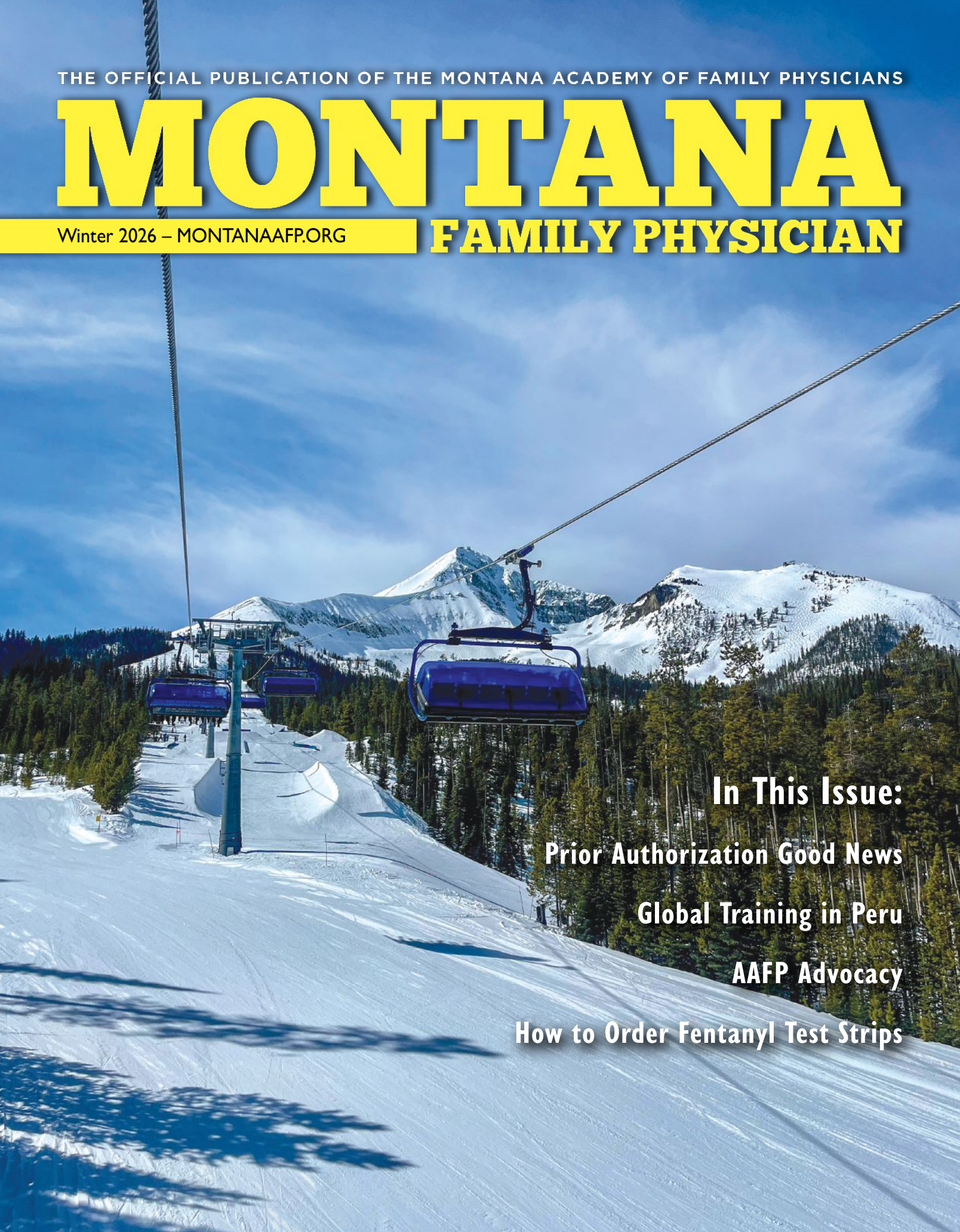
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Winter 2026 – MONTANAAFP.ORG



In This Issue:

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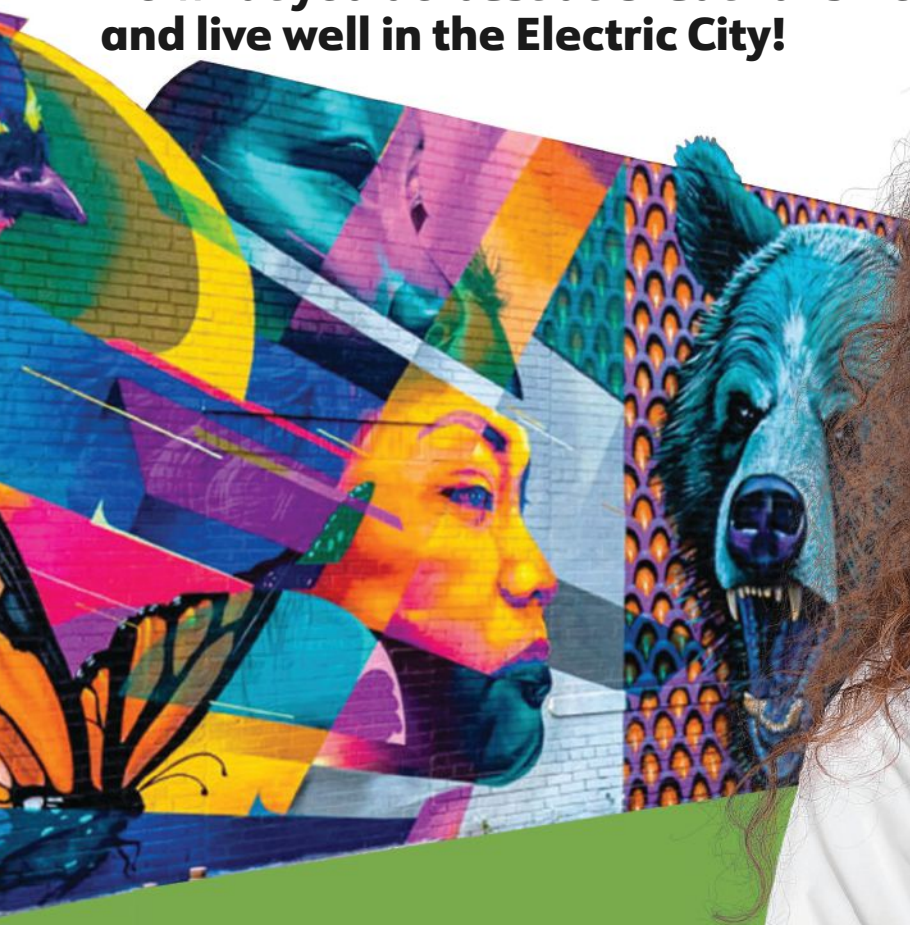

