DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

Final Report of Reference Committee J

David Jakubowicz, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 3 - Non-Medical Switching of Prescription Drugs
2. Council on Medical Service Report 4 - Determining Fair Market Value when Contracting with Physician Practices
3. Council on Medical Service Report 6 - Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries
4. Resolution 801 – Improving the External Appeals Process for Denied Claims
5. Resolution 807 - Continuing Care Retirement Communities (CCRC's)
6. Resolution 808 - Increasing Payment for Patient Portal Messages
7. Resolution 811 - Government Support of Adaptive Sports Programming
8. Resolution 813 - Small Medical Practice Website and other Digital Service Compliance with ADA Regulation
9. Resolution 818 - Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment

RECOMMENDED FOR ADOPTION AS AMENDED

10. Board of Trustees Report 11 – Opposing Unilateral Downcoding of Physician Services by Insurance Companies
11. Council on Medical Service Report 1 - Transparency with the Term "Emergency Department"
12. Council on Medical Service Report 2 - The Impact of the Inflation Reduction Act on Physician Practices
13. Council on Medical Service Report 5 - Improving Marketplace Affordability through Premium Tax Credits
14. Resolution 802 – Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs
15. Resolution 803 - Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit
16. Resolution 805 - Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine
17. Resolution 806 - Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked
18. Resolution 809 - Joint Commission Standards for Medical Staff Self-Governance
19. Resolution 810 - Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence

20. Resolution 817 - Proposed Revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care
21. Resolution 819 - Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers
22. Resolution 820 - Strengthening Emergency Interfacility Transfer Infrastructure

RECOMMENDED FOR ADOPTION IN LIEU OF

23. Resolution 804 - Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes
24. Resolution 812 - Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions
25. Resolution 814 – Coverage of SMART Therapy for Asthma
26. Resolution 815 – Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies
    Resolution 816 – Enhancing Advocacy to Combat Automated Insurance Downcoding of E/M Services

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 3 – NON-MEDICAL SWITCHING OF PRESCRIPTION DRUGS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 3 is adopted and the remainder of the report filed.

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) 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.

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

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

Testimony on Council on Medical Service Report 3 was unanimously supportive of its adoption. Testimony explained the harms that can be caused by non-medical switching not only on patients, but also on physicians and physician practices. An individual offered an additional recommendation to prohibit pharmacy benefit managers (PBMs) from influencing patient choice of pharmaceutical via copays or preferred pharmacies. However, the Council on Medical Service explained that while this is an important issue,

it is outside the scope of the report, and a number of existing policies are already in place that prevent these actions by PBMs. Since this amendment is covered by existing policy and there was strong and overwhelming support for the report's recommendations, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 4 – DETERMINING FAIR MARKET VALUE WHEN CONTRACTING WITH PHYSICIAN PRACTICES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 4 is adopted and the remainder of the report filed.

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 enable value-based, patient-centered care while maintaining appropriate safeguards against fraud and abuse and protecting patients from conflicts of interest and inappropriate utilization. (New HOD Policy)

2. That our AMA support the Centers for Medicare & Medicaid Services (CMS) explicitly defining factors that can be utilized to calculate "fair market value" (FMV) as it relates to physician compensation including, but not limited to, the following factors:
    - Physician specialty, subspecialty, or physician services to be provided;
    - Geographic location;
    - Supervision of non-physician providers or trainees;
    - Whether a restrictive covenant is in place and its level of restrictiveness;
    - Additional roles and responsibilities (e.g., education, quality improvement duties, alternative payment model or value-based care participation, serving as licensed directors of hospital departments or laboratories);
    - Restrictions on outside activities or income opportunities (e.g. work at a Veterans Affairs facility, work at an academic institution, moonlighting, consulting, development of intellectual property owned by the physician, or other outside professional activities);
    - Specialty or subspecialty shortages, either locally or nationally; and/or
    - Other factors that impact value to the health system. (New HOD Policy)

3. That our AMA support CMS providing additional guidance on exceptions and/or safe harbors that physicians and employers can rely upon to adjust physician compensation, either through direct compensation, or through value-sharing of other payments that are based on the physician's contribution to the institution. (New HOD Policy)

4. That our AMA encourage physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide the methodology, data sources, and calculations used in determining FMV as it relates to the compensation of independent physicians contracting with the hospital whenever FMV is cited as a reason for the selected compensation level. (New HOD Policy)

5. That our AMA support transparency of ongoing and future proposed physician financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities during any negotiation to provide healthcare or administrative services between all parties. (New HOD Policy)

6. That our AMA encourage physicians, particularly those in independent practice that are entering contracting arrangements, to seek independent valuation, legal counsel, and third-party review when negotiating compensation and contractual agreements where FMV is an issue. (New HOD Policy)

7. That our AMA support policies that ensure fair and transparent integrity in physician-health system contractual relationships, including written, transparent, and time-limited agreements, appropriate limitations on restrictive covenants to protect patient access and continuity of care, and preservation of physician advocacy on behalf of patients. (New HOD Policy)

8. That our AMA reaffirm Policy D-405.988, which states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-385.940, which states that the AMA recognizes the substantial impact of 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. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-385.914, which states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. (Reaffirm HOD Policy)

Your Reference Committee heard unanimous, strong support from several delegations and no testimony opposing the report's recommendations. Testimony highlighted the importance of ensuring that fair market value for physicians encapsulates the full scope of their contributions. Due to the overwhelming support, your Reference Committee

recommends that the recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 6 – STUDY OF PHYSICIANS UTILIZING AMBULATORY SURGICAL CENTERS AND OFFICE-BASED LABORATORIES OR PERFORMING OFFICE-BASED SURGERIES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 6 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 6 is adopted and the remainder of the report filed.

