17 Whereas, economic evaluations have demonstrated favorable returns on investment and cost
18 savings for supervised exercise therapy in adults with chronic conditions in the United States,
19 including positive returns on investment ranging from 1.15:1 to 1.7:1, while an Australian
20 analysis estimated a return of A\$4.75 for every A\$1 invested in structured diet and physical
21 activity interventions integrated into antenatal care;^{11, 12} and
22

23 Whereas, national policy efforts have identified gaps in integrating physical activity assessment,
24 prescription, referral, and connections to qualified exercise professionals and evidence-based
25 programs into health care delivery;⁴ and
26

27 Whereas, the Calendar Year 2027 Medicare Physician Fee Schedule proposed rule identifies
28 nutrition, physical activity, and healthy lifestyles as priorities in chronic disease prevention and
29 management and includes proposals concerning health and well-being coaching, including the
30 qualifications and certification standards for personnel eligible to furnish coaching services, as
31 well as remote physiologic and therapeutic monitoring, shared medical appointments, and
32 longitudinal and multidisciplinary care, creating multiple potential pathways to better integrate
33 physical activity and lifestyle interventions and inform future roles for qualified exercise
34 professionals;⁵ and
35

36 Whereas, federal tax rules allow Health Savings Account and health flexible spending
37 arrangement funds to be used for qualified medical expenses, including certain disease-
38 prevention expenses, but generally exclude expenditures primarily for general health, including
39 many nutrition, fitness, and exercise expenses;^{6, 7} and

Whereas, the Personal Health Investment Today Act of 2025, H.R. 2369 and S. 1144 of the 119th Congress, would amend the Internal Revenue Code to treat certain amounts paid for physical activity, fitness, and exercise as amounts paid for medical care;^{8,9} and

Whereas, existing national exercise-professional infrastructure supports verification of recognized professional credentials, and the developing U.S. National Exercise Referral Framework seeks to align exercise-professional education, training, and demonstrated competencies with patient health status, clinical needs, and complexity;¹⁰ and

Whereas, specific advocacy for coverage, clinically integrated referral pathways, and tax-advantaged benefits would further operationalize existing AMA support for physical activity and healthy lifestyles; therefore be it

RESOLVED, that our American Medical Association advocate for sustainable public and private payer coverage for evidence-based physical activity assessment, exercise prescription, and related behavioral counseling, referral, and longitudinal follow-up services (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policies supporting clinically integrated referral pathways to evidence-based exercise programs and qualified exercise professionals with education, training, and demonstrated competencies appropriate to patient needs and clinical complexity (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation and regulatory policies expanding eligibility under tax-advantaged, Health Savings Accounts and health flexible spending arrangements for physical activity and exercise services and programs, and related nutrition and behavior-change services and programs, for chronic disease prevention and general health promotion. (Directive to Take Action)

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

Received: 9/14/26

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RELEVANT AMA POLICY

Exercise and Physical Fitness H-470.997

1. Our American Medical Association encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity. The AMA encourages other organizations and agencies to join in promoting physical fitness through all appropriate means.
2. Our AMA advocates for continued research towards development of structured physical activity treatment plans for the specific diagnoses of anxiety and depression, as well as longitudinal studies to examine the effects of physical activity on health outcomes, particularly later in life.
3. Our AMA encourages the education of health care professionals on the role of physical activity and/or structured exercise in treating and managing anxiety and depression; the need to screen for levels of physical activity of patients; the need to motivate and educate patients of all ages about the benefits of physical activity, including positive mental health benefits.
4. Our AMA encourages the provision of coverage by health care payers and employers for fitness club memberships and access to other physical activity programs.
5. Our AMA encourages the implementation, trending, and utilization of evidenced-based physical activity measures in the medical record for treatment prescription, counseling, coaching, and follow up of physical activity for therapeutic use.

Policy Timeline – BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14; Modified: Res. 421, A-23; Modified: CSAPH Rep. 09, A-24.

Healthy Lifestyles H-425.972

1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the *Journal of the American Medical Association* in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Policy Timeline – Res. 423, A-12; Appended: Res. 959, I-17; Reaffirmed: Res. 302, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-26)

Introduced by: American Society for Reproductive Medicine, American College of Obstetricians and Gynecologists, American College of Medical Genetics and Genomics, Endocrine Section Council (The Endocrine Society, American Association of Clinical Endocrinology, and the American Society for Reproductive Medicine)

Subject: Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit

Referred to: Reference Committee J

1 Whereas, monogenic disorders affect approximately 400 million individuals worldwide and
2 collectively represent a significant cause of morbidity, mortality, disability, and healthcare
3 utilization; and
4

5 Whereas, advances in genetic technologies have improved the accuracy, accessibility, and
6 clinical utility of monogenic disorder screening, including carrier screening and preimplantation
7 genetic testing for monogenic disorders (PGT-M); and
8

9 Whereas, screening embryos for known familial monogenic disorders can inform reproductive
10 decision-making, reduce transmission of known monogenic disorders, and improve patient
11 outcomes; and
12

13 Whereas, professional organizations, including the American Society for Reproductive Medicine
14 (ASRM), the American College of Obstetricians and Gynecologists (ACOG), and the American
15 College of Medical Genetics and Genomics (ACMG) recognize the important role of genetic
16 testing in the evaluation and management of individuals and families at risk for inherited
17 disorders; and
18

19 Whereas, insurance coverage for carrier testing and embryonic monogenic disorder screening
20 remains inconsistent and often absent across public and private payers, creating financial
21 barriers that may disproportionately affect underserved populations and exacerbate existing
22 healthcare disparities; and
23

24 Whereas, the lack of coverage for clinically indicated embryonic monogenic disorder screening
25 may prevent patients from accessing appropriate reproductive planning options and specialized
26 care, as well as increasing the need for invasive screening tests and procedures in pregnancy;
27 and
28

29 Whereas, expanding insurance coverage for evidence-based embryonic monogenic disorder
30 screening has the potential to improve health outcomes by reducing the genetic transmission of
31 monogenic conditions to offspring from known carriers; therefore be it
32

33 **RESOLVED**, that our American Medical Association support public and private health insurance
34 coverage for clinically indicated monogenic disorder screening, including carrier and

preimplantation embryo testing, when supported by evidence-based clinical guidelines and physician judgment (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for embryonic monogenic disorder screening to be recognized as a medically necessary covered benefit by public and private payers when such testing is recommended according to established professional society guidelines or based on individualized clinical assessment (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage insurers to develop transparent and standardized coverage policies for embryonic monogenic disorder screening that minimize administrative barriers, including burdensome prior authorization requirements, that may delay medically appropriate care (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for equitable access to medically indicated embryonic monogenic disorder screening to reduce disparities in reproductive healthcare decision-making among historically underserved populations (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant medical specialty societies, patient advocacy organizations, and policymakers to promote education regarding the clinical utility and cost-effectiveness of embryonic monogenic disorder screening of embryos in improving patient outcomes and informing patient-centered care. (Directive to Take Action)

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

Received: 9/15/26

REFERENCES

1. American Society for Reproductive Medicine practice guideline, "Indications and management of preimplantation genetic testing for monogenic conditions: a committee opinion"
2. American College of Obstetricians and Gynecologists (ACOG) Committee Opinion, "Preimplantation Genetic Testing"
3. American College of Medical Genetics and Genomics (ACMG) practice resource, "Screening for autosomal recessive and X-linked conditions during pregnancy and preconception: a practice resource of the American College of Medical Genetics and Genomics"

RELEVANT AMA POLICY

H-185.919 Payment and Coverage for Genetic/Genomic Precision Medicine

H-185.923 Integrating Precision Medicine into Alternative Payment Models

H-480.944 Improving Genetic Testing and Counseling Services

2.2.5 Genetic Testing of Children

4.1.1 Genetic Testing & Counseling

4.1.2 Genetic Testing for Reproductive Decision Making

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-26)

Introduced by: Kentucky

Subject: Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes

Referred to: Reference Committee J

1 Whereas, type 2 diabetes mellitus is highly prevalent among older adults and is associated with
2 substantial morbidity, mortality, health care utilization, and expenditures; and
3

4 Whereas, older adults with type 2 diabetes who are not treated with insulin may experience
5 clinically significant hyperglycemia, hypoglycemia, and glycemic variability, which may
6 contribute to falls, cardiovascular events, cognitive impairment, hospitalization, and other
7 adverse outcomes; and
8

9 Whereas, traditional self-monitoring of blood glucose by fingerstick provides intermittent glucose
10 measurements and may be burdensome, painful, and insufficient to identify clinically important
11 patterns of hyperglycemia, hypoglycemia, and glycemic variability; and
12

13 Whereas, continuous glucose monitoring (CGM) provides dynamic glucose information,
14 including glucose trends and, for appropriate devices, alerts for hypo- and hyperglycemia,
15 thereby supporting timely patient and clinician interventions and individualized diabetes
16 management; and
17