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*The **Montana Family Physician** is printed, addressed, and mailed to every family physician, resident, and medical student in Montana as well as all 50 other state chapters.*

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Heated ski chair lift in Big Sky, Montana

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Edition 27

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EDITION 27

MAFP President's Message

Katrina Maher, M.D.
2025/2026 MAFP President

Finding the Joy and Charting the Future

Fellow members of the Montana Academy of Family Physicians, as the crisp air settles over Big Sky Country and the first snow dusts the peaks, I find myself reflecting on a profoundly encouraging start to the autumn season. Just last month, many of us had the privilege of gathering at the Congress of Delegates and FMX in Anaheim. Being surrounded by so many dedicated family medicine physicians from across the nation—our peers, our champions—was a powerful reminder of the strength and solidarity of our specialty.

For me, attending these conferences is always a source of deep professional and personal rejuvenation. In the rush of daily practice, it's easy to get lost in the endless stream of patient charts and administrative tasks. Conferences, however, offer us a crucial opportunity to step back and rediscover the pure **joy of learning**—that initial spark of curiosity and dedication that first drew me to medicine. That feeling of being a student again, engaging with new ideas and connecting with colleagues, recharges the soul.

Returning to Montana is always a joy, even when the snow comes the next day! We are uniquely privileged to practice in a state where epic outdoor recreation, stunning scenery, and wide-open spaces offer us the ability to truly decompress and find balance. That inherent quality of life is a vital component of physician well-being, but we know the systemic burdens of practice still weigh heavily on us all.

This is why, looking ahead, I am increasingly optimistic about the role future technology can play in revitalizing our profession. We have heard much about Artificial Intelligence (AI) recently, and its most immediate and impactful benefit for Family Physicians is clear: drastically decreasing the administrative burden that leads to burnout.

Imagine technology that seamlessly drafts clinical documentation by ambiently listening to a patient encounter, significantly reducing the time you spend on the keyboard after hours. Or consider AI tools that can quickly calculate complex Hierarchical Condition Categories (HCCs), draft initial responses to routine patient portal messages, or even automate portions of the notoriously frustrating prior authorization process by pulling necessary clinical data from the EHR. Early studies are already showing that use of ambient AI scribes can lead to a significant decrease in after-hours documentation time and a reduction in professional burnout. By allowing AI to handle these repetitive, high-friction tasks—the "pajama time" of our careers—we can reclaim our most valuable resource: our time.

AI is not here to replace the fundamental importance of the doctor-patient relationship; rather, it is poised to be our most powerful administrative assistant, freeing us to focus on the deeply rewarding, high-value work of diagnosis, connection, and comprehensive patient care.

Imagine technology that seamlessly drafts clinical documentation by ambiently listening to a patient encounter, significantly reducing the time you spend on the keyboard after hours.

Here's to finding more moments of joy in our practice and working together to shape a future where technology supports—rather than hinders—our mission. Don't forget to pencil in the summer conference at Chico Hot Springs on June 18-19, 2026.

Sincerely,

Katrina Maher

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No-cost services for providers

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How to access MTPAL

1

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Call 844.406.8725 to consult with one of our MTPAL psychiatrists during daytime business hours: Monday-Friday from 8 AM - 5 PM.

*Online e-consult requests are also available for providers serving pregnant and post-partum patients.

2

Step 2

A care coordinator will screen and triage calls to ensure they are appropriate for the line and ask for patient demographics, contact information, and a summary of the consultation request. Please have patient information on-hand.

3

Step 3

A Psychiatrist will return your call within approximately 30 minutes, during business hours.

Good News for Prior Authorization with Legislative Changes In Montana

By Lauren Wilson, MD

Prior authorization (PA), over the last few decades, has transformed from a selective cost-control tool for the highest-cost therapies to a ubiquitous barrier that directs therapeutic options, even among relatively low-cost alternatives. A recent AMA survey (source) found that physicians and their staff spend 13 hours each week completing PAs. Ninety three percent of physicians report that PA causes care delays and 82% report treatment abandonment. Patient harms are also widely reported: 29% say PA has caused a serious adverse event for a patient in their care.

PA reform is a complex proposition. For Medicare and Medicare Advantage plans, federal regulation is necessary. And although some positive reforms were made in 2023, in June of this year the Centers for Medicare & Medicaid Services announced a pilot of artificial intelligence (AI) in approving and denying certain services (source).

Increasingly, states have been taking the lead in implementing reforms. In the 2025 legislative session, Montana joined in as well, passing several bills aimed at reforming different parts of the PA process: increasing the duration of a PA, specifying the qualifications of reviewers, and exempting certain medications.

Because the Montana laws changed only apply to Montana-based private insurers, these changes apply to Montana marketplace plans, but do not apply to Medicaid/Medicare, out-of-state private plans (usually, people with out of state employers and employer-based insurance), ERISA self-insured plans, and the state employee health plan. Sometimes it can be hard to sort out which insurance a patient has.

If you suspect an insurer is not following the law regarding PAs or denial of payment, you or the patient or caregiver can contact the Montana Commissioner of Securities and Insurance at (406) 444-2524. There are some resources regarding navigating the PA process at the Montana Chapter of the American Academy of Pediatrics web site (mtpeds.org).