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, and OBS should be evidence-based, proportional to patient risk, and should not create unnecessary barriers to medically appropriate care:

a. When applicable, transfer agreements and backup plans should be coordinated between physicians.

i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician who would be designated to be among those receiving and caring for the patient must give explicit consent to the agreement to provide follow-up care.

ii. When patient transfer is required, an appropriate and timely handoff of the patient and the transfer of relevant patient records should be completed.

iii. Transfer agreements should be evidence-based, proportional to patient risk, and should not create unnecessary barriers to patient access to medically appropriate care.

b. Protocols and agreements for ensuring continuity of care with physicians in the local community should be established when clinically indicated and feasible. Such protocols should be proportionate to patient risk and the services provided.

c. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.

d. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements.
(New HOD Policy)

2. That our AMA reaffirm Policy 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, and that the AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in order to deliver reproductive health services, including contraception and abortion. (Reaffirm HOD Policy)

Your Reference Committee heard unanimous, strong support from several delegations and no testimony opposing the report's recommendations. Testimony outlined how the report adequately addressed concerns brought up in its referral and sufficiently balances protecting patient access, physician practice, and the AMA's opposition to Targeted Regulation of Abortion Providers (TRAP) laws. Due to the unanimous support, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted and the remainder of the report be filed.

(4) RESOLUTION 801 - IMPROVING THE EXTERNAL APPEALS PROCESS FOR DENIED CLAIMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 801 be <u>adopted</u>.

HOD ACTION: Resolution 801 is <u>adopted</u>.

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

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;~~ <u>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</u>

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)

Testimony on Resolution 801 supported strengthening AMA policy on health plans' external appeals since these review processes are often complex, burdensome, and difficult to navigate. Your Reference Committee heard a call for referral to study the potential implications of eliminating the requirement to exhaust internal grievance procedures before seeking an independent external review. However, because most of testimony was widely supportive of Resolution 801, your Reference Committee recommends that it be adopted.

(5) RESOLUTION 807 - CONTINUING CARE RETIREMENT COMMUNITIES (CCRC'S)

RECOMMENDATION:

Your Reference Committee recommends that Resolution 807 be adopted.

HOD ACTION: Resolution 807 is adopted.

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) (Directive to Take Action)

Testimony was supportive of Resolution 807 and the proposed study intended to help seniors better understand Continuing Care Retirement Communities and make informed decisions when choosing retirement communities. Although a commenter warned against imposing more regulations on these entities, testimony unanimously supported a study. Accordingly, your Reference Committee recommends that Resolution 807 be adopted.

(6) RESOLUTION 808 - INCREASING PAYMENT FOR PATIENT PORTAL MESSAGES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 808 be adopted.

HOD ACTION: Resolution 808 is adopted.

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

1. Our American Medical Association will advocate that ~~pilot projects of innovative~~ physician payment models be structured to include ~~incentive~~ fair market payment for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, patient portal messages, 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.
(Update current policy); and be it further

RESOLVED, that our AMA advocate for employers to a.) educate physicians on how to effectively and fairly bill for electronic communications b.) create workflows and templates which make such billing easy to implement, and c.) incorporate protected time

into a physician's schedule in order to adequately address patient portal messages (Directive to take Action); and be it further

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

Testimony on Resolution 808 was supportive of the intent, but several concerns were raised. Testimony highlighted that patient portal messages require physician time, clinical judgment, and responsibility, yet often remain inadequately compensated and extend beyond scheduled clinical hours. Potential concern was noted regarding broader implications related to physician payment, particularly Medicare budget neutrality as well as the impact that recommended payment strategies could have on smaller physician practices. However, even with the noted concerns, testimony was supportive of adopting the resolution. A delegation recommended that the resolution be referred, arguing that it does not clearly distinguish among expanding use of existing payment mechanisms, increasing payment for already recognized services, and creating new payment arrangements. However, no other testimony supported referral and thus, given the support for resolution as written, your Reference Committee recommends that Resolution 808 be adopted.

(7) RESOLUTION 811 - GOVERNMENT SUPPORT OF ADAPTIVE SPORTS PROGRAMMING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 811 be adopted.

HOD ACTION: Resolution 811 is adopted.

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)

Testimony was entirely supportive of Resolution 811. Testifiers explained the importance of adaptive sport in preventing secondary complications, supporting independence, and improving overall patient health. Further, testimony explained that the awareness and availability of adaptive sport has increased substantially, but there are many individuals that still face barriers due to cost and lack of integration. Due to the overwhelming support, your Reference Committee recommends that Resolution 811 be adopted.

(8) RESOLUTION 813 - SMALL MEDICAL PRACTICE WEBSITE AND OTHER DIGITAL SERVICE COMPLIANCE WITH ADA REGULATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 813 be adopted.

HOD ACTION: Resolution 813 is adopted.

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

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

Testimony on Resolution 813 was generally supportive. Testimony explained that it is important to not only ensure that healthcare-related online systems are accessible but also to support small practices who may struggle to meet these requirements in the same manner as larger health systems. Testimony also highlighted the importance of ensuring that assistance referenced in the second resolve clause should be meaningful and, when possible, prioritize financial assistance, technical support, and flexibility in timelines. An individual proffered an amendment that asks for AMA support of for public sections of physician websites to be exempted from privacy and tracking requirements. While this amendment did receive support from a delegation, your Reference Committee is concerned that this is not germane to the original resolution and thus does not recommend amending this resolution. However, should they wish to, your Reference Committee encourages the author of this amendment to consider its submission as a separate resolution at a future AMA HOD meeting. Due to the support for the resolution, your Reference Committee recommends that Resolution 813 be adopted.

(9) RESOLUTION 818 - PROPOSED REVISED D-385.958 - PATIENT SATISFACTION SURVEYS AND QUALITY PARAMETERS AS CRITERIA FOR PHYSICIAN PAYMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 818 be adopted.

HOD ACTION: Resolution 818 is adopted.

RESOLVED, that our American Medical Association amend Policy D-385.958 by addition and deletion to read as follows:

Our American Medical Association will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers, hospitals, health systems, and physician employers to ensure that;

(1) subjective criteria, such as patient satisfaction surveys, ~~be used only as an adjunctive and not a determinative~~ not be used as a measure of physician quality for the purpose of physician payment, employment, credentialing, or contracting; and
(2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Modify Current HOD Policy)

Your Reference Committee heard predominantly supportive testimony on Resolution 818. Testifiers stated that subjective satisfaction measures alone should not be used to assess physician quality for payment, employment, credentialing, or contracting decisions. Testimony proffered an amendment to retain existing language in subsection (1) of AMA Policy D-385.958, which allows patient satisfaction surveys to be used only as supplemental—not determinative—measures of physician quality, rather than adopting the proposed prohibition, citing concern that adoption of this resolution would prohibit institutions and organizations from using this data to provide intervention early. However, the preponderance of testimony strongly supported the resolutions adoption outlining the importance of ensuring subjective satisfaction measures not be used for decisions related to physician employment. Therefore, your Reference Committee recommends that 818 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) BOARD OF TRUSTEES REPORT 11 – OPPOSING UNILATERAL DOWNCODING OF PHYSICIAN SERVICES BY INSURANCE COMPANIES

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation in Board of Trustees Report 11 be amended by addition to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 11 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Boart of Trustees Report 11 is adopted as amended and remainder of report filed.