18 Whereas, the American Diabetes Association's Standards of Care in Diabetes—2026
19 recommends CGM for adults with diabetes receiving insulin therapy, receiving noninsulin
20 therapies that can cause hypoglycemia, and for individuals receiving any diabetes treatment for
21 which CGM assists in management; and the Standards of Care report that randomized
22 controlled trials in adults with type 2 diabetes not using insulin increasingly demonstrate
23 improvements in A1C, time in range, time above, and other glycemic outcomes with CGM
24 compared with blood glucose monitoring ^{1,2}; and
25

26 Whereas, current Medicare coverage criteria for CGM require that a beneficiary with diabetes
27 either be treated with insulin or have documented problematic hypoglycemia meeting specified
28 criteria, thereby excluding some Medicare beneficiaries with non-insulin-treated type 2 diabetes
29 for whom CGM may be clinically appropriate³; and
30

31 Whereas, Medicare currently classifies CGMs as durable medical equipment and recognizes
32 their clinical utility for diabetes management, but its coverage criteria do not fully reflect the
33 expanding evidence supporting CGM use in selected patients with non-insulin-treated type 2
34 diabetes⁴; and
35

36 Whereas, the American Medical Association already supports Medicare coverage of continuous
37 and flash glucose monitoring systems for patients with insulin-dependent diabetes through AMA
38 Policy H-330.885, and the AMA has previously recognized the importance of expanding access
39 to clinically effective and cost-saving glucose monitoring technologies^{5,6}; and

Whereas, expanding evidence-based access to CGM may improve diabetes self-management, facilitate individualized treatment decisions, reduce preventable complications, and support value-based care while allowing physicians and patients to determine whether CGM is clinically appropriate⁷; therefore be it

RESOLVED, that our American Medical Association amend Policy H-330.885, “Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes,” by addition and deletion to read as follows:

Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Diabetes H-330.885

Our American Medical Association supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring devices systems for patients with diabetes, including patients with type 2 diabetes who are not treated with insulin, when it is evidenced-based and determined clinically appropriate by the treating physicians.

Our AMA advocate that the Centers for Medicare & Medicaid Services (CMS) revise Medicare coverage criteria for CGM to permit coverage for beneficiaries with non-insulin-treated type 2 diabetes when clinically appropriate, without requiring insulin use or a documented history of problematic hypoglycemia as the sole qualifying criteria.

Our AMA advocate for Medicare CGM coverage policies that preserve physician clinical judgment, incorporate evolving evidence and clinical guidelines, and avoid unnecessary administrative barriers to medically appropriate CGM access.

Our AMA support continued research evaluating the clinical effectiveness, health outcomes, health care utilization, quality of life, health equity, and cost-effectiveness of CGM among patients with non-insulin-treated type 2 diabetes.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

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2. American Diabetes Association Professional Practice Committee for Diabetes. 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes-2026. *Diabetes Care*. 2026;49(Suppl 1):S183-S215.
3. Centers for Medicare & Medicaid Services. Medicare Coverage of Diabetes Supplies. Medicare Learning Network. February 2026.
4. Centers for Medicare & Medicaid Services. LCD L33822: Glucose Monitors. Medicare Coverage Database.
5. American Medical Association. Policy H-330.885: Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes.
6. American Medical Association House of Delegates. Resolution 816 (I-22): Coverage for Continuous or Flash Glucose Monitoring Devices. 2022.
7. American Diabetes Association Professional Practice Committee for Diabetes. 6. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises: Standards of Care in Diabetes—2026. *Diabetes Care*. 2026;49(Suppl 1):S132-S149.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Meaningful Enforcement of Prohibitions on the Corporate Practice of
Medicine

Referred to: Reference Committee J

1 Whereas, at the 2026 Annual Meeting, our American Medical Association substantially
2 strengthened its corporate practice of medicine policy through Board of Trustees Report 25 and
3 Resolution 241, and Policy H-215.981 now directs our AMA to create a state corporate practice
4 of medicine template; and

5
6 Whereas, our AMA has established extensive policy protecting physician clinical autonomy,
7 independent professional judgment, due process, patient advocacy, and physicians who report
8 unsafe or unethical care; however, these protections may be ineffective when physicians lack
9 meaningful mechanisms to report, challenge, or obtain relief from corporate interference; and

10
11 Whereas, prohibitions on the corporate practice of medicine exist in many states, but such
12 protections have limited value without effective enforcement, meaningful remedies, and
13 protection for physicians who exercise independent clinical judgment or report conduct that
14 threatens patient safety or violates applicable law; and

15
16 Whereas, states have begun adopting statutory approaches that strengthen enforcement of
17 protections against impermissible corporate interference and provide remedies for affected
18 physicians; and

19
20 Whereas, Policy H-215.981 already supports enforcement of laws and regulations pertaining to
21 corporate control of medical practice and directs our AMA to develop a state corporate practice
22 of medicine template, creating an opportunity to ensure that these protections are accompanied
23 by meaningful enforcement mechanisms; therefore be it

24
25 RESOLVED, that our American Medical Association amend Policy H-215.981, "Corporate
26 Practice of Medicine," by modification to read as follows:

27
28 **1.** Our American Medical Association vigorously opposes any effort to pass legislation or
29 regulation that removes or weakens state or federal laws prohibiting the corporate practice of
30 medicine.

31 **2.** Our AMA opposes the corporate practice of medicine and supports the restriction of
32 ownership and operational authority of physician medical practices to physicians or physician-
33 owned groups.

34 **3.** Our AMA, at the request of state medical associations, will provide guidance, consultation,
35 and model legislation regarding the corporate practice of medicine, to ensure the autonomy of
36 hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting
37 with corporately owned management service organizations.

- 1 4. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to
- 2 its effect on the patient-physician relationship, financial conflicts of interest, patient-centered
- 3 care and other relevant issues.
- 4 5. Our AMA will work with interested state medical associations, the federal government, and
- 5 other interested parties to develop and advocate for regulations and appropriate legislation
- 6 pertaining to corporate control of practices in the health care sector such that physician clinical
- 7 autonomy and operational authority are preserved and protected.
- 8 6. Our AMA will create a state corporate practice of medicine template to assist state
- 9 medical associations and ~~national medical~~ specialty societies as they navigate the
- 10 intricacies of corporate investment in physician practices and health care ~~generally at~~
- 11 ~~the state level~~ and develop the most effective means of prohibiting the corporate
- 12 practice of medicine in ways that are not detrimental to the sustainability of physician
- 13 practices, including meaningful enforcement mechanisms, remedies, and protections
- 14 against retaliation and provisions rendering unenforceable contractual restrictions that
- 15 interfere with physicians' independent professional judgment, patient advocacy, or
- 16 good-faith reporting]
- 17 7. Our AMA supports meaningful enforcement of existing regulations and legislation
- 18 pertaining to corporate control of practices in the health care sector to ensure that
- 19 physician clinical autonomy and operational authority is are preserved and protected,
- 20 including appropriate enforcement authority and meaningful remedies for violations.
- 21 8. Our AMA supports capital reserve requirements and leverage standards that preserve access
- 22 to care for patients and fulfillment of contractual obligations to physicians and trainees by
- 23 providing stable financing for hospitals, clinics, and other health care facilities.
- 24 (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981

1. Our American Medical Association vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine.
2. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
4. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
5. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected.
6. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

7. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
8. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

[Res. 247, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CMS Rep. 7, A-11Modified: CMS Rep. 6, I-13Reaffirmed: CMS Rep. 07, A-17Modified: Res. 713, A-18Reaffirmed: CMS Rep. 11, A-19Reaffirmed: CME Rep. 01, I-22Modified: Res. 710, A-24Modified: BOT Rep. 09, I-24Appended: CMS Rep. 03, A-25Modified: BOT Rep. 25, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-26)

Introduced by: Senior Physicians Section

Subject: Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked

Referred to: Reference Committee J

Whereas, evidence continues to demonstrate a growing shortage of practicing physicians^{1,2,3}; and

Whereas, the number of senior physicians who are no longer engaged in clinical practice continues to rise^{1,2,3}; and

Whereas, a significant barrier to the increased utilization of senior physicians is the high cost of professional liability insurance^{1,2,3}; and

Whereas, senior physicians engaged in part-time clinical practice are frequently charged the full premium for professional liability insurance^{1,2,3}; therefore be it

RESOLVED, that our American Medical Association advocate for the development of prorated liability insurance policies for senior physicians to enhance incentives for them to remain in, or re-enter, medical practice on a part-time basis (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association develop a position paper addressing prorated professional liability insurance premiums as a means to expand access to medical care, with proration based on physician specialty, hours worked, and prior medical liability claims history, and report its findings back to the House of Delegates by A-28, thereafter to the major insurance carriers of professional liability. (Directive to Take Action)

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

Received: 9/16/26

References

1. Pollich, M. *Understanding Part Time Malpractice Insurance and Policy Options*. CGAA. Published January 24, 2025. Accessed August 13, 2026. <https://www.cgaa.org/article/part-time-malpractice-insurance>
2. Mello, M.M., Frakes, M.D., Blumenkranz E., Studdert, D.M., Malpractice liability and health care quality: a review. *JAMA* 2020; 323 (4): 352-366.doi: 10.1001/jama.2019.21411. (jamanetwork.com)
3. Resident Advisor. *Going Part-Time or Per Diem: Adjusting Your Malpractice Without Gaps*. Published January 7, 2026. Accessed August 13, 2026 (residencyadvisor.com)

RELEVANT AMA POLICY

G-620.045 Medical Malpractice Discount Rates

Our AMA encourages member organizations of the Federation to offer access to discounted medical liability insurance premiums where legally permissible.