A summary of prior authorization changes in Montana for 2026

(New laws are effective for Montana employer sponsored plans such as Blue Cross Blue Shield, Pacific Source, or Mountain Health Co-Op, for policies issued or renewed on or after January 1, 2026)

1. **Short prior authorization (PA) validity periods are no longer allowed**
   - No PA may last less than 6 months (increased from 3 months previously).
   - For chronic conditions, **PAs must now remain valid for at least 12 months** unless discontinued due to safety concerns.
2. **Insurers must honor prior authorizations during plan transitions**
   - A new insurer must **honor existing PAs for at least 90 days** (3 months) after a patient switches health plans, provided the service is covered at any level in the plan.
3. **Retroactive denials after prior approval are severely limited**
   - Insurers may **no longer retroactively deny** coverage for services that were pre-approved, except in cases of fraud or intentional misrepresentation, noncoverage at the time of service, nonpayment of premiums, or exhaustion of benefits.
4. **Reviewers who deny a prior authorization or service must be qualified**
   - Denials of any requested service must be made by a reviewer who has the **same licensure** as the requesting provider and **has experience treating the same or similar conditions.**
   - In the case of grievances, reviews must be conducted by a **physician** licensed in a **specialty that focuses on the diagnosis and treatment of the condition** that is being treated.
5. **Hospital discharge medications may be dispensed without prior authorization, as a bridge**
   - **No PA is required for up to 3 days of medication prescribed at discharge** from inpatient or observation care.
   - The physician must note on the prescription or notify the pharmacy that **the prescription is being provided at discharge**, and the medication must cost less than $5000 per day.
6. **Minors must be considered for adult biologic therapies if clinical evidence supports it**
   - Insurers **can no longer deny biologic therapies** to minors *solely* because the treatment is only FDA-approved for adults.
   - If a physician provides **at least 2 peer-reviewed journal sources** showing safety and efficacy for the condition in the minor's age group, the insurer must consider the request on clinical grounds.
7. **Prior authorization requirements are not allowed for certain medications, as long as they are covered under the plan at any level**
   - No PA is allowed for **oral or inhaled generic medications.**
   - No PA is allowed for certain time-sensitive medications: **Insulin** for diabetes, **inhalers** for asthma, COPD or chronic lung disease.

Montana 2025 Insurance Law Changes – Summary Table

Old Practice	Now Disallowed / Restricted
PA valid only 3 months, requiring frequent renewals for chronic therapy	PA must be valid at least 6 months generally, and 12 months for chronic condition treatments
PA can expire immediately when insurance coverage changes	New insurer must honor prior PA for at least 3 months
Denials or rescissions after service can happen, even when prior approved	Retroactive denials are now prohibited unless there is fraud, noncoverage, etc.
PA review by general reviewers with no specialty requirement	Adverse determinations must be made by qualified specialists in same field
Surprise PA requirements can mean patients don't pick up discharge medications	No PA required for 3 days post-discharge for discharge prescriptions
Denial of biologics for minors based solely on FDA adult approval status	Must consider pediatric use if supported by clinical literature and physician justification
Prior authorization allowed for all new prescriptions, except for injectable antipsychotics	Prior authorization no longer allowed on any covered generic medications (oral or inhaled), or on inhalers (for asthma, COPD or chronic lung disease), or on insulin for diabetes

By Paolo Gerbasi

How Global Medicine Can Train Better Providers at Home

There are very few situations in medicine when you can't reach into a drawer and pull out a curette. However, during a recent trip to a clinic in Peru, in order to clean a patient's ear, students and I fashioned one out of a pen cap and a piece of wood.

That technique is not something I will incorporate into my practice, but the experience is a valuable one for any medical student or resident to learn the resourcefulness, resiliency and creative thinking needed to practice rural medicine.

Thanks to a partnership with the Global Studies department at University of Mary in Bismarck, ND, and coordinated by Dr. Paula H. Kitzenberg, OTD, MHA, OTR, my wife Nancy and I traveled with a group of students to the mountains of southern Peru. The university has been traveling to this region for 10 years, working with the local Catholic diocese to provide medical triage and skilled care for patients. The students were training in physical therapy, occupational therapy, nursing and more.

Many of the barriers to care mirror the challenges faced in rural medicine in Montana: Difficulty with transportation to medical care, complex medical issues, mistrust of the health care system and lack of resources for follow-up care with treatment or medications.

Lines were long outside of the tiny rehab clinic in Ayaviri, a town of about 23,000 and at 12,820 feet above sea level. Most of the people in this area are farmers and ranchers, and presented with issues including skin care, primary care needs, STIs, and foot care. We also did home visits for people who could not travel.

We also saw patients at a tiny clinic in the town of Macari even higher in the Andes Mountains. Our team provided medical care and education on everything from basic hygiene to at-home physical therapies for patients to continue their treatment after we left.

Our goals for care were treating the patient's complaint while also educating them to make sure the treatment is sustainable in a place with few resources. Our work relied on collaborating with the community and the entire team to provide the best treatment and to overcome the barriers to care.

The impact of this trip was profound. The gratitude from the people we served showed the effect that health care can have, and for me, was a reminder of why I got into medicine in the first place.

Montana Family Medicine Residency has offered one of our residents each year a global health rotation in Mongolia, which has been a valuable and life changing experience for them. Because of the growing interest in this rotation and our wilderness medicine program, my trip to Peru was a chance to explore another opportunity for our residents to experience practicing medicine in an austere environment.

The first resident will travel with the University of Mary team in 2026. It will be an invaluable opportunity for them to not only practice their skills, but also to build resiliency and cultural awareness. When these providers return to Montana, their patients here will have a provider who is a better educator, communicator, collaborator and global citizen.

Paolo Gerbasi, MD, is a faculty physician at Montana Family Medicine Residency.

Montana Pre-Med Summit

Pictured left to right Bernadette Duperron, Sara Houston, Judi Sullivan, Lisa Benzel, Vanessa Siddoway, Rohanna Erin, Liz Kelsey

Montana WWAMI, along with PreMed Advisors from Carroll College, MSU and UM organizes a pre-med summit every year for those interested in finding out more about the medical school application process. The 2025 event was held at Missoula College on October 25th. This all-day event gathered over 100, mostly undergraduate attendees and marked our highest registration and attendance to date.

Representatives from the UWSOM and the Montana WWAMI Clinical Education team were on hand to present details about the application and financing process and med school interview preparation.

The event was made possible by the following Montana Sponsors: Carroll College, Griz Med, Montana AHEC, MHA, Montana Health Research & Education Foundation, MSU, PureView Health Center, and Sidney Health Center.

Current Montana WWAMI medical students provided a student perspective and answered questions. Breakout sessions included loan repayment programs, preparing for the MCAT, pre-med research opportunities, and application advice. The session on crafting a personal statement is a perennial favorite, presented by MT WWAMI faculty Mike Geurin, MD. Also included was a Q&A session about the Montana TRUST program and the combined MD/PhD program. Three military arms, the US Navy, US Army, and the Air National Guard were on hand to answer students' questions.