ADOPTED LANGUAGE:

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

2. That our AMA amend Policy D-70.940[3] to read as follows:
Our AMA will develop, regularly update, and disseminate, and widely promote 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. (Modify Current HOD Policy)

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

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

The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed:
1. That our American Medical Association (AMA), in collaboration with state medical associations, communicate legislative guardrails on health plans' downcoding policies to physician practices and provide guidance on how any payer noncompliance can be reported to the appropriate regulatory body for enforcement. (New HOD Policy)

2. That our AMA amend Policy D-70.940[3] to read as follows:
Our AMA will develop, regularly update, and disseminate, and widely promote 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. (Modify Current HOD Policy)

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

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

Testimony on Board of Trustees Report 11 was universally supportive. Testimony explained the essential need for advocacy against downcoding and strengthening protection for physicians against the inappropriate insurer practice. An amendment was proffered to include specialty societies in the first recommendation, which garnered support throughout testimony. An additional amendment was proffered that would ensure the AMA support systematic data collection on downcoding; however, since no other testimony was received on this amendment, your Reference Committee is not convinced that this amendment should be added. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 11 be adopted as amended with reference to specialty societies and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 1 – TRANSPARENCY WITH THE TERM "EMERGENCY DEPARTMENT"

RECOMMENDATION A:

Your Reference Committee recommends that the third Recommendation in Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

3) That our AMA support:
a. limiting the designations "emergency department" and "emergency room" to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and provide 24/7 on-site coverage by a qualified physician ~~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)

b. allowing any EMTALA-covered facility that meets EMTALA requirements to be classified as an emergency place of service for billing purposes.

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 1 is adopted as amended and remainder of report filed.

ADOPTED LANGUAGE:

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:

- **a. limiting the designations "emergency department" and "emergency room" to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and provide 24/7 coverage by a qualified physician who is immediately available in person.**
- **b. allowing any EMTALA-covered facility that meets EMTALA requirements to be classified as an emergency place of service for billing purposes. (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 was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)

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 was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 1 was supportive overall but Recommendation 3 engendered debate. Testimony recognized and agreed with the intent of the report but suggested Recommendation 3 did not go far enough to promote transparency and informed patient decision-making. Further, it was suggested that Recommendation 3 may be inconsistent with current AMA policy. While there were a variety of options proposed to amend Recommendation 3, other testimony expressed support for the recommendation as written, explaining the importance of ensuring that all emergency departments, including those in rural areas, are able to remain viable. In-person testimony offered an amendment to split Recommendation 3 into two sub recommendations, which received significant testimony. Those who supported this amendment noted that it successfully addresses the remaining concerns, while those who opposed it felt that it fell short of offering a solution for rural hospitals in their challenge to meet the condition of onsite staffing. Your Reference Committee agreed that our policy should represent the ideal, which in this case would be an emergency department staffed by an onsite physician. While we do recognize that this may be a challenge in rural areas, the amendment only supports full-time physician coverage but does not legally require it. Therefore, your Reference Committee recommends that the recommendations in the Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

(12) COUNCIL ON MEDICAL SERVICE REPORT 2 – THE IMPACT OF THE INFLATION REDUCTION ACT ON PHYSICIAN PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends the second Recommendation of Council on Medical Service Report 2 be further amended by addition and deletion to read as follows:

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 Medicare Part B drug price negotiation on the availability of Medicare Part B medications to patients and the sustainability of independent physician practices at A-28 ~~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)\

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 2 is adopted as amended and remainder of report filed.

ADOPTED LANGUAGE:

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:

Impact of Medicare Drug Price Negotiation Physician-Owned Practices

1. Our AMA will report on the impact of the Medicare Part B drug price negotiation on the availability of Medicare Part B medications to patients and the sustainability of independent physician practices at A-28.

2. Our AMA encourages any future drug pricing policies to balance patient affordability and access, with the stability of physician practices 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)

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

1. That our American Medical Association (AMA) 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)

Testimony on Council on Medical Service Report 2 was strongly supportive of the report and its recommendations. Testimony explained the importance of ensuring balance between patient drug affordability and practice sustainability. Testifiers explained that for many practices, especially smaller and independent physician practices, providing patients with expensive, physician-administered drugs can threaten their ability to stay financially viable. Further, testimony explained the importance of ensuring that as negotiation continues, and if alternative payment models are explored, it will be essential to ensure that the AMA has strong policy outlining requirements to protect physicians and patients. A delegation offered amendments that would move to ensure that AMA advocacy efforts were focused on value-based models as an alternative to the changes in reimbursement rates due to the Inflation Reduction Act. However, the report authors, the Council on Medical Service, explained that while this *may* be a viable alternative payment model this is beyond the scope of the current report. The Council also voiced serious concerns with these amendments limiting advocacy moving forward. Further, other testimony agreed that while value-based payment models could be a good alternative, the report's recommendations establish practical principles that ensure stability, security, and access for patients and physicians. In-person testimony offered an amendment that asked for report back to the House at the 2028 annual meeting regarding the impact of the Medicare drug price negotiation on patient access and physician practice. This amendment garnered support from others, including the authors of the report. Therefore, your Reference Committee recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

(13) COUNCIL ON MEDICAL SERVICE REPORT 5 – IMPROVING MARKETPLACE AFFORDABILITY THROUGH PREMIUM TAX CREDITS

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation in Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) ~~support~~ advocate for enhancements to Affordable Care Act (ACA) marketplace subsidies, including premium tax credits, without redirecting subsidies into health savings accounts (HSAs). (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 5 is adopted as amended and remainder of report filed.