[Res.603, A-14; Reaffirmed: CCB/CLRPD Rep.01, A-24]

H-200.972 Primary Care Physicians in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

- a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
- b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
- c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
- d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
- e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
- f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
- g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:

- a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
- b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

[CMS Rep. I-93-2; Reaffirmation A-01; Reaffirmation I-03; Modified: CME Rep. 13, A-06; Reaffirmed: CMS Rep.01, A-16; Modified: CME Rep.04, I-18; Appended: Res. 206, I-19; Reaffirmation: I-22; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 724, A-23; Reaffirmed BOT Rep.07, I-24]

H-435.998 Equitable Risk Classification in Medical Liability Premiums

Our American Medical Association supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums [Res.15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep.12, A-02; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: BOT Rep.09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-26)

Introduced by: Senior Physicians Section

Subject: Continuing Care Retirement Communities (CCRC's)

Referred to: Reference Committee J

Whereas, seniors have a great deal of difficulty understanding the complexity of the finances of Continuing Care Retirement Communities (CCRC's); and

Whereas, CCRC's are exploding in popularity among baby boomers; and

Whereas, there are approximately 1,900 CCRC's nationwide, with a 4% - 4.5% annual growth rate expected annually^{1,2}; and

Whereas, deciding if a CCRC is right for each senior means puzzling out a complex business model that blends real estate, healthcare, and insurance; and

Whereas, there is a risk you may pay for care you do not need, as well as the risk of the CCRC not fulfilling its financial duties; and

Whereas, there is no federal oversight of CCRC's and there are no nationwide standards; and

Whereas, CCRC's are regulated primarily at the state level; therefore be it

RESOLVED, that our American Medical Association study the issue of Continuing Care Retirement Communities (CCRC's), including how they are regulated, disclosures needed, contract terms, and financial safeguards in an effort to advocate for and protect older adults and senior physicians (Directive to Take Action); and be it further

RESOLVED, that there be a report back to the HOD by I-27. (Directive to Take Action)

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

Received: 9/16/26

REFERENCES

1. AARP How Continuing Care Retirement Communities Work. AARP, January 27, 2022. (aarp.org)
2. National Investment Center for Seniors Housing & Care (NIC). 2026 Outlook for U.S. Continuing Care Retirement Communities (CCRC's). (nic.org)

RELEVANT AMA POLICY

H-160.897 Inclusion of Continuing Care Retirement Centers and Long-Term Care Facilities in Accountable Care Organizations Investment Model

Our American Medical Association supports participation of physicians practicing in Continuing Care Retirement Centers and other community-based long-term care settings in ACOs, medical homes, and other APMs.

[BOT Action in response to referred for decision: Res. 707, A-17]

H-280.984 Residential Facility Regulations

Our AMA advocates for patients in long-term care, group home and other residential settings and will: (1) strive to see that enhanced quality of care results from any new proposed state or federal regulations; (2) attempt to ensure that appropriate and necessary physician involvement be maintained for patients; (3) urge state regulatory bodies and HHS to seek consultation and advice from the AMA and other professional medical societies when developing rules and regulations that affect medical care; (4) support cooperative efforts with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations; (5) support efforts to monitor federal and state legislation and regulations which affect physicians involved in long-term, group home or other residential setting care, and provide testimony and information about appropriate medical management of patients to regulatory and/or licensing bodies; and (6) support actions to establish better understanding and cooperation among federal and state health agencies as they formulate health and safety standards.

[Res. 89, I-89; Sub. Res. 168, A-89; Sub. Res. 109, I-87; CMS Rep. 11, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Modified: CMS Rep. 3, A-10; Reaffirmed: CMS Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-26)

Introduced by: Women Physicians Section, Organized Medical Staff Section, Private
Practice Physicians Section

Subject: Increasing Payment for Patient Portal Messages

Referred to: Reference Committee J

Whereas, a study of patient portal message volume estimate that patient authored portal messages have increased by 153% since the start of the COVID-19 pandemic ¹ and show no signs of slowing down; and

Whereas, a retrospective study from the University of Wisconsin Department of Family Medicine showed that, over a 2 year period, female family physicians on average received 1754 messages each compared to an average of 1235 messages received per male family physician, equaling a 42% higher rate of patient portal messages received over their male colleagues ²; and

Whereas, female physicians spend approximately 20% more time managing electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, patient portal messages, email and telephone communications than their male counterparts ³; and

Whereas, much of the time and effort spent on managing electronic patient communications is unpaid work; and

Whereas, lack of protected time to manage electronic patient communications becomes time taken away from seeing patients, caring for oneself, and spending time with friends and family, leading to increased rates of burnout; and

Whereas, while Medicare does offer payment for some electronic patient communications that meet strict requirements, fewer than 1% of Medicare beneficiaries are billed for portal message services ⁴; and

Whereas, more insurance companies are starting to cover reimbursement for electronic patient communications, physicians generally submit billing codes for only a tiny fraction of billable messages ⁵; and

Whereas, our AMA's policy, advocacy and member education surrounding payment for electronic patient communications has been limited despite broad advocacy for overall physician payment reform; therefore be it

RESOLVED, that our American Medical Association amend Policy H-385.919, "Payment for Electronic Communication," by addition and deletion to read as followed:

1. Our American Medical Association will advocate that ~~pilot projects of~~
~~innovative physician~~ payment models be structured to include ~~incentive fair~~

- 1 market payment for the use of electronic communications such as Web
- 2 portals, remote patient monitoring, real-time virtual office visits, patient portal
- 3 messages, and email and telephone communications.
- 4 2. Our AMA will continue to update its guidance on communication and
- 5 information technology to help physicians meet the needs of their patients and
- 6 practices.
- 7 3. Our AMA will educate physicians on how to effectively and fairly bill for
- 8 electronic communications between patients and their physicians.
- 9 (Update current policy); and be it further

10
11 RESOLVED, that our AMA advocate for employers to a.) educate physicians on how to
12 effectively and fairly bill for electronic communications b.) create workflows and templates which
13 make such billing easy to implement, and c.) incorporate protected time into a physician's
14 schedule in order to adequately address patient portal messages (Directive to take Action); and
15 be it further

16
17 RESOLVED, that our AMA prioritize the promotion of already available toolkits and member
18 education resources pertaining to how to more effectively manage inbasket work and bill for
19 patient portal messages. (Directive to Take Action)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

REFERENCES

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2. Couture A, Birstler J. The Gender of the Sender: Assessing Gender Biases of Greetings in Patient Portal Messages. *J Womens Health (Larchmt)*. 2023;32(2):171-177. doi:10.1089/jwh.2022.0333
3. Rittenberg E, Liebman JB, Rexrode KM. Primary Care Physician Gender and Electronic Health Record Workload. *J Gen Intern Med*. 2022;37(13):3295-3301. doi:10.1007/s11606-021-07298-z
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5. Holmgren AJ, Byron ME, Grouse CK, Adler-Milstein J. Association Between Billing Patient Portal Messages as e-Visits and Patient Messaging Volume. *JAMA*. 2023;329(4):339–342. doi:10.1001/jama.2022.24710

RELEVANT AMA POLICY

H-385.919 Payment for Electronic Communication

1. Our American Medical Association will advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications.
2. Our AMA will continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices.
3. Our AMA will educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.

[CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11; Reaffirmation: I-18; Reaffirmed: Res. 801, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Joint Commission Standards for Medical Staff Self-Governance

Referred to: Reference Committee J

1 Whereas, autonomy and independence of the medical staff of a healthcare facility forms the
2 backbone of quality care delivery; and
3

4 Whereas, when the independence of the medical staff and its leadership is compromised, the
5 ability of medical staff to fulfill their responsibility to provide quality patient care is jeopardized;
6 and
7

8 Whereas, selection of medical staff leadership and control over medical staff duties by a
9 healthcare facility's board or other leadership is diametrically opposed to self-governance and
10 threatens patient safety and physician professionalism; and
11

12 Whereas, the Joint Commission revised its hospital accreditation standards effective January
13 2025, significantly reducing references to medical staff self-governance and autonomy that
14 appear to weaken support for these vital components of care delivery; and
15

16 Whereas, Joint Commission standards affect accredited hospitals but also influence national
17 policy and practices in other care facilities throughout the healthcare industry; and
18

19 Whereas, AMA policy strongly supports medical staff self-governance to protect patients and
20 preserve physician professionalism; therefore be it
21

22 RESOLVED, that our American Medical Association, through its appointees to the Joint
23 Commission Board of Commissioners and other appropriate channels, advocate for restoring
24 clear accreditation standards affirming medical staff self-governance and physician-led
25 oversight of credentialing, privileging, peer review, professional competence, quality
26 improvement, patient safety, and other matters involving the professional practice of medicine.
27 (Directive to Take Action)