FAST FACTS | Behavioral Health 2025

662

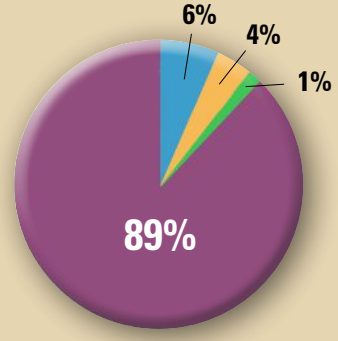
Number of specialty behavioral health hospitals in the U.S. in 2023

DEFINING BEHAVIORAL HEALTH

Behavioral health conditions include both mental illness and substance use disorders. Specialty behavioral health hospitals, as well as community hospitals with behavioral health services, provide unique treatment programs to meet the health needs of patients with behavioral health conditions.

11%

of all U.S. hospitals were specialty behavioral health hospitals



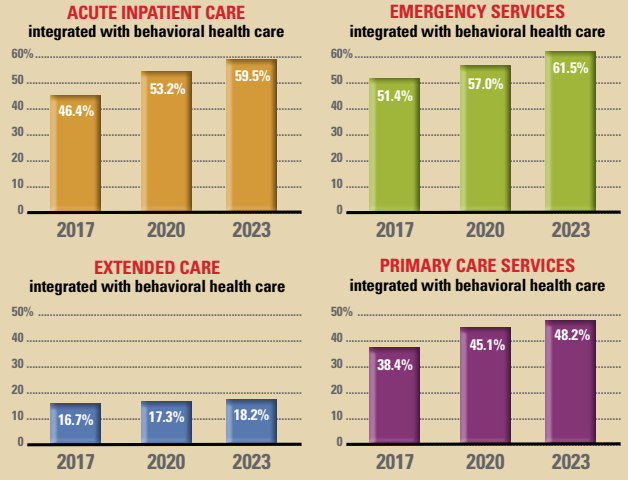
U.S. specialty behavioral health hospitals, 2023

- Psychiatric *(N=592)*
- Children's psychiatric *(N=42)*
- Substance use disorder *(N=24)*
- Intellectual disabilities *(N=4)*

26

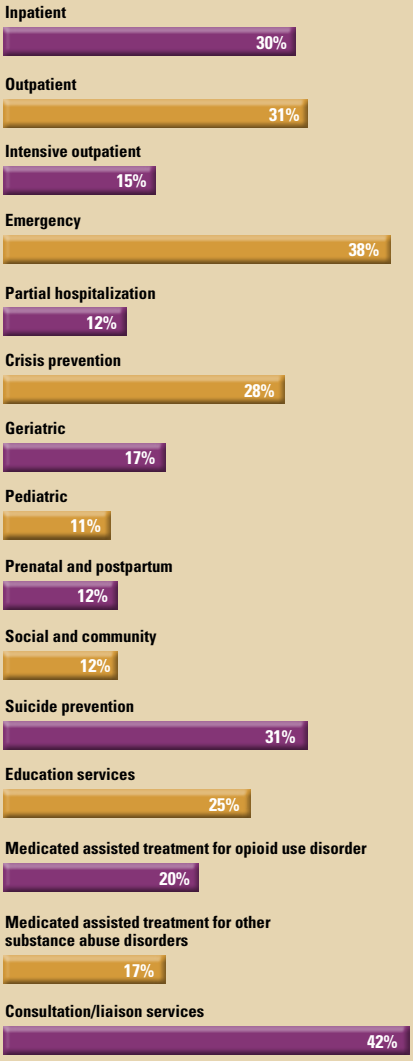
Increase in number of behavioral health hospitals since 2019

Behavioral health integration with other health services is growing



The provision of integrated physical and behavioral health care services in a range of settings has been increasing, and hospitals often provide a variety of behavioral health treatment programs beyond the inpatient setting.

Community hospitals provide a variety of psychiatric health services, 2023



SOURCE: AHA Annual Survey Database, FY2017-FY2023 | www.ahadata.com | ©The American Hospital Association, 2025
For more information or to purchase access to AHA data | ahadatainfo@aha.org

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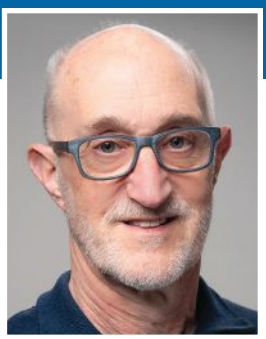
Jack Hensold MD, FASCO, on behalf of the Montana State Oncology Society and the Montana Cancer Coalition