ADOPTED LANGUAGE:

1. That our American Medical Association (AMA) advocate for 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)

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)

A majority of the testimony on Council on Medical Service 5 supported its recommendations as a way to improve ACA marketplace affordability. There were also requests to refer the clause in Recommendation 1 that states “without redirecting subsidies into HSAs;” however, other testimony argued against referral, including a response from the Council on Medical Service. The Council reiterated that the intent of Recommendation 1 is not to nullify any existing policy on HSAs but rather to ensure ongoing support for restoration of the enhanced premium tax credits without requiring enhanced subsidy amounts to be redirected into HSAs. Testimony also noted that the Council just analyzed the pros and cons of redirecting enhanced subsidies into HSAs, and therefore a second study is not warranted. A commenter in support of the Council’s recommendations encouraged the AMA to also focus on strengthening insurer accountability, highlighting high denial rates for in-network claims among marketplace insurers. Your Reference Committee incorporated a suggestion to replace “support” with “advocate for” in Recommendation 1, which does not materially change the recommendation’s intent. Because testimony largely supported the recommendations in Council on Medical Service Report 5, your Reference Committee recommends that they be adopted as amended and the remainder of the report be filed.

(14) RESOLUTION 802 - PAYER COVERAGE AND TAX-ADVANTAGED ACCESS FOR PHYSICAL ACTIVITY PROFESSIONALS, SERVICES, AND PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 802 be amended by addition to read as follows:

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 with particular attention to availability of such pathways in rural and medically

underserved areas; and be it further (New HOD Policy).

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 802 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 802 be adopted as amended.

HOD ACTION: The first and second resolve of Resolution 802 are adopted as amended and the third resolve is referred.

ADOPTED LANGUAGE:

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; 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 with particular attention to availability of such pathways in rural and medically underserved areas; and be it further (New HOD Policy).

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; 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; 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).

Testimony was largely supportive of Resolution 802. Testimony noted that the resolution builds on existing AMA policy by establishing a framework for exercise programs led by qualified professionals for all patients, regardless of insurance coverage. An amendment was proffered to the second resolve clause to emphasize referral pathways in rural and medically underserved areas, where such access is particularly needed. The Council on Medical Service recommended referral of the third resolve clause, explaining that it may commit the AMA to advocating for broader eligibility of health savings account (HSA) and flexible spending account expenses and, although current AMA policy supports allowing HSAs to cover health plan premiums, it does not clearly address tax-advantaged spending on expenses outside the current definition of qualified medical care and thus this new policy, if adopted as written, could contradict existing policy. Testimony regarding the first two resolve clauses was universally supportive and your Reference Committee was persuaded by the testimony related to the amendment in resolve two. However, testimony regarding the third resolve voiced concern about fiscal considerations, accountability, and clinical outcomes measures. Your Reference Committee agrees that these concerns related to the third resolve warrant further study. Thus, your Reference Committee recommends the first two resolve clauses of Resolution 802 be adopted as amended and the third resolve be referred.

(15) RESOLUTION 803 - COVERAGE OF EMBRYONIC MONOGENIC DISORDER SCREENING AS A MEDICALLY NECESSARY BENEFIT

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 803 be amended by deletion to read as follows:

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

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 803 be adopted as amended.

HOD ACTION: Resolution 803 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association support public and private health insurance 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 (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)

RESOLVED, that our American Medical Association support public and private health insurance 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)

A majority of testimony supported the intent of Resolution 803 to increase coverage of and access to clinically indicated embryonic monogenic disorder screening. While amendments were proffered to change the wording of the first, second, and fifth resolve clauses, testimony was not heard on these amendments, and we are unsure if the House is amenable to the changes. Your Reference Committee also heard limited testimony opposing the use of embryonic monogenic disorder screening. However, the majority of testimony supported the resolution with the proposed amendment to delete "or based on individualized clinical assessment" from the second resolve clause and thus we recommend Resolution 803 be adopted as amended.

(16) RESOLUTION 805 – MEANINGFUL ENFORCEMENT OF PROHIBITIONS ON THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 805 be <u>amended by addition and deletion</u> to read as follows:

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

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, including meaningful enforcement mechanisms, remedies, and protections against retaliation and provisions rendering unenforceable contractual restrictions ~~that interfere with~~ on the exercise of physicians' independent professional judgment, patient advocacy, or good-faith reporting]
7. Our AMA supports meaningful 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~~ are preserved and protected, including ~~appropriate enforcement authority and meaningful remedies for violations~~ a) appropriate investigative and enforcement authority; b) disclosure of ownership, control, and material management arrangements; and c) meaningful remedies for violations.
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. (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 805 be adopted as amended.

HOD ACTION: Resolution 805 is adopted as amended.

ADOPTED LANGUAGE:

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

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 specialty societies as they navigate the intricacies of corporate investment in physician practices and health care 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, including meaningful enforcement mechanisms, remedies, and protections against retaliation and provisions rendering unenforceable contractual restrictions on the exercise of physicians' independent professional judgment, patient advocacy, or good-faith reporting]
7. Our AMA supports meaningful 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 are preserved and protected, including a) appropriate investigative and enforcement authority; b) disclosure of ownership, control, and material management arrangements; and c) meaningful remedies for violations.
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. (Modify Current HOD Policy)

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

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, including meaningful enforcement mechanisms, remedies, and protections against retaliation and provisions rendering unenforceable contractual restrictions that interfere with physicians' independent professional judgment, patient advocacy, or good-faith reporting.
7. Our AMA supports meaningful 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~~ are preserved and protected, including appropriate enforcement authority and meaningful remedies for violations.
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.
(Modify Current HOD Policy)

Testimony was supportive of Resolution 805 and the proposed changes to Policy H-215.981 on the corporate practice of medicine. In response to a commenter's concern that amended language should not open a door to non-compete clauses, the resolution's author suggested a change to Subpart 6. The author also suggested amended language to Subpart 7 in response to a proffered amendment that delineated a number of specific enforcement mechanisms. Your Reference Committee concurs with these changes and recommends that Resolution 805 be adopted as amended.

(17) RESOLUTION 806 - PRORATION OF LIABILITY INSURANCE PREMIUMS FOR SENIOR PHYSICIANS BASED ON HOURS WORKED

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 806 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for the development of ~~prorated~~ professional liability insurance policies for ~~senior~~ physicians to incentivize ~~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

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 806 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association study the development of ~~develop a position paper addressing prorated~~ professional liability insurance premiums to incentivize physicians to remain in, or re-enter medical practice on a part-time basis, ~~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)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 806 be adopted as amended.