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

Received: 9/16/26

RELEVANT AMA POLICY

Hospital Medical Staff Self-Governance H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.
2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.
3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
 - (a) Application, reapplication, credentialing and privileging standards;
 - (b) Fair hearing and appeal process;
 - (c) Selection, election and removal of medical staff officers;
 - (d) Clinical criteria and standards which manage quality assurance, utilization review;
 - (e) Structure of the medical staff organization;
 - (f) Rules and regulations that affect the entire medical staff.
4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

Citation: Sub. Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed; CMS Rep. 01, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence

Referred to: Reference Committee J

1 Whereas, the Medicare Conditions of Participation require hospitals to maintain an organized
2 medical staff that operates under governing-body-approved bylaws, is responsible for the quality
3 of medical care, and is well-organized and accountable to the governing body^{1,2}; and
4

5 Whereas, the Centers for Medicare and Medicaid Services (CMS) interpretive guidance
6 describes a collaborative system of checks and balances in which the medical staff exercised
7 oversight through credentialing, privileging, peer review, policy approval, and quality
8 improvement participation²; and
9

10 Whereas, the current Medicare Conditions of Participation address medical staff organization,
11 accountability, composition, and bylaws but do not expressly prescribe the functional reporting
12 relationship of medical staff office personnel or minimum protected budgetary, staffing, and
13 independent-counsel resources for the organized medical staff^{1,2}; and
14

15 Whereas, AMA Policies H-225.957 and H-235.980 recognize medical staff self-governance,
16 control of medical staff funds, access to independent legal counsel, and the organized medical
17 staff's role in determining the resources and financial support required to fulfill its
18 responsibilities^{3,4}; and
19

20 Whereas, AMA Policy H-375.962 recognizes the central role of confidentiality, privilege, good-
21 faith participation, immunity, and protection from retaliation in effective peer review⁵; and
22

23 Whereas, because Medical Staff Office personnel administer credentialing, privileging, peer
24 review, corrective action, quality improvement, and medical staff governance, exclusive
25 administrative control over their medical-staff duties may create actual or perceived conflicts
26 when the interests of hospital administration and the organized medical staff differ^{2,3,5}; and
27

28 Whereas, CMS-approved accrediting organizations may survey hospitals for deemed
29 compliance only through programs whose standards meet or exceed applicable Medicare
30 requirements⁶; therefore be it
31

32 RESOLVED, that our American Medical Association advocate that the Centers for Medicare &
33 Medicaid Services (CMS) establish standards requiring, as a Condition of Participation for
34 hospitals participating in Medicare, that Medical Staff Office personnel performing functions on
35 behalf of organized medical staff have clearly defined functional accountability to the organized
36 medical staff, through the Medical Executive Committee or its designee for credentialing,
37 privileging, peer review, corrective action, medical staff governance, quality oversight, and other
38 organized medical staff functions (Directive to Take Action); and be it further

1 RESOLVED, that our AMA advocate that CMS require hospital medical staff bylaws or related
 2 governing documents approved through the medical staff bylaw process to define the Medical
 3 Staff Office reporting structure, authority over medical-staff work assignments and performance
 4 evaluation, safeguards against administrative interference or retaliation, and standards
 5 governing access to, use of, and disclosure of confidential medical staff information (Directive to
 6 Take Action); and be it further

7
 8 RESOLVED, that our AMA advocate that CMS-approved hospital accrediting organizations
 9 adopt uniform standards concerning Medical Staff Office functional accountability, protected
 10 medical staff resources, access to independent legal counsel when appropriate, and
 11 confidentiality of credentialing, privileging, peer review, quality-improvement, corrective-action,
 12 and disciplinary information (Directive to Take Action); and be it further

13
 14 RESOLVED, that our AMA advocate that Joint Commission standards explicitly protect the
 15 organized medical staff's access to timely, transparent, and interpretable information, adequate
 16 resources, and independent authority necessary to meaningfully fulfill its self-governance
 17 responsibilities, regardless of how supporting personnel, technology, or administrative
 18 infrastructure are organized. (Directive to Take Action)

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

Received: 9/16/26

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1. Electronic Code of Federal Regulations. 42 CFR § 482.22, Condition of Participation: Medical Staff. [eCFR § 482.22](#) Accessed August 4, 2026.
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9. American Medical Association. Policy D-235.982, Model Hospital Medical Staff Bylaws; reproduced in Resolution 024 (A-24), Relevant AMA Policy section. [AMA HOD source](#) Accessed August 4, 2026.
10. American Medical Association. AMA Physician's Guide to Medical Staff Organization Bylaws, 7th ed. [AMA guide landing page](#) Accessed August 4, 2026.

RELEVANT AMA POLICY**Principles for Strengthening the Physician-Hospital Relationship H-225.957**

Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
 - a. duration of leave allowed before and after delivery;
 - b. category of leave credited;
 - c. whether leave is paid or unpaid;
 - d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
 - e. whether sick leave and vacation time may be accrued from year to year or used in advance;
 - f. how much time must be made up in order to be considered board eligible;
 - g. whether make-up time will be paid;
 - h. whether schedule accommodations are allowed; and
 - i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
 - a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
 - b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
 - c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave, and with eligibility beginning at the start of employment without a waiting period.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
 - a. leave policy for birth or adoption;
 - b. duration of leave allowed before and after delivery;
 - c. duration of leave allowed after abortion or stillbirth;
 - d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
 - e. whether leave is paid or unpaid;
 - f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
 - g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;

- h. how time can be made up in order for a resident physician to be considered board eligible;
 - i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
 - j. whether time spent in making up a leave will be paid; and
 - k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
- 8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
 - a. leave policy for birth or adoption;
 - b. duration of leave allowed before and after delivery;
 - c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
 - d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
 - e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
 - f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
- 9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
- 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
- 11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
- 12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
- 13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
- 14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.
- 15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
- 16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
- 17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
- 18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely

means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.

19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.
21. Our AMA supports policies that provide physician employees with paid leave for routine prenatal care or any medical care related to pregnancy in addition to other existing forms of leave.

Citation: CCB/CLRPS Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24; Appended: Res. 306, I-25

Hospital Medical Staff Self-Governance H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.
2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.
3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
 - (a) Application, reapplication, credentialing and privileging standards;
 - (b) Fair hearing and appeal process;
 - (c) Selection, election and removal of medical staff officers;
 - (d) Clinical criteria and standards which manage quality assurance, utilization review;
 - (e) Structure of the medical staff organization;
 - (f) Rules and regulations that affect the entire medical staff.
4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

Citation: Sub. Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25

Medical Staff Bylaws and Medical Staff Autonomy H-235.976

Our AMA reaffirms that (1) medical staff bylaws are a contract between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application.

Citation: Res. 8, A-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 9, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 01, A-24

Model Hospital Medical Staff Bylaws D-235.982

1. Our AMA will continue to update the Physician's Guide to Medical Staff Organization Bylaws to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations.
2. Our AMA will develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians.
3. Our AMA will pursue opportunities to improve the accessibility and usability of the content contained in the Physician's Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth.

Citation: BOT Rep. 35, A-18

Legal Protections for Peer Review H-375.962

Definition and Purpose of Peer Review

Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.

Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.

Composition of the Peer Review Committee

Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.

Definitions

Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.

Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care

consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment and intentional misconduct.

Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within their knowledge; but such witness cannot be asked about their testimony before a peer review organization or about opinions formed by them as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24

9.5.1 Organized Medical Staff

The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. The core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.

Members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concerns the interest of the organized medical staff and its members. This is ethical so long as there is no adverse effect on patient safety and the quality of care.

[AMA Principles of Medical Ethics: IV,VI](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-26)

Introduced by: American Academy of Physical Medicine & Rehabilitation, American Academy of Pediatrics, Association of Academic Physiatrists, American Association of Neuromuscular & Electrodiagnostic Medicine, Medical Student Section

Subject: Government Support of Adaptive Sports Programming

Referred to: Reference Committee J

Whereas, only 53% of adults with disabilities report engaging in at least 10 minutes of dedicated aerobic physical activity in a given week, compared to 74% of adults without disabilities;^{1,2} and

Whereas, adaptive sports provide a crucial outlet through which all individuals can engage in necessary physical activity, helping to address disparities in exercise engagement;³ and

Whereas, participation in adaptive sports is associated with improved bone density, decreased adiposity, self-perceived improvement in fitness, and improved health-related fitness outcomes;^{2,4-6} and

Whereas, adaptive sports are an effective rehabilitation tool for individuals with congenital or acquired illnesses or injuries such as central neurological lesions, including brain injury, spinal cord injury, stroke, and multiple sclerosis; limb amputation; vision loss, etc., with benefits for function and quality of life;⁷ and

Whereas, individuals with disabilities who participate in adaptive sports form supportive communities, which are critical given the disproportionate rates of social isolation and mental health challenges among individuals with disabilities;^{2,8-12} and

Whereas, adaptive sports can have a positive economic impact by reducing burden on the healthcare system through improved physical health, while also being positively associated with employment among individuals with disabilities;^{5,13} and