A Primer on Targeted Therapies for Cancer

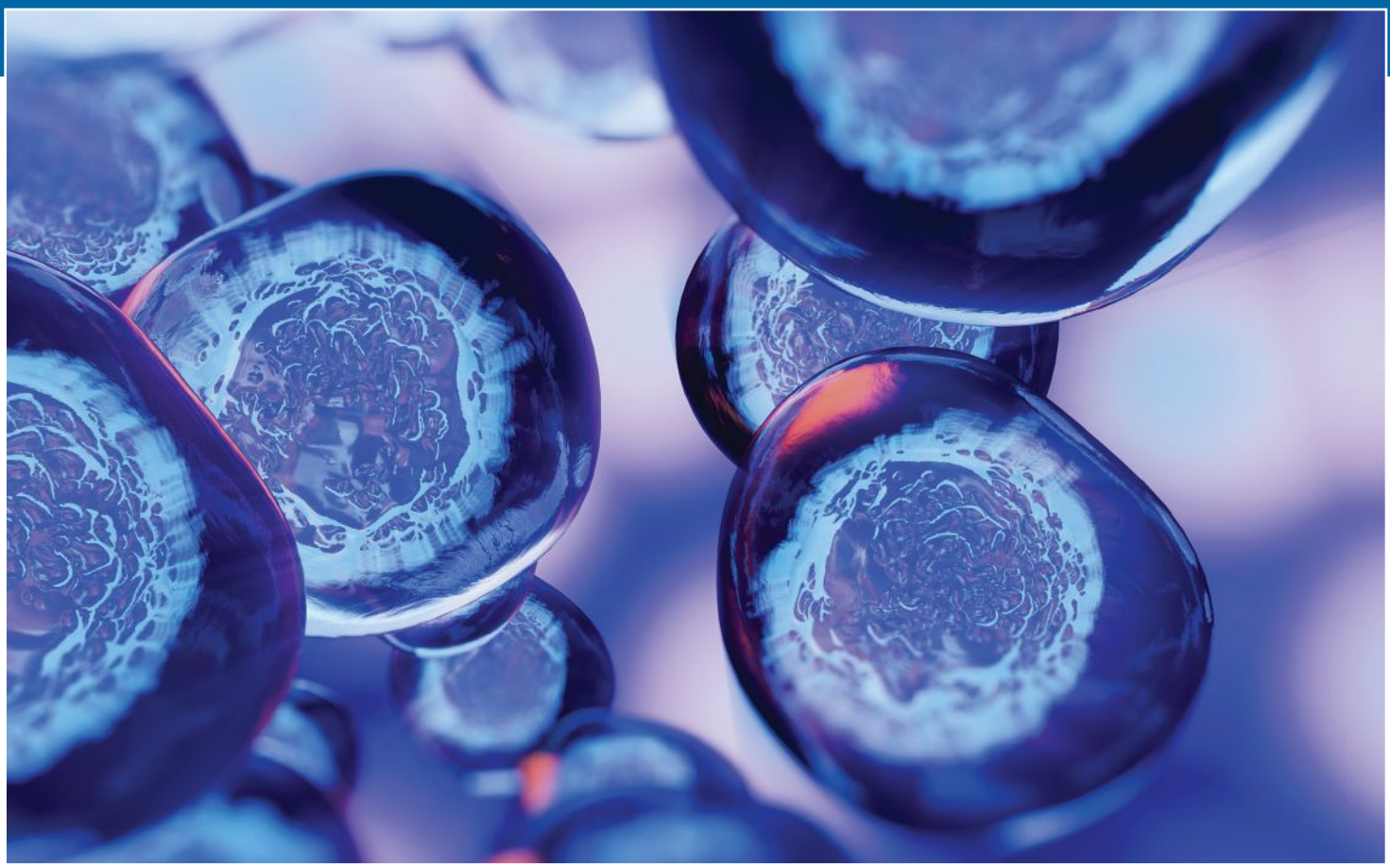
Patients with cancer living in rural areas have worse outcomes than those in urban areas. Limited access to care, either due to financial or geographic barriers is a common cause. These barriers are amplified in Montana where the resources to deliver cancer care are limited compared to national averages.[1] Despite the barriers that exist to cancer care delivery in rural areas, improvements in care coordination can improve care delivery. In 2013 the Institute of Medicine (IOM) acknowledged the importance of primary care providers (PCPs) as part of a well-coordinated, patient-centered cancer care team.[2] Inclusion of PCPs in the care of their patients with cancer is particularly important in rural areas where cancer care may be administered at great distance from the patient's home.

Patients benefit from continued engagement with their PCP throughout the course of their cancer, from the time of diagnosis, through treatment and after completing treatment. The role of a PCP during the latter time, cancer survivorship, was reviewed in the previous article in this journal. As with survivorship, the role of a PCP during cancer treatment is the provision of primary care and not the provision of the care for which an oncologist is uniquely trained. PCPs are uniquely skilled at the management of non-oncologic comorbidities. Some of these may be exacerbated by treatment of the patient's cancer. In addition, a diagnosis of cancer is often accompanied by decreased adherence to the treatments of coexisting diseases.[3] For early-stage cancers, the risk of dying from cancer may be less than the risk of death from other causes and ongoing management of co-existing health risks is appropriate.[4] In addition, when a patient resides at a long distance from an oncologist the PCP may also be called upon to identify complications related to a cancer and its treatment. In both situations, information exchange and care coordination with the oncology team is appropriate. This article focuses on the time during which a cancer patient is receiving treatment. A broad overview will be provided of a specific class of commonly used cancer treatments that have emerged as important cancer treatments over the past two decades, targeted therapies.

Drugs have been successfully employed in the treatment of cancer for over 70 years. Until 20 years ago these were nonspecific cellular toxins whose targets were processes that were common to all cells. Such drugs are referred to as cytotoxic therapies. The most common side effects of cytotoxic therapies are nausea and vomiting, fatigue and suppression of blood counts. In 2001 a new class of therapies emerged, targeted therapy, when imatinib was approved for the treatment of chronic myelogenous leukemia (CML). Imatinib is a tyrosine kinase inhibitor (TKI) with a specific target, the Abelson tyrosine kinase (TyK). Under normal conditions, tyrosine kinases provide the initial intracellular signal that follows stimulation of growth factor receptors and hence, initiate a "signal transduction" cascade that results in cell growth and division. Mutations in tyrosine kinases that result in an unregulated "on" signal have proven to be "oncogenes." In the case of CML, the Philadelphia chromosome translocation (the hallmark of CML) results in unregulated activation of the Abelson TyK. Treatment of CML patients with imatinib converted a disease that was universally fatal (in absence of a bone marrow transplant), to one in which life expectancy was normal. Since TyKs exhibit a degree of cell specific expression, there was also hope for a restricted side effect profile for these drugs, as was the case for imatinib, which was generally well-tolerated. (An occasional bothersome side effect was extracellular fluid accumulation).

The success of imatinib led to a proliferation of novel TKIs with specificity for other TyKs expressed in other cell types. Inhibitors of serine/threonine kinases, which are downstream of TyKs in growth signaling cascades, were also developed. Some of these TKIs had notable activity, leading to prolongation of patient survival in different cancers, most notably in a subset of lung cancers. The efficacy of the serine/threonine kinase inhibitors was mixed, with some providing survival benefits, although less than the most efficacious TKIs. However, none of these first-generation drugs were as effective as imatinib was in CML. This is due to the dependence of CML on the Abelson TyK for proliferation and survival.

Analyses of the results of treatment with the first-generation targeted therapies provided an important observation regarding efficacy of targeted therapies. Inhibition of a growth regulatory kinase had minimal impact unless the cancer cell had become dependent upon that signaling pathway, usually due to an acquired mutation that led to persistent kinase activation. This was the case for lung cancer where activating mutations in the epidermal growth factor receptor (EGFR) kinase were associated with response to treatment with EGFR TKIs. Activating mutations in other TyKs were subsequently described and have been successfully targeted for clinical benefit. This has given rise to "precision medicine," whereby activating mutations in growth regulatory genes in a patient's cancer cells are identified before treatment is initiated to target the appropriate signaling pathway. As an additional evolution in treatments, drug development has achieved inhibition of mutant kinase activity while having minimal impact on activity of the same non-mutated kinase in normal cells. This selective inhibition allows for an anti-cancer effect while reducing side effects due to inhibition of that same growth signaling pathway in normal cells.