HOD ACTION: Resolution 806 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for the development of professional liability insurance policies for physicians to incentivize 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 study the development of professional liability insurance premiums to incentivize physicians to remain in, or re-enter medical practice on a part-time basis, and report its findings back to the House of Delegates by A-28. (Directive to Take Action)

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)

Testimony on Resolution 806 was mixed. Testifiers recognized the value of part-time professional liability coverage and argued that premiums should reflect actual liability exposure rather than hours worked, but others questioned the feasibility of both the position paper and prorating coverage. To address these concerns, amendments were proposed that would support the development of the position paper, while other testimony called for referral of the item to better study the issue. However, supportive testimony urged the expansion of the resolution to apply to all physicians practicing part-time, not only senior physicians, and removing references to proration as it could limit advocacy efforts. Your Reference Committee recommends amendments to both resolve clauses. First, your Reference Committee recommends that the first resolve be amended to include all part-time practicing physicians, regardless of age, and to remove specific reference to prorated insurance in an effort to mitigate concern while maintaining the goal of the resolution. Second, your Reference Committee agrees with testimony highlighting the complexity of this issue and believes that it is most appropriate for the issue to be studied with report back to the House. Your Reference Committee wishes to note that the amended wording of the second resolve is inclusive of all the original topics including proration options based on specialty, hours worked, and prior medical liability claims history, and notes that the report on this item should incorporate these topics. Your Reference Committee believes that these amendments adequately balance the original intent of the resolution and the concerns voiced in testimony. Therefore, your Reference Committee recommends that Resolution 806 be adopted as amended.

(18) RESOLUTION 809 - JOINT COMMISSION STANDARDS FOR MEDICAL STAFF SELF-GOVERNANCE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 809 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our American Medical Association, through its appointees to the Joint Commission Board of Commissioners, the Joint Commission's standards review and public comment process and other appropriate channels, advocate for ~~restoring~~ clear accreditation standards that affirm~~ing~~ and strengthen medical staff self-governance and physician-led oversight of credentialing, privileging, peer review, professional competence, quality improvement, patient safety, and other matters involving the professional practice of medicine. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 809 be adopted as amended.

HOD ACTION: Resolution 809 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association, through its appointees to the Joint Commission Board of Commissioners, the Joint Commission's standards review and public comment process and other appropriate channels, advocate for clear accreditation standards that affirm and strengthen medical staff self-governance and physician-led oversight of credentialing, privileging, peer review, professional competence, quality improvement, patient safety, and other matters involving the professional practice of medicine. (Directive to Take Action)

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

Testimony was supportive of Resolution 809 and ensuring clear Joint Commission accreditation standards regarding medical staff self-governance, independence, and authority. Although a commenter suggested combining Resolutions 809 and 810, the author explained the distinctions between these resolutions and maintained that Resolution 809 should be adopted as a stand-alone item. Proffered amendments suggesting that AMA advocacy affirm and strengthen the standards were supported by the author. Your Reference Committee also heard that the year in the fourth Whereas clause should be 2026 instead of 2025. Therefore, your Reference Committee recommends that Resolution 809 be adopted as amended.

(19) RESOLUTION 810 - STRENGTHENING MEDICARE AND ACCREDITATION STANDARDS FOR ORGANIZED MEDICAL STAFF INDEPENDENCE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 810 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) ~~establish standards requiring, as a Condition of Participation for hospitals participating in Medicare,~~ issue interpretive guidance under the Medical Staff Condition of Participation (42 CFR 482.22) clarifying that Medical Staff Office personnel performing functions on behalf of organized medical staff should have clearly defined functional accountability to the organized medical staff, through the Medical Executive Committee or its designee for credentialing, privileging, peer review, corrective action, medical staff governance, quality oversight, and other organized medical staff functions (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 810 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate that CMS ~~require~~ interpretive guidance encourage hospital medical staff bylaws or related governing documents approved through the medical staff bylaw process to define the Medical Staff Office ~~reporting structure, authority over medical staff work assignments and performance evaluation,~~ functional accountability to the organized medical staff, medical staff input into medical-staff work assignments and performance evaluation, safeguards against administrative interference or retaliation, and standards governing access to, use of, and disclosure of confidential medical staff information (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 810 be adopted as amended.

HOD ACTION: Resolution 810 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) issue interpretive guidance under the Medical Staff Condition of Participation (42 CFR 482.22) clarifying that Medical Staff Office personnel performing functions on behalf of organized medical staff should have clearly defined functional accountability to the organized medical staff, through the Medical Executive Committee or its designee for credentialing, privileging, peer review, corrective action, medical staff governance, quality oversight, and other organized medical staff functions (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that CMS interpretive guidance encourage hospital medical staff bylaws or related governing documents approved through the medical staff bylaw process to define the Medical Staff Office functional accountability to the organized medical staff, medical staff input into medical staff work assignments and performance evaluation, safeguards against administrative interference or retaliation, and standards governing access to, use of, and disclosure of confidential medical staff information (Directive to Take Action); and be it further

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

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

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) establish standards requiring, as a Condition of Participation for hospitals participating in Medicare, that Medical Staff Office personnel performing functions on behalf of organized medical staff have clearly defined functional

accountability to the organized medical staff, through the Medical Executive Committee or its designee for credentialing, privileging, peer review, corrective action, medical staff governance, quality oversight, and other organized medical staff functions (Directive to Take Action); and be it further

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

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

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

Your Reference Committee heard supportive testimony on Resolution 810, although a commenter opposed its adoption and instead encouraged hospital medical staffs to include necessary protections in their medical staff bylaws. In response to this comment, the author asserted that advocacy with both the Centers for Medicare & Medicaid Services and Joint Commission is needed in order to adequately safeguard hospital medical staff protections. A testifier also suggested amendments that would reword each of the four resolve clauses, some of which the author seemed open to. That said, your Reference Committee did not hear sufficient testimony on whether these amendments were warranted. Amendments to the first and second resolve clauses were proffered in-person to address concerns with a new Condition of Participation that would reach into employment relationships of hospitals and health systems with a centralized medical staff office. Instead, the amendments suggested that advocacy seek accountability through CMS interpretive guidance under the existing medical staff Condition of Participation. Because the author testified in support of the proffered amendments, your Reference Committee recommends that Resolution 810 be adopted as amended.