Whereas, despite the clear physical, mental, and social benefits of adaptive sports, participation is often limited by barriers, including the cost of adaptive equipment, transportation challenges, inaccessible facilities, limited program availability, and lack of awareness of existing opportunities, all of which may be especially pronounced in rural and low-income communities;^{2,14-17} and

Whereas, Congress and the Department of Veterans Affairs have previously funded veteran adaptive sports programming through grants for their development, implementation, and management that include direct operational costs such as equipment, training, event facilitation, and travel, at both the recreational and competitive levels;¹⁸⁻²⁰ and

Whereas, lawmakers continue to introduce, sponsor, or support legislation to increase funding for recreational sports and sporting infrastructure;^{21,22} and

Whereas, our American Medical Association has existing policy addressing insurance coverage of activity-specific adaptive sports and exercise equipment including prostheses and orthoses (Policy H-90.961), and governmental incentives for the development of community recreational fitness facilities (Policy H-470.952), but has no policy addressing operational support for adaptive sports programming itself including coaching, trained personnel, transportation, and event facilitation; which the literature identifies as principal barriers to participation; therefore be it

RESOLVED, that our American Medical Association advocate for increased public funding for the development, expansion, accessibility, and sustainability of adaptive sports programming for athletes of all ages, particularly in low-income and rural communities (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the integration of adaptive sports and recreation into the rehabilitation care continuum, including physician counseling of patients of all ages with disabilities regarding the health benefits of adaptive sports participation and referral to community adaptive sports programs (New HOD Policy); and be it further

RESOLVED, that our AMA support the inclusion of appropriately trained medical and coaching personnel, pre-participation medical assessment, and proper fitting of adaptive sports equipment within publicly funded adaptive sports programming (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm Policy H-90.961, "Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses." (Reaffirm HOD Policy)

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

Received: 9/22/26

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RELEVANT AMA POLICY

Exercise and Physical Fitness H-470.997

1. Our American Medical Association encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity. The AMA encourages other organizations and agencies to join in promoting physical fitness through all appropriate means. [BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14; Modified: Res. 421, A-23; Modified: CSAPH Rep. 09, A-24]

Promotion of Exercise H-470.991

1. Our American Medical Association: a. supports the promotion of exercise, particularly exercise of significant cardiovascular benefit. b. encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. [Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses H-90.961

1. Our American Medical Association recognizes activity-specific adaptive sports and exercise equipment as assistive devices that are integral to the health maintenance of persons with disabilities in accordance with national exercise guidelines. 2. Our AMA recognizes activity-specific adaptive sports and exercise equipment, such as activity-specific prostheses and orthoses, as medical devices that facilitate independence and community participation. 3. Our AMA advocates for coverage by all private and public insurance plans for activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities in order to promote health maintenance and chronic disease prevention. [Res. 112, A-24]

Support for Persons with Intellectual Disabilities H-90.967

Our American Medical Association encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible. [Res. 01, A-16]

Government to Support Community Exercise Venues H-470.952

1. Our American Medical Association encourages towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities. 2. Our AMA encourages governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. [CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-26)

Introduced by: New York

Subject: Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions

Referred to: Reference Committee J

1 Whereas, the proposed merger of Maimonides Medical Center in Brooklyn, New York and NYC
2 Health+Hospitals appears to be inevitable; and
3

4 Whereas, the current patients in Brooklyn have a choice of seeing independent physicians or
5 Maimonides employed physicians and having their surgery performed at Maimonides Hospital
6 by board-certified surgeons, and private practice physicians have full and unrestricted admitting
7 and surgical privileges at Maimonides Hospital; and
8

9 Whereas, malpractice carriers as well as insurance contracts require full admitting and surgical
10 privileges for surgical specialists even to perform in-office procedures; and
11

12 Whereas, the NYC Health+Hospitals does not have a provision for private practice physicians to
13 have full admitting and surgical privileges, and the merger will lead to the loss of full practice
14 privileges for private practice physicians at Maimonides Hospital and the limitation of choices for
15 patients in Brooklyn; and
16

17 Whereas physicians that provide in-patient care to their own patients require the ability to admit
18 and operate on patients at hospitals, physicians are legally precluded from opening and
19 operating independent hospitals in New York State; hospitals are essentially “utilities” in terms
20 of physician livelihoods; and
21

22 Whereas insurance networks vary, with some hospitals out-of-network with particular plans and
23 others in-network, surgeons and other hospital-care providing physicians require the ability to
24 admit and treat patients at more than one facility to minimize patient costs; and
25

26 Whereas, the NYS Attorney General James concluded that court review would be more
27 appropriate for Maimonides' deal to join the New York City public hospital network, due to
28 pending litigation and significant community engagement with the merger; therefore be it
29

30 RESOLVED, that our American Medical Association advocate to protect the full admitting and
31 surgical privileges of private practice physicians as a necessary condition of any hospital merger
32 or acquisition and will advocate to protect the employment benefit for physicians, residents and
33 fellows including preservation of salary and benefit levels and Public Service Loan Forgiveness
34 (PSLF) eligibility as a necessary condition of any hospital merger or acquisition. (Directive to
35 Take Action)

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

Received: 9/22/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-26)

Introduced by: New York

Subject: Small Medical Practice Website and other Digital Service Compliance with
ADA Regulation

Referred to: Reference Committee J

1 Whereas, countless small medical practices across the country have been consolidated into
2 large groups and health systems due to the extraordinary costs and requirements of maintaining
3 a private medical practice; and
4

5 Whereas, recent Department of Justice (DOJ) rule specifically sets digital accessibility deadlines
6 for public entities (Title II) to comply with Web Content Accessibility Guidelines (WCAG) 2.1
7 Level AA by April 24, 2026 (or April 26, 2027, for smaller populations); and
8

9 .
10 Whereas, there is no specific, new, fixed compliance date for private/non-government entities
11 (Title III). Non-government entities face compliance risk, as Title III of the Americans with
12 Disabilities Act (ADA) requires public accommodations to be accessible, and the new Title II
13 web standards are likely to be adopted as the industry standard for private litigation; and

14 Whereas, there have been numerous lawsuits filed against businesses in recent years for failing
15 to comply with the requirements of the Americans with Disabilities Act with regard to the public
16 websites, apps, or digital services of these businesses; and
17

18 Whereas, these lawsuits are flourishing because of court decisions and settlements that direct
19 that websites of businesses must meet certain accessibility requirements; and
20

21 Whereas, there are no exceptions in the law or in these court decisions regarding applicability to
22 small businesses that have far less resources to update these websites to meet standards; and
23

24 Whereas, the American Medical Association and medical associations across the country have
25 been advocating on a number of fronts to ensure that physicians maintain a meaningful choice
26 whether to practice as part of their own medical practice or as an employee of a hospital or
27 health system; therefore be it
28

29 RESOLVED, that our American Medical Association educates its members on ADA compliance
30 requirements as they apply to medical practice websites and other digital services (Directive to
31 Take Action); and be it further
32

33 RESOLVED, that our AMA advocate for legislation, regulation or other legal mechanisms to
34 provide hardship exemption, financial assistance, enforcement flexibility and/or legal immunity
35 for solo and small-group medical practices that do not meet requirements of the Americans with
36 Disabilities Act as it applies to medical practice websites and other digital services. (Directive to
37 Take Action)

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

Received: 9/22/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-26)

Introduced by: American Thoracic Society

Subject: Coverage of SMART Therapy for Asthma

Referred to: Reference Committee J

1 Whereas, Single Maintenance and Reliever Therapy (SMART) is a guideline-recommended,
2 high-value asthma treatment that reduces preventable exacerbations and downstream health
3 care utilization; and
4

5 Whereas, SMART uses a single budesonide–formoterol inhaler for both maintenance and
6 symptom relief, simplifying treatment and ensuring rapid delivery of anti-inflammatory therapy
7 during symptom worsening; and
8

9 Whereas, compared with traditional regimens, SMART reduces severe asthma exacerbations
10 by approximately 30–40%, leading to fewer emergency department visits, hospitalizations, and
11 courses of systemic corticosteroids; and
12

13 Whereas, despite strong evidence and national guideline endorsement, SMART remains
14 underutilized, due in part to formulary restrictions, non-preferred drug placement, prior
15 authorization requirements, and inhaler quantity limits; and
16

17 Whereas, improving insurance coverage of SMART represents an opportunity to improve
18 outcomes and reduce avoidable health care utilization; and
19

20 Whereas, budesonide–formoterol is explicitly supported for SMART by national and
21 international guidelines, while mometasone–formoterol may be considered as an alternative
22 where clinically appropriate; and
23

24 Whereas, both the National Asthma Education and Prevention Program (NAEPP) and the
25 Global Initiative for Asthma (GINA) clinical practice guidelines for asthma recommend
26 maintenance-and-reliever therapy using inhaled corticosteroid (ICS)–formoterol for appropriate
27 patients; and
28

29 Whereas, our American Medical Association supports patient access to safe and effective
30 treatments prescribed by physicians, including clinically appropriate off-label uses of FDA-
31 approved medications, and supports reducing prior authorization and formulary barriers that
32 impede access to necessary drug therapy; and
33