Side effects of targeted therapies are generally a result of inhibition of the specific pathway that is targeted and in that sense are direct effects and not side effects. Some agents exhibit reduced specificity and can inhibit several different, but related kinases. This broadens the "side" effects that may be seen for that drug. But in general, the side effect profile is unique for each targeted therapy. Side effects of targeted therapies can include fatigue, hepatic abnormalities, blood count suppression, skin rashes (acneiform and others), blepharitis, diarrhea, hypertension, fluid retention, cardiac dysfunction and glucose intolerance. Nausea can occur but vomiting is uncommon. Side effects are reversible and dose related.[5] Management of side effects of treatment should be done in coordination with the oncology team, who should provide a description of the common side effects of treatment as part of care coordination. Severe side effects may require withholding treatment until symptoms resolve. Therapy may then be restarted but at a reduced dose. Mild side effects can be managed symptomatically. For many targeted therapies, effective management strategies have been developed that should be shared as part of coordinated, team-based care.

Two side effects of targeted therapies are worth noting, glucose intolerance and hypertension, since these exemplify the benefits of collaborative care of cancer patients. Cancer and its treatments do not alter the management of hypertension and diabetes. The management of these problems is best provided by the PCP, who is best qualified to do so. However, communication between oncologists and PCPs remains paramount, since inability to control diabetes or hypertension provide their own risks that could necessitate dose modifications or alternative therapies for cancer. Thus, best patient care requires coordination between the oncology team and the PCP to achieve the best outcomes. For patients in rural area establishing an open line of communication between the PCP and the oncology referral site is essential to achieving this goal and this is particularly true in the absence of a shared electronic medical record.

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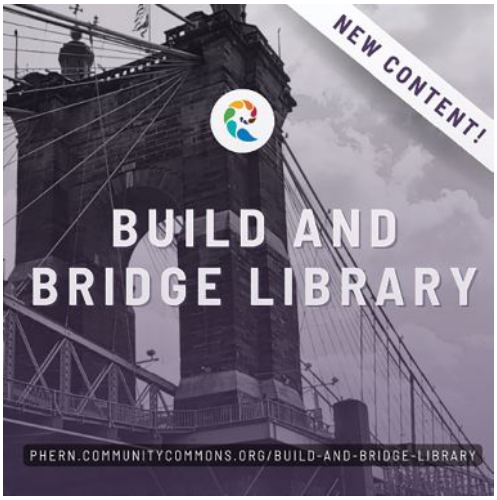
Build and Bridge Library

Strong, lasting change happens when health departments and communities work side-by-side. The new **Build and Bridge Library** was created to support that work by bringing together practical tools, strategies, and examples that help community-based organizations and cross-sector allies collaborate more effectively. It's a space to learn, get inspired and find approaches that can be adapted to fit local needs.



The Library offers resources health departments and their partners can put into practice right away — whether you're launching a new partnership, strengthening existing connections, or sharing ideas with colleagues. Each piece is designed to spark collaboration and collective action, helping us bridge sectors and build stronger, healthier communities. **Explore the Library today and see how it can support your work.**

From the website:

The Build and Bridge Library is designed with local and state health department staff in mind to help improve partnerships with community-based organizations and cross-sector partners. The Library offers a wide range of resources to support every stage of partnership development. It features a searchable library, with dozens of resources, AI-powered tools, and more to help you strengthen partnerships to improve the public's health. You can explore case studies, guides, toolkits, webinars, and more within the searchable library.

📢 **Explore and share: https://phern.communitycommons.org/build-and-bridge-library/**

Created by the American Public Health Association and Community Commons with advisory support from experts and community champions in public health and non-governmental organizations.

Naloxone and Fentanyl Test Strips (FTS)

Naloxone

The state-funded, no-cost naloxone and fentanyl test strip ordering system for organizations and agencies has resumed. The Help Save Lives from Overdose Action of 2017 directed DPHHS to increase the availability and distribution of naloxone. A link to the order form is provided below. Please note, this is a grant-funded program and is contingent on funding availability. If you have any questions or concerns, please contact Meaghan Kolar, Prevention Section Supervisor, BHDD, DPHHS, at meaghan.kolar@mt.gov.

Eligible recipients include:

- An individual at risk of an opioid-related overdose
- Family, friends, or other person in proximity to a person at risk of opioid-related overdose
- Others as listed on Montana's standing order

DPHHS encourages public health departments, the criminal justice system, behavioral health providers, harm reduction organizations, programs that serve veterans, and Montana Tribes to utilize this ordering process to have naloxone on hand for staff and to get naloxone into the hands of the end user.

- DPHHS and its contractors will use the information from the form to track naloxone distribution and to conduct other public health and epidemiological surveillance activities.

This online ordering process is not for individuals, DPHHS maintains a list of organizations that have naloxone available through their programs for free.

Fentanyl Test Strips

What are fentanyl test strips?

Fentanyl test strips (FTS) are a low-cost method of helping prevent drug overdoses and reducing harm. FTS are small strips of paper that can detect the presence of fentanyl in all different kinds of drugs (cocaine, methamphetamine, heroin, etc.) and drug forms (pills, powder, and injectables).1 FTS provide people who use drugs and communities with important information about fentanyl in the illicit drug supply so they can take steps to reduce risk of overdose. For information on how to use FTS, visit Fentanyl Test Strips: A Harm Reduction Strategy (cdc.gov).

You can go to the Montana DPHHS website and click on the link and fill the form to place an order for state-funded, no-cost naloxone kits or fentanyl test strips.

https://dphhs.mt.gov/BHDD/naloxone/Organizations

Family Medicine Advocacy Rounds

Issue 39, September 2025

Welcome to Family Medicine Advocacy Rounds — the American Academy of Family Physicians' monthly tip sheet to educate, engage and update you on the latest policy issues affecting family physicians and their patients.