(20) RESOLUTION 817 - PROPOSED REVISED H-450.982, PATIENT SATISFACTION, PATIENT EXPERIENCE, AND QUALITY OF CARE

RECOMMENDATION A:

Your Reference Committee recommends that the third resolve of Resolution 817 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate that ~~opposes~~ ~~tying individual physician compensation, bonuses, hiring, employment retention or termination, promotion, credentialing, contracting, or network participation to~~ patient-experience or patient-satisfaction survey data may be used in aggregate, alongside other relevant measures, to identify trends, support quality improvement, and inform professional development and peer review, but should not be used to determine individual physician compensation, employment, promotion, credentialing, contracting, or network participation ~~scores~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 817 be adopted as amended.

HOD ACTION: Resolution 817 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association recognizes patient feedback and appropriately designed patient-experience and patient-satisfaction measures as valuable tools for improving communication, patient-centered care, health care delivery, quality improvement, formative feedback, and professional development (New HOD Policy); and be it further

RESOLVED, that our AMA supports continued efforts to improve the measurement of patient experience and patient satisfaction, including ensuring that such measures are valid, reliable, and used for the purposes for which they were developed (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that patient-experience or patient-satisfaction survey data may be used in aggregate, alongside other relevant measures, to identify trends, support quality improvement, and inform professional

development and peer review, but should not be used to determine individual physician compensation, employment, promotion, credentialing, contracting, or network participation (New HOD Policy); and be it further

RESOLVED, that our AMA opposes policies or incentives based on patient-experience or patient-satisfaction survey scores that may interfere with independent clinical judgment or incentivize medically unnecessary, inappropriate, or unsafe care (New HOD Policy); and be it further

RESOLVED, that our AMA rescind policy H-450.982. (Rescind Current HOD Policy)

RESOLVED, that our American Medical Association recognizes patient feedback and appropriately designed patient-experience and patient-satisfaction measures as valuable tools for improving communication, patient-centered care, health care delivery, quality improvement, formative feedback, and professional development (New HOD Policy); and be it further

RESOLVED, that our AMA supports continued efforts to improve the measurement of patient experience and patient satisfaction, including ensuring that such measures are valid, reliable, and used for the purposes for which they were developed (New HOD Policy); and be it further

RESOLVED, that our AMA opposes tying individual physician compensation, bonuses, hiring, employment retention or termination, promotion, credentialing, contracting, or network participation to patient-experience or patient-satisfaction survey scores (New HOD Policy); and be it further

RESOLVED, that our AMA opposes policies or incentives based on patient-experience or patient-satisfaction survey scores that may interfere with independent clinical judgment or incentivize medically unnecessary, inappropriate, or unsafe care (New HOD Policy); and be it further

RESOLVED, that our AMA rescind policy H-450.982. (Rescind Current HOD Policy)

Testimony largely supported Resolution 817. Testifiers emphasized that physician evaluations involve many factors and that reviews and patient-satisfaction scores alone do not reliably measure quality of care, particularly because reviewer bias may distort results. Some testimony favored striking the third resolve clause, arguing that medical staff and peer review committees should be able to use patient feedback for early intervention before formal corrective action is necessary. Another testifier agreed, stating that the clause too broadly excluded patient feedback from employment, promotion, credentialing, and other professional decisions. Acknowledging these unintended consequences, the author proposed amended language allowing patient-satisfaction and patient-experience data to be used in aggregate with other measures to identify trends, support quality improvement, and inform professional development and peer review, while prohibiting its use to determine individual physician compensation, employment, promotion, credentialing, contracting, or network participation. Your Reference

Committee believes that the proffered amendment fully addresses the concerns regarding the third resolve and thus recommends that Resolution 817 be adopted as amended.

(21) RESOLUTION 819 - MODIFIERS INDICATING INDEPENDENT NON-PHYSICIAN PRACTITIONER USE OF PHYSICIAN CONSULTS AND TRANSFERS

RECOMMENDATION A:

Your Reference Committee recommends that resolution 819 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports efforts~~the development of new modifiers~~ to improve ~~coding accuracy and~~ data collection when independently practicing non-physician practitioners consult with a physician or transfer care to a physician.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 819 be adopted as amended.

HOD ACTION: Resolution 819 is referred for decision.

RESOLVED, that our American Medical Association supports the development of new modifiers to improve coding accuracy and data collection when independently practicing non-physician practitioners consult with a physician or transfer care to a physician. (New HOD Policy)

Testimony on Resolution 819 supported the intent of the authors; however, it was noted that the more appropriate route to address this issue is through national medical societies that have a vested interest and the Current Procedural Terminology (CPT®) Editorial Panel. An amendment was proffered to recognize this distinction and to further support better research on the impact of non-physician practice on cost and quality of care. Two additional resolve clauses were proffered that reference specific CPT® codes for interprofessional consultations and testified that the codes outlined in the new resolve clauses may significantly address the author's goal. The author expressed their support for the amendment to the first resolve clause, acknowledging a willingness to submit this request to the CPT® Editorial Panel. However, the author was opposed to the proffered additional second and third resolve clause, testifying that the cited codes require both a verbal and a written note by the requesting clinician and adds work to the physician. One delegation testified in support of the amendments but also suggested referral might be most appropriate. While in-person testimony on this item was somewhat limited, there was some support for referral. Testimony explained that this is a complex topic and the

specifics of the data collection should be specified further. However, others, including the resolution authors and the Council on Medical Service, supported the language presented by CPT® experts via the online forum. Given the overwhelming support for the amendment proffered to the resolution, your Reference Committee recommends that Resolution 819 be adopted as amended.

(22) RESOLUTION 820 - STRENGTHENING EMERGENCY INTERFACILITY TRANSFER INFRASTRUCTURE

RECOMMENDATION A:
Your Reference Committee recommends that the first resolve of Resolution 820 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for federally supported regional emergency transfer coordination systems providing a single point of access to real-time receiving-hospital capabilities and medical transport availability for time-sensitive interfacility transfers, with participation by Medicare-participating hospitals with relevant emergency or specialized capabilities, and that each Medicare-participating hospital maintain a designated, publicly accessible transfer coordinator contact to facilitate timely interfacility transfers (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 820 be adopted as amended.