34 Whereas, our AMA Policy D-185.907, “Access to Single Maintenance and Reliever Therapy for
35 Asthma,” supports removing or increasing quantity limits for inhaled corticosteroid/long-acting
36 beta-agonist combination inhalers when prescribed in accordance with evidence-based
37 guidelines and supports efforts to improve access to asthma inhalers in state Medicaid
38 programs; and

Whereas, multiple state Medicaid programs have adopted coverage policies supporting access to budesonide–formoterol and/or mometasone–formoterol; therefore be it

RESOLVED, that our American Medical Association advocate that public and private health plans, including state Medicaid programs, provide formulary coverage of brand-name formulations and FDA-approved generic equivalents of budesonide–formoterol and mometasone–formoterol, without prior authorization requirements (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that health plans increase quantity limits per month, allow three-month supplies when possible, and adjust the days' supply per month and refill thresholds to support the dispensing of budesonide-formoterol and/or mometasone-formoterol in adequate quantities for patients to correctly follow SMART dosing without disruptions in inhaler dispensing (Directive to Take Action); and be it further

RESOLVED, that our AMA recommends that pharmacies adjust dispensing and claims-adjudication protocols to ensure that the National Drug Code (NDC) submitted reflects the patient's formulary coverage and preference for brand-name versus generic products. (New HOD Policy)

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

Received: 9/22/26

RELEVANT AMA POLICY

Access to Single Maintenance and Reliever Therapy for Asthma D-185.907

Our AMA supports working with CMS and major national insurance carriers to remove or increase quantity limits for inhaled corticosteroid/long-acting beta-agonist combination inhalers when prescribed according to evidence-based guidelines. The policy also directs AMA collaboration with state medical associations to advocate for removal of copays for asthma inhalers in state Medicaid plans.

[Res. 102, A-25]

Cost of Prescription Drugs H-110.997

Our AMA supports prescription-drug cost-containment programs only when patients retain access to medications necessary to treat their illnesses and physicians retain freedom to select the most appropriate drug and delivery method. AMA policy also affirms physician discretion to prescribe either brand-name or generic pharmaceuticals and supports expanded third-party coverage of prescription medications as necessary medical therapies.

[BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 07, A-26]

Patient Access to Treatments Prescribed by Their Physicians H-120.988

Our AMA supports physicians' autonomous clinical decision-making authority, including clinically appropriate off-label use of FDA-approved drugs or devices when supported by sound scientific evidence or medical opinion. AMA policy also supports third-party coverage of safe and effective off-label therapies and emphasizes physicians' responsibility to interpret scientific information in the context of individual patient care.

[Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: CSAPH Rep. 02, A-23; Reaffirmed: CSAPH Rep. 02, A-24]

Prior Authorization and Utilization Management Reform H-320.939

Our AMA supports reducing prior-authorization administrative burdens and improving patients' access to necessary care. AMA policy supports measuring the effects of prior authorization and utilization-management processes on patient access and clinical outcomes and advocates that health plans minimize burdens on patients, physicians, and medical centers.

[CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22; Reaffirmed: BOT Rep. 20, A-26]

Managed Care Cost Containment Involving Prescription Drugs H-285.965

Our AMA supports formulary policies that adequately reflect the needs of individual patients and provide mechanisms for physicians to seek formulary additions or exceptions when medically appropriate. The policy specifically states that prescription caps, prior authorization, and other cost-containment mechanisms should not unduly burden physicians or patients in obtaining optimal drug therapy.

[CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res. 714, A-98; Reaffirmed: Res. 511, A-99; Modified: Res. 501; Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10; Reaffirmed in lieu of Res. 822, I-11; Reaffirmation A-14; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-26)

Introduced by: Florida

Subject: Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies

Referred to: Reference Committee J

1 Whereas, the mechanism of automated downcoding, wherein payer algorithms reduce higher-
2 level E/M codes such as 99214 and 99215 to 99213 based solely on proprietary statistical
3 models and peer-comparison benchmarks applied at the point of claim adjudication without
4 requesting or reviewing the physician's medical record, constitutes adjudication without
5 adequate clinical review, violates standard billing practices, and conflicts with the AMA policy (1)
6 and AMA CPT E/M guidelines that define service levels by Medical Decision Making (MDM) or
7 total physician time, not by diagnosis codes or population-level outlier comparisons; and
8

9 Whereas, automated and artificial intelligence-directed downcoding of Evaluation and
10 Management (E/M) services by commercial health insurance companies has increased sharply
11 since 2022 despite AMA advocacy (2), driven by AI and machine learning algorithms deployed
12 at scale by major payers including Medicare Advantage Plans (3); and
13

14 Whereas, a recent survey found that 75 percent of independent specialty practices report that
15 insurer downcoding has increased over the past year, with thousands of E/M claims routinely
16 downgraded, often by automated payer algorithms without any clinical review, and one practice
17 reporting that 98 of 100 audited downcoded charts were originally coded correctly (4); and
18

19 Whereas, automated downcoding inflicts significant and often invisible financial harm on
20 physician practices, with revenue erosion from algorithmic downcoding alone estimated at
21 \$28,000 to \$74,000 per physician annually in family practice settings, and \$40,000 to \$180,000
22 annually for multi-specialty practices, with the loss frequently undetected because downcoded
23 claims are posted as paid rather than denied, bypassing standard denial management
24 workflows (5,6); and
25

26 Whereas, automated downcoding disproportionately threatens the financial viability and long-
27 term sustainability of small independent practices, rural practices, and practices serving minority
28 and underserved communities, which lack the administrative infrastructure and revenue cycle
29 staffing capacity of large health systems to detect, track, and appeal downcoded claims; the
30 American Academy of Family Physicians has stated that automated downcoding is an
31 existential threat to many practices, especially those in rural and underserved areas who may
32 be the only health care access point for entire communities (7); and
33

34 Whereas, because downcoded claims are processed and posted as paid rather than denied,
35 they do not appear in denial queues, denial rate reports, or standard billing exception reports,
36 making them effectively invisible to current revenue cycle management workflows, and the vast
37 majority of EHR-integrated billing platforms and practice management systems currently lack

any native automated detection mechanism that compares the submitted CPT code against the paid CPT code and alerts billing staff to the discrepancy (8); therefore be it

RESOLVED, that our American Medical Association advocate with urgency, including through EHR certification criteria and standard billing and clearinghouse functionality, for electronic health record, billing, and practice management systems to automatically detect from the electronic remittance advice when a payer has adjudicated or reimbursed a claim at an E/M service level lower than the level submitted — whether by code reassignment or payment reduction — and to alert physicians or their billing staff, with the original and adjudicated codes, the payer's stated reason, and the applicable appeal deadline, within the time needed to appeal (Directive to Take Action); and be it further

RESOLVED, that our AMA increase awareness of automated, algorithmic, and artificial intelligence-directed E/M downcoding among physicians, medical societies, policymakers, regulators, and other stakeholders; develop, provide, and update resources — including downcoding-specific appeal templates, model contract language, and documentation guidance — to help physicians identify, document, and appeal inappropriate downcoding; and collect and periodically report data on the prevalence and payer-level patterns of such downcoding. (New HOD Policy)

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

Received: 9/16/26

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9. MD Clarity. (2026). Payer Downcoding: A Provider's Guide to Automated E/M Reductions. URL: <https://www.mdclarity.com/blog/payer-downcoding>

RELEVANT AMA POLICY

Litigation Center Cases to Combat Automatic Downcoding and/or Recoding H-70.924

The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices.

Citation: BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22; Bundling and Downcoding of CPT Codes H-70.937

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948

It is the policy of our American Medical Association, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes:

1. The principal reason(s) for the determination.
2. The clinical rationale used in making the determination.
3. A statement describing the process for appeal.

Automatic Downcoding of Claims D-320.972

1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.

2. Our AMA supports that, after review of the patient's medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.

3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.

4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995

1. Our American Medical Association will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.

2. Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review.

3. AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to

- a. develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims.
- b. seek information on a regular basis from those associations that collect such information.
- c. respond with appropriate legislation, advocacy, and communication initiatives.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-26)

Introduced by: Florida

Subject: Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services

Referred to: Reference Committee J

1 Whereas, several AMA policies exist to oppose health plans from using software, algorithms, or
2 methodologies, other than manual review of the patient's medical record, to deny or downcode,
3 and the AMA has created tool kits and model state legislation to oppose unjustified downcoding
4 of medical claims, yet AI driven automatic downcoding continues to escalate and an update and
5 enforcement of these policies is needed (1,2,3); and
6

7 Whereas, automated downcoding without medical record review may constitute a violation of
8 state insurance claim-settlement laws requiring claims to be adjudicated based on reasonable
9 investigation, a legal theory already applied when the Maryland Insurance Administration, on
10 March 13, 2026, fined Cigna \$80,000 and ordered it to cease automatic E/M downcoding under
11 Policy R49, finding that the mechanism of applying a policy rule before any human reviewed the
12 encounter independently constituted a violation of state law(4); and
13

14 Whereas, Medicare Advantage (MA) plans continue to automatically downcode physician E/M
15 services using proprietary algorithms and internal edits not used in traditional Medicare, and
16 despite CMS's 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) requiring MA
17 plans to follow traditional Medicare billing standards and base determinations on the medical
18 record, MA plans still downgrade claims without reviewing physician documentation; (2, 5); and
19

20 Whereas, state medical societies and patient advocates have made progress in curbing
21 unjustified automatic AI driven downcoding by introducing and passing legislation against
22 automatic downcoding (6), (7), (8), (9); therefore be it
23

24 RESOLVED, that our American Medical Association uses its legal and advocacy resources,
25 when appropriate, to support litigation, including class action suits, challenging automated,
26 algorithmic, or artificial intelligence-directed downcoding of properly documented E/M services
27 without appropriate medical record review (New HOD Policy); and be it further
28

29 RESOLVED, that our AMA advocates and requests CMS to enforce and strengthen its 2024
30 Final Rule requirements applicable to Medicare Advantage plans regarding automated coverage
31 and coding criteria, restricts downcoding without clear separate notification of each incident with
32 the explanation of benefits, and establishes minimum transparency standards for all algorithmic
33 claims adjudication policies including public disclosure of the criteria and methodologies used.
34 (Directive to Take Action)

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

Received: 9/16/26

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RELEVANT AMA POLICY**Litigation Center Cases to Combat Automatic Downcoding and/or Recoding H-70.924**

The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices.