AAFP Shares Fall Priorities with Policymakers

Why it matters: Health care costs keep rising, straining physicians, families and communities. Too many patients still struggle to access primary care, partly due to a graduate medical education system that doesn't produce enough primary care doctors. Despite spending more than peer nations, the U.S. continues to lag in outcomes such as treatable diseases and preventable deaths.

What we're working on: The AAFP urged Congress to expand support for primary care by:

- Reauthorizing and funding key programs that expand access, especially in rural and underserved areas (Teaching Health Center Graduate Medical Education, Community Health Center Fund, National Health Service Corps).
- Making permanent the telehealth flexibilities that empower patients and physicians to choose the best mode of care.
- Protecting federal investments in core health programs through appropriations.
- Permanently extending ACA Advanced Premium Tax Credits to keep coverage affordable for lower-income families.

AAFP Responds to ACIP Decisions

Why it matters: Vaccines have saved countless lives and remain one of our most important tools for protecting patients and communities. Narrowing vaccine recommendations limits patient autonomy and risks undermining the trust in public health we've worked so hard to build

What we're working on:

- The AAFP submitted written testimony go the Advisory Committee on Immunization Practices (ACIP), calling on ACIP to "restore and prioritize scientific integrity, transparency and continuity in deliberations."
- The ACIP's vote to remove shared clinical decision-making for the combination MMRV vaccine for children under four years old could limit access to vaccination against preventable diseases and undermines efforts to protect vulnerable populations.
- The vote on COVID-19 vaccines will create real confusion and consequences for patients' trust. These vaccines have prevented countless hospitalizations and deaths for both children and adults. Family physicians remain the best source for conversations and trusted information about vaccines.

Family Physicians Call on President to Reconsider Secretary Kennedy's Ability to Serve

Under HHS Secretary Robert F. Kennedy Jr.'s leadership, key public health protections have been weakened, and the immunization review process is devoid of experts and evidence. The American Academy of Family Physicians urged the president to prioritize the health and safety of the American people by re-evaluating Secretary Kennedy's ability to serve in his current capacity. Read our full statement.

The AAFP also expressed concern about turmoil at the Centers for Disease Control and Prevention. The firing of Director Susan Monarez, the resignation of multiple senior officials, and circumventing processes for reviewing data and science are alarming, threatening our nation's public health infrastructure. Leadership and oversight from Congress are needed now to ensure that our nation's public health is protected.

Physician Leaders Call on Lawmakers to Support Access to Care

Why it matters: AAFP President-elect Sarah Nosal, MD, FAAFP, joined leaders from the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Psychiatric Association and the American Osteopathic Association in Washington, D.C., to champion legislative policies that bolster access to care. The Group of Six fly in is one strategy in which we push for policy priorities that elevate primary care. Many of these echo our fall priorities, which we shared with lawmakers above.

What we're working on:

- **Making telehealth flexibilities permanent**: Telehealth has improved access and reduced missed appointments, especially in rural and underserved areas. With Medicare flexibilities set to expire Sept. 30, the AAFP, AAP, ACOG, ACP, AOA and APA urged Congress to make them permanent.

- **Strengthening the primary care workforce**: The U.S. faces a shortage of up to 40,400 primary care physicians by 2036. Key programs, including the Teaching Health Center Graduate Medical Education (THCGME) program, the National Health Service Corps (NHSC) and the Community Health Center (CHC) Fund, expire Sept. 30. Congress must reauthorize and fully fund them to preserve access to care in communities that need them the most.
- **Protecting vaccine access**: At the start of flu and respiratory illness season, patients need clear recommendations by qualified experts to ensure easy access to vaccines. Recommendations made by the Advisory Committee on Immunization Practices (ACIP) set insurance coverage requirements, and conflicting guidance is creating barriers to vaccine access.

Family Physicians Spotlight Priorities in 2026 Medicare Physician Fee Schedule

Why it matters: The Centers for Medicare and Medicaid Services (CMS) is recognizing the vital link between community-based physicians and community health, a step forward for primary care.

What we're working on: The AAFP is urging CMS to:

- **Advance payment accuracy:** Implement an efficiency adjustment for non-time-based services and update direct practice expense inputs, so payments better reflect real-world clinical practice and technological advancements.
- **Modernize data sources:** Transition to empiric, regularly updated data—such as Medicare claims and hospital cost reports—for rate setting and collaborate with medical specialty societies to ensure that future data collection is robust and representative.
- **Strengthen primary care management:** Refine and expand Advanced Primary Care Management (APCM) codes and waive patient cost-sharing for APCM services to improve access and uptake for Medicare beneficiaries.
- **Recognize care complexity:** Expand the use of the G2211 add-on code to home and residence visits, ensuring that physicians providing longitudinal, relationship-based care are appropriately compensated for the complexity of their work.

The AAFP is also supporting CMS proposals in the 2026 Outpatient Prospective Payment System to reduce site-differential payments that reward consolidation and improve hospital price transparency. CMS should develop a more consistent, cohesive approach to addressing upstream drivers of health across all Medicare payment programs.

AAFP Continues to Fight for Student Debt Relief Options

Why it matters: Federal student debt relief programs are important tools that strengthen American communities and help fill critical workforce shortages. Reliance on the Public Service Loan Forgiveness (PSLF) program has increased significantly over recent years, with some studies showing more than 40% of physicians are enrolled.

Student loan debt incurred during training is a significant barrier to addressing the physician workforce shortage the U.S. is facing, which is why the AAFP supports efforts to reduce the debt burden incurred by physicians, including through medical school educational loan forgiveness programs.

What we're working on: The AAFP submitted two recent comment letters to the U.S. Department of Education, emphasizing that addressing the burden of student loan debt for physicians and medical students is one essential step to improving our nation's health care system. We also highlighted that:

- Implementing H.R.1 loan provisions in ways that support future primary care physicians will strengthen the health care workforce in the long term.
- Minimizing administrative burdens on medical students is crucial to those students successfully accessing federal debt relief programs that enable them to choose the practice environment that best suits them.
- Protecting GRAD PLUS loans is critical to supporting medical students.
- Recognizing and supporting the PSLF program as an important tool in building a strong primary care workforce will contribute to a healthier America with fewer chronic diseases.
- Expanding federal loan repayment programs will reduce debt and help address physician shortages in rural and underserved areas.