HOD ACTION: Resolution 820 is adopted as amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for federally supported regional emergency transfer coordination systems providing a single point of access to real-time receiving-hospital capabilities and medical transport availability for time-sensitive interfacility transfers, with participation by Medicare-participating hospitals with relevant emergency or specialized capabilities, and that each Medicare-participating hospital maintain a designated, publicly accessible transfer coordinator contact to facilitate timely interfacility transfers (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to Congress and the Centers for Medicare & Medicaid Services for payment models that support emergency interfacility transport readiness, including dedicated or regionally shared advanced and

critical-care transport capacity without compromising 911 response. (Directive to Take Action)

RESOLVED, that our American Medical Association advocate for federally supported regional emergency transfer coordination systems providing a single point of access to real-time receiving-hospital capabilities and medical transport availability for time-sensitive interfacility transfers, with participation by Medicare-participating hospitals with relevant emergency or specialized capabilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to Congress and the Centers for Medicare & Medicaid Services for payment models that support emergency interfacility transport readiness, including dedicated or regionally shared advanced and critical-care transport capacity without compromising 911 response. (Directive to Take Action)

Testimony on Resolution 820 was relatively limited but overall supportive of resolution's intent. Testimony outlined the importance of ensuring that transfers between hospitals are timely and streamlined to ensure that patients receive the highest quality care possible. Further, testimony explained the importance of these systems in supporting rural and smaller community hospitals. A delegation proffered an amendment that outlined the need for maintenance of a designated transfer coordinator in Medicare-participating hospitals. Your Reference Committee agrees that this amendment enhances the original resolution and thus recommends that Resolution 820 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(23) *RESOLUTION 804 - MEDICARE COVERAGE OF CONTINUOUS GLUCOSE MONITORING FOR NON-INSULIN-TREATED TYPE 2 DIABETES

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 804 be adopted in lieu of Resolution 804.

COVERAGE OF CONTINUOUS GLUCOSE MONITORING FOR NON-INSULIN-TREATED TYPE 2 DIABETES

RESOLVED, that our American Medical Association (AMA) advocate that all payers, including the Centers for Medicare & Medicaid Services, revise coverage criteria for continuous glucose monitoring (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 (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for CGM coverage policies that preserve physician clinical judgment, incorporate evolving evidence and clinical guidelines, and avoid unnecessary administrative barriers to medically appropriate CGM access (New HOD Policy); and be it further

RESOLVED, that our AMA support continued research evaluating the clinical effectiveness, health outcomes, healthcare utilization, quality of life, health equity, and cost-effectiveness of CGM among patients with non-insulin-treated type 2 diabetes. (New HOD Policy)

HOD ACTION: Alternate Resolution 804 is adopted in lieu of Resolution 804.

ADOPTED LANGUAGE:

COVERAGE OF CONTINUOUS GLUCOSE MONITORING FOR NON-INSULIN-TREATED TYPE 2 DIABETES

RESOLVED, that our American Medical Association (AMA) advocate that all payers, including the Centers for Medicare & Medicaid Services, revise coverage criteria for continuous glucose monitoring (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 (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for CGM coverage policies that preserve physician clinical judgment, incorporate evolving evidence and clinical guidelines, and avoid unnecessary administrative barriers to medically appropriate CGM access (New HOD Policy); and be it further

RESOLVED, that our AMA support continued research evaluating the clinical effectiveness, health outcomes, healthcare utilization, quality of life, health equity, and cost-effectiveness of CGM among patients with non-insulin-treated type 2 diabetes. (New HOD Policy)

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 physician~~s~~.

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)

Your Reference Committee heard testimony strongly supportive of the intent of Resolution 804. Testifiers emphasized the importance of affordable Medicare access to continuous glucose monitors for patients with type 2 diabetes who do not use insulin. While supportive of the intent, an amendment was proffered to establish a new policy rather than revising existing Policy H-330.885, expressing concern that the proposed

revisions could unintentionally narrow its broader call for all insurers to cover continuous and flash glucose monitoring by focusing only on Medicare. Additional testimony agreed with the amendment, stating that existing policy is broad and encompasses all payers. Your Reference Committee agrees that revision may have an unintended negative impact on coverage outlined in existing policy and, therefore, the creation of a new policy is more appropriate to the intent of the author. In-person testimony was supportive of the alternative language but suggested removal of reference to Medicare specifically so that the resolution be expanded to cover all payers. Other testimony supported this change, and therefore, your Reference Committee recommends that Alternate Resolution 804 be adopted in lieu of Resolution 804.

(24) RESOLUTION 812 - PROTECT PATIENT CHOICE AND PHYSICIAN PRIVILEGES IN HOSPITALS MERGER AND ACQUISITIONS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 812 be adopted in lieu of Resolution 812.

RESOLVED, that our AMA advocate for full transparency regarding potential effects on admitting and surgical privileges, credentialing, and employment benefits throughout the negotiation process and prior to the finalization of any hospital mergers or acquisitions, and advocate for:
a. protection of existing admitting and surgical privileges and credentialing of private practice and employed physicians as a necessary condition of any hospital merger or acquisition, and
b. protection of employment benefits for physicians, residents and fellows including preservation of salary and benefit levels and public service loan forgiveness (PSLF) eligibility as a necessary condition of any hospital merger or acquisition; and
c. the primacy of the organized medical staff(s) to set policy throughout the merger and acquisition process.
(Directive to Take Action)

HOD ACTION: Alternate Resolution 812 is adopted in lieu of Resolution 812.

ADOPTED LANGUAGE:

RESOLVED, that our AMA advocate for full transparency regarding potential effects on admitting and surgical privileges, credentialing, and employment benefits throughout the negotiation process and prior to the finalization of any hospital mergers or acquisitions, and advocate for:

a. protection of existing admitting and surgical privileges and credentialing of private practice and employed physicians as a necessary condition of any hospital merger or acquisition, and
b. protection of employment benefits for physicians, residents and fellows including preservation of salary and benefit levels and public service loan forgiveness (PSLF) eligibility as a necessary condition of any hospital merger or acquisition; and
c. the primacy of the organized medical staff(s) to set policy throughout the merger and acquisition process. (Directive to Take Action)

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

Your Reference Committee heard strong support for Resolution 812. Testimony highlighted hospital mergers and acquisitions occurring all over the country and the importance of preserving community physicians' privileges at these facilities after mergers have taken place. In-person testimony offered alternate language to ensure full transparency regarding potential effects as mergers are in process so that physicians can plan ahead and make proactive career decisions. This amendment was supported by the author. To address concerns raised in testimony calling for referral, your Reference Committee recommends additional language reaffirming the primacy of organized medical staff(s) to set policy throughout the merger process. Your Reference Committee recommends that Alternate Resolution 812 be adopted in lieu of Resolution 812.