Citation: BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Bundling and Downcoding of CPT Codes H-70.937

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948

It is the policy of our American Medical Association, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes:

1. The principal reason(s) for the determination.
2. The clinical rationale used in making the determination.
3. A statement describing the process for appeal.

Automatic Downcoding of Claims D-320.972

1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.

2. Our AMA supports that, after review of the patient's medical record and determination that a

lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.

3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.

4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995

1. Our American Medical Association will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.

2. Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review.

3. AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to

- a. develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims.
- b. seek information on a regular basis from those associations that collect such information.
- c. respond with appropriate legislation, advocacy, and communication initiatives.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care

Referred to: Reference Committee J

1 Whereas, patient feedback and appropriately designed patient-experience and patient-
2 satisfaction measures can provide valuable information about communication, patient-centered
3 care, access, and the delivery of health care and can support quality improvement, formative
4 feedback, and physician professional development; and
5

6 Whereas, patient-experience and patient-satisfaction measures vary in their design, reliability,
7 validity, and suitability for different purposes, and continued evaluation is needed to better
8 understand their relationship to clinical quality and health outcomes; and
9

10 Whereas, financial, employment, or other incentives tied to patient-experience or patient-
11 satisfaction survey scores may create pressure to prioritize patient expectations over
12 independent clinical judgment and evidence-based care; and
13

14 Whereas, physicians should be supported in providing medically appropriate care based on
15 clinical judgment and the best interests of the patient without incentives to provide unnecessary,
16 inappropriate, or unsafe care; and
17

18 Whereas, existing policy, H-450.982, Patient Satisfaction and Quality of Care states: Our AMA
19 believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals
20 and values of patients; and (2) efforts should be continued to improve the measurement of
21 patient satisfaction and to document its relationship, if any, to favorable outcomes and other
22 accepted criteria of high quality; therefore be it
23

24 RESOLVED, that our American Medical Association recognizes patient feedback and
25 appropriately designed patient-experience and patient-satisfaction measures as valuable tools
26 for improving communication, patient-centered care, health care delivery, quality improvement,
27 formative feedback, and professional development (New HOD Policy); and be it further
28

29 RESOLVED, that our AMA supports continued efforts to improve the measurement of patient
30 experience and patient satisfaction, including ensuring that such measures are valid, reliable,
31 and used for the purposes for which they were developed (New HOD Policy); and be it further
32

33 RESOLVED, that our AMA opposes tying individual physician compensation, bonuses, hiring,
34 employment retention or termination, promotion, credentialing, contracting, or network
35 participation to patient-experience or patient-satisfaction survey scores (New HOD Policy); and
36 be it further
37

38 RESOLVED, that our AMA opposes policies or incentives based on patient-experience or
39 patient-satisfaction survey scores that may interfere with independent clinical judgment or

- 1 incentivize medically unnecessary, inappropriate, or unsafe care (New HOD Policy); and be it
- 2 further
- 3
- 4 RESOLVED, that our AMA rescind policy H-450.982. (Rescind Current HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

RELEVANT AMA POLICY

Patient Satisfaction and Quality of Care H-450.982

Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality. [CMS Rep. E, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed BOT Rep. 9, A-13Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Pain Management and the Hospital Value-Based Purchasing Program D-450.962

1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain.
2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined. [BOT Rep. 9, A-13Modified: BOT Rep. 5, I-15Reaffirmed: CMS Rep. 01, A-25]

Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958

Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. [Res. 102, A-13Reaffirmed: Res. 806, I-13Reaffirmed in lieu of Res. 814, I-14Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Pain Medicine and Patient Adherence in Quality Care Assessment D-450.958

Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys. Our AMA encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. [BOT Rep. 5, I-15Modified: CMS Rep. 07, A-25Reaffirmed: Res. 210, A-26]

Accountable Care Organization Principles H-160.915

Our American Medical Association adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions

are not based on commercial interests but rather on professional medical judgment that puts patients' interests first:

- a. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.
 - b. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
 - c. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
 - d. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.
3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
 4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
 5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
 6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).
 7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

8. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
9. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
10. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
11. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
12. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.
13. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.
14. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
15. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.
16. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
17. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
18. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

[Res. 819, I-10Reaffirmed: A-11Reaffirmed: Res. 215, A-11Reaffirmed: I-12Reaffirmed: CMS Rep. 6, I-13Reaffirmed: Sub. Res. 711, A-15Reaffirmed: I-15Reaffirmed: A-16Reaffirmed: I-17Reaffirmed: A-19Reaffirmed: A-23Reaffirmed: CMS Rep. 1, I-23Reaffirmed: Res. 217, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality
Parameters as Criteria for Physician Payment

Referred to: Reference Committee J

1 Whereas, patient experience and patient satisfaction are important dimensions of health care
2 and can provide valuable information for improving communication, access, and the overall
3 delivery of care; and
4

5 Whereas, patient-experience and patient-satisfaction survey scores may be influenced by
6 factors beyond an individual physician's control, including facility operations, staffing, wait times,
7 access to services, and other aspects of the care environment; and
8

9 Whereas, the use of patient-experience or patient-satisfaction survey scores in individual
10 physician compensation and employment decisions may attribute system-level factors to
11 individual physicians and may use such measures for purposes for which they were not
12 designed or validated; and
13

14 Whereas, measures used for consequential decisions regarding individual physicians should be
15 valid, reliable, appropriately attributable to the physician being evaluated, and suitable for the
16 specific purpose for which they were developed; therefore be it
17

18 RESOLVED, that our American Medical Association amend Policy D-385.958 by addition and
19 deletion to read as follows:
20

21 Our American Medical Association will work with the Centers for Medicare & Medicaid Services
22 (CMS) and non-government payers, hospitals, health systems, and physician employers to
23 ensure that;
24

25 (1) subjective criteria, such as patient satisfaction surveys, ~~be used only as an adjunctive and~~
26 ~~not a determinative~~ not be used as a measure of physician quality for the purpose of physician
27 payment, employment, credentialing, or contracting; and
28

29 (2) physician payment determination, when incorporating quality parameters, only consider
30 measures that are under the direct control of the physician. (Modify Current HOD Policy)

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

Received: 9/16/26

RELEVANT AMA POLICY

Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958

Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. [Res. 102, A-13Reaffirmed: Res. 806, I-13Reaffirmed in lieu of Res. 814, I-14Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Patient Satisfaction and Quality of Care H-450.982 Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality.[CMS Rep. E, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed BOT Rep. 9, A-13Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Pain as the Fifth Vital Sign D-450.956 Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics. [BOT Rep. 19, A-16Reaffirmation: A-19]

Pain Medicine and Patient Adherence in Quality Care Assessment D-450.958 (1)Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys. (2) Our AMA encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. [BOT Rep. 5, I-15Modified: CMS Rep. 07, A-25Reaffirmed: Res. 210, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-26)

Introduced by: Minnesota

Subject: Modifiers Indicating Independent Non-Physician Practitioner Use of Physician
Consults and Transfers

Referred to: Reference Committee J

1 Whereas, non-physician practitioners (NPPs) provide a vital service in health care; and

2
3 Whereas, nurse practitioners now have independent practice authority in 29 U.S. states plus the
4 District of Columbia and two U.S. territories and 34% of them plan on going into independent
5 practice within the next 5 years¹; and

6
7 Whereas, studies have found that independent practice authority for NPs has resulted in an
8 increased interest in self-employment with a predicted 374.1% increase in the probability of
9 being self-employed²⁻³; and

10
11 Whereas, the literature on quality of care provided by independently practicing NPPs does not
12 account for consultations with physicians or when care is transferred to a physician, which could
13 have a great impact on the proper diagnosis and treatment plans, and thus impact quality
14 metrics; and

15
16 Whereas, when patient care is transferred from an NPP to a physician on the same day, the
17 entire visit is attributed to the physician; and

18
19 Whereas, modifier SA only applies to NPPs in collaborative practice settings but is not used by
20 NPPs in independent practice; and

21
22 Whereas, new modifiers to be used by NPPs when they consult with a physician on patient care
23 could be used to better determine actual quality of care; and

24
25 Whereas, current coding modifiers do not adequately capture scenarios in which independently
26 practicing NPPs consult with or transfer care to a physician, resulting in incomplete data on care
27 patterns; therefore be it

28
29 RESOLVED, that our American Medical Association supports the development of new modifiers
30 to improve coding accuracy and data collection when independently practicing non-physician
31 practitioners consult with a physician or transfer care to a physician. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

REFERENCES

1. Nurse.org's 2024 Nurse Practitioner Study. <https://nurse.org/education/nurse-practitioner-survey/>
2. Waite A . Highlighting the lived experience of nurse practitioners in independent practice. *Journal for Nurse Practitioners*. 2019 Nov-Dec;15(10), 787–791, doi:
3. DePriest K, D'Aoust R, Samuel L, Commodore-Mensah Y, Hanson G, Slade EP. Nurse practitioners' workforce outcomes under implementation of full practice authority. *Nurs Outlook*. 2020 Jul-Aug;68(4):459-467. doi: 10.1016/j.outlook.2020.05.008. Epub 2020 Jun 24. PMID: 32593462; PMCID: PMC7581487. Yadav KN, et al.

