REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-26

Subject: Expanding Medicare Coverage of Medical Nutrition Therapy

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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

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

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

BACKGROUND

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

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

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

MEDICAL NUTRITION THERAPY

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

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

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

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

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

MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY

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

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

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

AMA ADVOCACY & RESOURCES

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

AMA POLICY

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

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

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

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

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

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

DISCUSSION

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

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

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

RECOMMENDATIONS

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

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

Fiscal Note: Minimal

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

Obesity as a Major Public Health Problem H-150.953

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

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

Physician Payment Reform H-390.849

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

c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
d. Not require budget neutrality within Medicare Part B.
e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
h. Use adequate risk adjustment methodologies.
i. Incorporate incentives large enough to merit additional investments by physicians.
j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

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

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

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

Physician Payment Reform H-400.972

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

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

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

Addressing Adult and Pediatric Obesity D-440.954

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

- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults.
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.

6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5 above.

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

Models / Guidelines for Medical Health Care Teams H-160.906

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

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

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

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

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

treatment plans.

p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.

q. Care coordination and case management are integral to the team's practice.

r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:

s. Electronic medical records are used to the fullest capacity.

t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.

u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.

v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

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