(25) RESOLUTION 814 - COVERAGE OF SMART THERAPY FOR ASTHMA

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 814 be adopted in lieu of Resolution 814.

RESOLVED, that our American Medical Association (AMA) work with the Centers for Medicare & Medicaid Services, major national insurance carriers, state Medicaid programs, and pharmacy benefit managers to remove or increase quantity limits for inhaled corticosteroid–formoterol inhalers when prescribed in accordance with evidence-based guidelines (New HOD Policy); and be it further

RESOLVED that our AMA advocate that, when inhaled corticosteroid–formoterol inhalers are prescribed as single maintenance and reliever therapy (SMART) in

accordance with evidence-based guidelines, public and private health plans will:

a. cover at least one guideline-recommended inhaled corticosteroid–formoterol product, including brand-name and FDA-approved generic formulations where available, without prior authorization or step therapy requirements;
b. calculate days' supply and refill thresholds based on the combined maintenance and reliever dosing of a SMART regimen, rather than maintenance dosing alone;
c. permit 90-day supplies; and
d. not impose age restrictions inconsistent with guideline-recommended use (New HOD Policy); and be it further

RESOLVED, that our AMA will work with health plans, pharmacy benefit managers, and pharmacy organizations to ensure that dispensing and claims-adjudication processes for inhaled corticosteroid–formoterol inhalers reflect each patient's formulary coverage, including plan preference for brand-name versus generic products, to prevent avoidable claim rejections and dispensing delays. (New AMA Policy)

HOD ACTION: Alternate Resolution 814 is <u>adopted in lieu</u> of Resolution 814.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association (AMA) work with the Centers for Medicare & Medicaid Services, major national insurance carriers, state Medicaid programs, and pharmacy benefit managers to remove or increase quantity limits for inhaled corticosteroid–formoterol inhalers when prescribed in accordance with evidence-based guidelines (New HOD Policy); and be it further

RESOLVED that our AMA advocate that, when inhaled corticosteroid–formoterol inhalers are prescribed as single maintenance and reliever therapy (SMART) in accordance with evidence-based guidelines, public and private health plans will:

a. cover at least one guideline-recommended inhaled corticosteroid–formoterol product, including brand-name and FDA-approved generic formulations where available, without prior authorization or step therapy requirements;
b. calculate days' supply and refill thresholds based on the combined maintenance and reliever dosing of a SMART regimen, rather than maintenance dosing alone;
c. permit 90-day supplies; and
d. not impose age restrictions inconsistent with guideline-recommended use (New HOD Policy); and be it further

RESOLVED, that our AMA will work with health plans, pharmacy benefit managers, and pharmacy organizations to ensure that dispensing and claims-adjudication processes for inhaled corticosteroid–formoterol inhalers reflect each patient's formulary coverage, including plan preference for brand-name versus generic products, to prevent avoidable claim rejections and dispensing delays. (New AMA Policy)

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)

Testimony on Resolution 814 was limited but supportive of the intent. The authors agreed that the resolution, as originally written, was largely covered by existing policy and suggested that AMA policy be amended to address the concerns in the resolution. While existing policy cannot be modified outside of the original resolution, your Reference Committee agrees that the new language will achieve the goal of the original resolution in the best manner: to ensure that patients have access to the inhaler(s) prescribed to them at the most affordable price to the patient. Further, your Reference Committee believes that the language offered broadens the resolution beyond the existing policy, making reaffirmation inappropriate. The authors of the resolution offered a minor amendment to the first resolved clause, so language is consistent throughout. Your Reference Committee views this as editorial and since no opposition was voiced, we recommend that Alternate Resolution 814 be adopted in lieu of Resolution 814.

(26) RESOLUTION 815 - IMPROVING TECHNOLOGY TO COMBAT AUTOMATED AND ARTIFICIAL INTELLIGENCE-DIRECTED DOWNCODING OF EVALUATION AND MANAGEMENT SERVICES BY HEALTH INSURANCE COMPANIES

RESOLUTION 816 - ENHANCING ADVOCACY TO COMBAT AUTOMATED INSURANCE DOWNCODING OF E/M SERVICES

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 815 be adopted in lieu of Resolutions 815 and 816.

RESOLVED, that our American Medical Association (AMA) directly engage the electronic health record (EHR) and health technology vendor community to promote additional functionality for EHR, billing, and practice management systems to automatically detect from the electronic remittance advice when a payer has adjudicated or paid a claim at an evaluation and management (E/M) service level lower than the level submitted or with different modifiers and to alert user(s) 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 utilize its resources to increase awareness of and challenge public and private payers, including Medicare Advantage, on the use of automated, algorithmic, and/or artificial/augmented intelligence-directed E/M downcoding without appropriate medical review. (Directive to take Action)

HOD ACTION: Alternate Resolution 815 is adopted in lieu of Resolutions 815 and 816.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association (AMA) directly engage the electronic health record (EHR) and health technology vendor community to promote additional functionality for EHR, billing, and practice management systems to automatically detect from the electronic remittance advice when a payer has adjudicated or paid a claim at an evaluation and management (E/M) service level lower than the level submitted or with different modifiers and to alert user(s) 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 utilize its resources to increase awareness of and challenge public and private payers, including Medicare Advantage, on the use of automated, algorithmic, and/or artificial/augmented intelligence-directed E/M downcoding without appropriate medical review. (Directive to take Action)

RESOLUTION 815

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)

RESOLUTION 816

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

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

Testimony on Resolutions 815 and 816 was strongly supportive of the intent of the resolutions. The Council on Medical Service provided alternative language combining the resolutions due to their substantial overlap. This alternative language garnered wide support in testimony, including from the author of the original resolutions. Testimony noted that the practices of downcoding outlined in these resolutions is harmful to patients and physicians. Further, testimony explained the need for active advocacy and education on this topic as the practice is widespread and seems to be growing in usage among payers. Due to the overwhelming support of the alternative language presented, your Reference Committee recommends that Alternate Resolution 815 be adopted in lieu of Resolutions 815 and 816.

This concludes the report of Reference Committee J. I would like to thank Andrew Cooke, MD, Deborah Fuller, MD, Jennifer Hone, MD, Adele Lewis, MD, John Maa, MD, and Ajanta Patel, MD.

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