RELEVANT AMA POLICY**Coding of Physician and Non-Physician Services H-70.994**

- 1) Our AMA opposes the development of modifiers to physicians' CPT to identify services rendered by non-physicians, but supports efforts to develop appropriate coding systems for non-physician services.
- 2) The AMA CPT Editorial Panel continues to identify areas where services performed by non-MD/DOs may be separately coded so that the AMA/Specialty Society RVS Update Committee (RUC) and the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board may develop work relative values which are reflective of the differential level of work between MD/DO and non-MD/DO services.

Practicing Medicine by Non-Physicians H-160.949

- 1) Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
- 2) Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
- 3) Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
- 4) Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
- 5) Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
- 6) Our AMA opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-26)

Introduced by: American Academy of Emergency Medicine

Subject: Strengthening Emergency Interfacility Transfer Infrastructure

Referred to: Reference Committee J

1 Whereas, Interfacility transfer is an essential component of emergency care for patients who
2 require services unavailable at the facility where they initially present, particularly in rural,
3 geographically isolated, and other resource-limited settings; and
4

5 Whereas, patients awaiting interfacility transfer remain in emergency departments while
6 awaiting definitive care, and transfer boarding can adversely affect the timeliness of care for all
7 emergency department patients, with a disproportionate impact on low-volume rural emergency
8 departments¹; and
9

10 Whereas, successful emergency interfacility transfer requires both identification of an
11 appropriate accepting facility and timely availability of medically appropriate transportation, and
12 studies of interfacility transfer have identified transportation availability and delays in initiating
13 transport as significant barriers to timely transfer^{2,3}; and
14

15 Whereas, the fragmented process of separately locating an accepting facility and arranging
16 transportation can contribute to delays in definitive care, while centralized transfer coordination
17 can improve transfer efficiency; and
18

19 Whereas, use of the statewide Arkansas Trauma Communication Center to facilitate interfacility
20 transfers was associated with a 21-minute reduction in emergency department length of stay at
21 sending facilities for severely injured patients requiring transfer⁴; and
22

23 Whereas, regional emergency transfer coordination that provides real-time information
24 regarding receiving-hospital capabilities and capacity and available medical transportation could
25 allow transfer requests and transportation needs to be addressed through a single coordinated
26 system rather than through multiple independent processes; and
27

28 Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) already requires
29 hospitals with specialized capabilities to accept appropriate transfers when they have the
30 capacity to treat the patient⁵; and
31

32 Whereas, participation by Medicare-participating hospitals in regional emergency transfer
33 coordination systems would facilitate identification of appropriate receiving facilities and
34 operationalize access to capabilities and capacity already subject to federal emergency transfer
35 requirements; and
36

37 Whereas, the Centers for Medicare & Medicaid Services (CMS) Emergency Care Access &
38 Timeliness measure identifies boarding for more than 240 minutes after a decision to transfer as
39 a quality gap, demonstrating federal recognition of prolonged transfer boarding, but does not

1 itself provide a mechanism to locate an accepting facility, secure transportation, or escalate a
2 time-sensitive transfer when either is unavailable⁶; and
3

4 Whereas, the Medicare Ambulance Fee Schedule provides payment for ambulance services
5 furnished but does not establish a dedicated payment mechanism for maintaining advanced life
6 support or critical-care interfacility transport resources in readiness for time-sensitive transfers ⁷;
7 and
8

9 Whereas, maintaining dedicated or regionally shared interfacility transport readiness could
10 improve access to time-sensitive transportation while preserving emergency medical services
11 resources necessary for community 911 response; therefore be it
12

13 RESOLVED, that our American Medical Association advocate for federally supported regional
14 emergency transfer coordination systems providing a single point of access to real-time
15 receiving-hospital capabilities and medical transport availability for time-sensitive interfacility
16 transfers, with participation by Medicare-participating hospitals with relevant emergency or
17 specialized capabilities (Directive to Take Action); and be it further
18

19 RESOLVED, that our AMA advocate to Congress and the Centers for Medicare & Medicaid
20 Services for payment models that support emergency interfacility transport readiness, including
21 dedicated or regionally shared advanced and critical-care transport capacity without
22 compromising 911 response. (Directive to Take Action)

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

Received: 9/16/26

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2. Myers V, Nolan B. Delays to initiate interfacility transfer for patients transported by a critical care transport organization. *Air Med J*. 2021;40(6):436-440. doi:10.1016/j.amj.2021.06.005.
3. Slocum JD, Holl JL, Brigode WM, et al. Failure Mode Effects Analysis of re-triage of injured patients to receiving high-level Illinois trauma centers. *Ann Surg*. Published online October 11, 2024. doi:10.1097/SLA.0000000000006561. The study identified insufficient trained transport staff as the highest-priority failure in the receiving-center transfer process.
4. Porter A, Wyrick D, Bowman SM, Recicar J, Maxson RT. The effectiveness of a statewide trauma call center in reducing time to definitive care for severely injured patients. *J Trauma Acute Care Surg*. 2014;76(4):907-912. doi:10.1097/TA.0000000000000142.
5. Centers for Medicare & Medicaid Services. Emergency Medical Treatment and Labor Act (EMTALA) & Surges in Demand for Emergency Department Services. QSO-24-02-Hospitals/CAHs/REH. CMS states that hospitals with specialized capabilities may not refuse an appropriate transfer under EMTALA when they have capacity to treat the patient.
6. Centers for Medicare & Medicaid Services. Emergency Care Access & Timeliness (REHQR), CMS1264v2. The measure identifies transfer boarding exceeding 240 minutes after a decision to transfer as a quality gap.
7. Centers for Medicare & Medicaid Services. Medicare Ambulance Fee Schedule. CMS national fee schedule for ambulance services and annual payment amounts.

RELEVANT AMA POLICY

Interfacility Patient Transfers of Emergency Patients H-130.982

1. Our American Medical Association supports the following principles for interfacility patient transfers:
 - a. All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay.
 - b. An interfacility patient transfer should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical care at the receiving facility rather than the transferring facility.
 - c. All interfacility patient transfers should be subject to the sound medical judgment and consent of both

the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer;

2. Our AMA urges physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and
3. Our AMA urges state medical associations to encourage and provide assistance to physician organizations that are developing such protocols and interhospital agreements with their local hospitals.

Refusal of Appropriate Patient Transfers H-130.965

1. Our American Medical Association opposes the refusal by an institution to accept patient transfers solely on the basis of economics;
2. Our AMA supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer.
3. Our AMA supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred.

The Future of Emergency and Trauma Care D-130.971

1. Our American Medical Association will expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care.
2. Our AMA, with the advice of specific specialty societies, will advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties.
3. Our AMA will continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care.
4. Our AMA will disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation.
5. Our AMA supports demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care.
6. Our AMA supports the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension.
7. If an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950

- Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;
- (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;
 - (3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and
 - (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.

Medicare's Ambulance Service Regulations H-240.978

1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.
2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Overcrowding and Hospital EMS Diversion H-130.945

1. It is the policy of our American Medical Association that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds.
2. It is the policy of our AMA to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department.
3. It is the policy of our AMA to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups.
4. It is the policy of our AMA that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities.
5. It is the policy of our AMA that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility.
6. It is the policy of our AMA to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions.

Emergency Transfer Responsibilities H-130.957

Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:

- (1) require that the Office of the Inspector General (IG) request and receive the review of the Quality Improvement Organization (QIO) prior to imposing sanctions;
- (2) make the QIO determination in alleged patient transfer violations binding upon the IG;
- (3) expand the scope of QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
- (4) restore the knowing standard of proof for physician violation;
- (5) recognize appropriate referral of patients from emergency departments to physician offices;
- (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
- (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
- (8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
- (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.

Addressing and Reducing Patient Boarding in Emergency Departments D-130.957

1. Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.
2. Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions.
5. Our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care.
6. Our AMA will report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.