What We're Reading

- The AAFP released fall immunization recommendations. "History shows us that vaccines have eradicated diseases that were disabling and deadly in the past, and we can keep it that way if we continue to vaccinate," said Margot Savoy, MD, MPH, CPE, FAAFP, chief medical officer of the AAFP.
- AAFP President Jen Brull told *Prevention*, "we need innovation that strengthens connection, not just efficiency." She added: "In my dream world, every person in America would have access to a trusted primary care physician, and AI and automation would help free up physicians to do what we do best: listen, connect and care."
- Robert Graham Center Director Yalda Jabbarpour, MD, spoke to Medscape about how Medicaid cuts reflect a "deeply concerning trend" in health policy: the "systematic underinvestment" in primary care. "At a time when more than a third of adults and 15% of children lack a usual source of care, we should be expanding access — not restricting it," she said.

Issue 40, October 2025

Welcome to Family Medicine Advocacy Rounds — the American Academy of Family Physicians' monthly tip sheet to educate, engage and update you on the latest policy issues affecting family physicians and their patients.

Family Physicians Concerned about Shutdown's Impact on Patients

In the face of a government shutdown, our ask is clear: Congress must safeguard the programs that keep care within reach. Funding for the Teaching Health Center Graduate Medical Education program and the Community Health Center Fund is essential, not just for training tomorrow's primary care physicians but also to ensure that every family has a place to turn when they need help. Additionally, telehealth serves as a lifeline for so many; preserving flexibility and access is crucial. Read our full statement here, and read our letter to the administration here.

We are particularly concerned about the announcement that the Centers for Medicare and Medicaid Services will hold claims for Medicare services impacted by the expiring programs, including telehealth services.

AAFP Weighs in on New Proposed Rules Impacting IMGs

Why it matters:

The health of our nation depends on a strong primary care foundation. Despite overwhelming evidence to support primary care as the solution to the chronic disease crisis, it is projected that the U.S. will face a shortage of up to 40,000 primary care physicians by 2036.

Placing unnecessary restrictions on U.S. visa programs could discourage international medical graduates (IMGs) from entering family medicine or accepting positions in high-need areas, which would exacerbate existing workforce shortages, limit communities' access to essential care and compromise public health outcomes.

What we're working on:

- The AAFP wrote a letter to the U.S. Department of Homeland Security (DHS), as well as joining two sign-on letters, opposing a proposed rule to force non-U.S. medical residents to reapply for their visas after four years. Currently, IMGs visas are approved for the duration of their program, no matter how long the program is. If finalized, this rule would have far-reaching consequences for the primary care workforce.
- We urged DHS to recognize IMGs' importance in building a strong primary care workforce and to acknowledge how transparent, clear visa processes contribute to expanding that workforce.
- The AAFP urged DHS to use its authority to advance visa policies that support medical students, residents and physicians being able to serve U.S. patients and communities.
- The AAFP also wrote a letter and signed onto a joint letter with the American Medical Association pushing back against new rules that require a non-U.S. citizen applying for a new H-1B visa to pay a $100,000 fee.
  - The letter explains that doctors, including family physicians, are essential to our country and should be excluded from this requirement.
  - It also points out that physicians who hold H-1B visas are especially important in rural and underserved communities, and that states with more H-1B visa-holding doctors usually have fewer physicians per capita, making the contributions of IMGs even more critical.

Why it matters: Step therapy is a prior-authorization policy that requires patients to try and fail one or more insurer-preferred treatments before coverage is granted for the medication originally prescribed by their clinician. While intended to reduce unnecessary utilization, these protocols too often jeopardize patient health, increase administrative burdens for physicians and undermine continuity of care.

What we're working on: The AAFP applauds Congress for reintroducing the Safe Step Act, which would limit the use of step-therapy protocols to ensure that patients have access to treatment. This bipartisan legislation is a concrete step toward minimizing care delays for patients.

AAFP: Linking Vaccines to Autism Is Unproven and Dangerous

Following remarks from the president and the Health and Human Services secretary, the AAFP doubled down: Vaccines do not cause autism and taking acetaminophen while pregnant does not cause autism. These claims risk public health by causing people to suffer, delay or defer vaccination out of fear. Read our full statement.

The AAFP will always be an agent of truth when it comes to public health. The 2025 Edelman Trust Barometer found that 82% of respondents trust their doctor more than any other source of medical information, including the internet and family and friends.

Sarah C. Nosal, MD, FAAFP, Takes Office as AAFP President

On October 6, Sarah C. Nosal, MD, FAAFP, was installed as AAFP president. Nosal, a family physician in Bronx, New York, brings nearly two decades of experience serving diverse and under-resourced communities, as well as state and national advocacy and leadership. Nosal is vice president for innovation and optimization and chief medical information officer at the Institute for Family Health, a network of federally qualified health centers spanning the Mid- Hudson, Bronx, Manhattan and Brooklyn.

The AAFP also announced its 2025-26 officers and board members. Read our full press release here.

What We're Reading

- The AAFP released fall immunization recommendations. "History shows us that vaccines have eradicated diseases that were disabling and deadly in the past, and we can keep it that way if we continue to vaccinate," said Margot Savoy, MD, MPH, CPE, FAAFP, chief medical officer of the AAFP.
- AAFP Board Chair Jen Brull, MD, FAAFP, spoke with NPR about changing public health guidance, what doctors are hearing from patients and how to best navigate changes. "If you hear something, wherever that source is—whether it's the television, TikTok or a headline—and you have a question about it, that's the time to have a conversation with the person who knows your health best," she said.
- Dr. Brull wrote in the *Oklahoman* about the importance of family physicians as trusted messengers. "The expertise your physician brings and the self-advocacy you bring to appointments are what helps us navigate the uncertainty and questions—big or small," she wrote.
- Robert Graham Center Director Yalda Jabbarpour, MD, spoke to Medscape about how Medicaid cuts reflect a "deeply concerning trend" in health policy: the "systematic underinvestment" in primary care. "At a time when more than a third of adults and 15% of children lack a usual source of care, we should be expanding access—not restricting it," she said.

Save the Date!

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Presents The 66th Annual

Big Mountain Medical Conference

January 28, 29, 30, 2026

The Lodge at Whitefish Lake Whitefish, Montana

Register on line at:http://www.montanaafp.org

Application for CME credit will be filed with the AAFP. Determination of credit is pending.

Congress of Delegates Delivers on Advancing AAFP Policy

Adapted from the AAFP posting

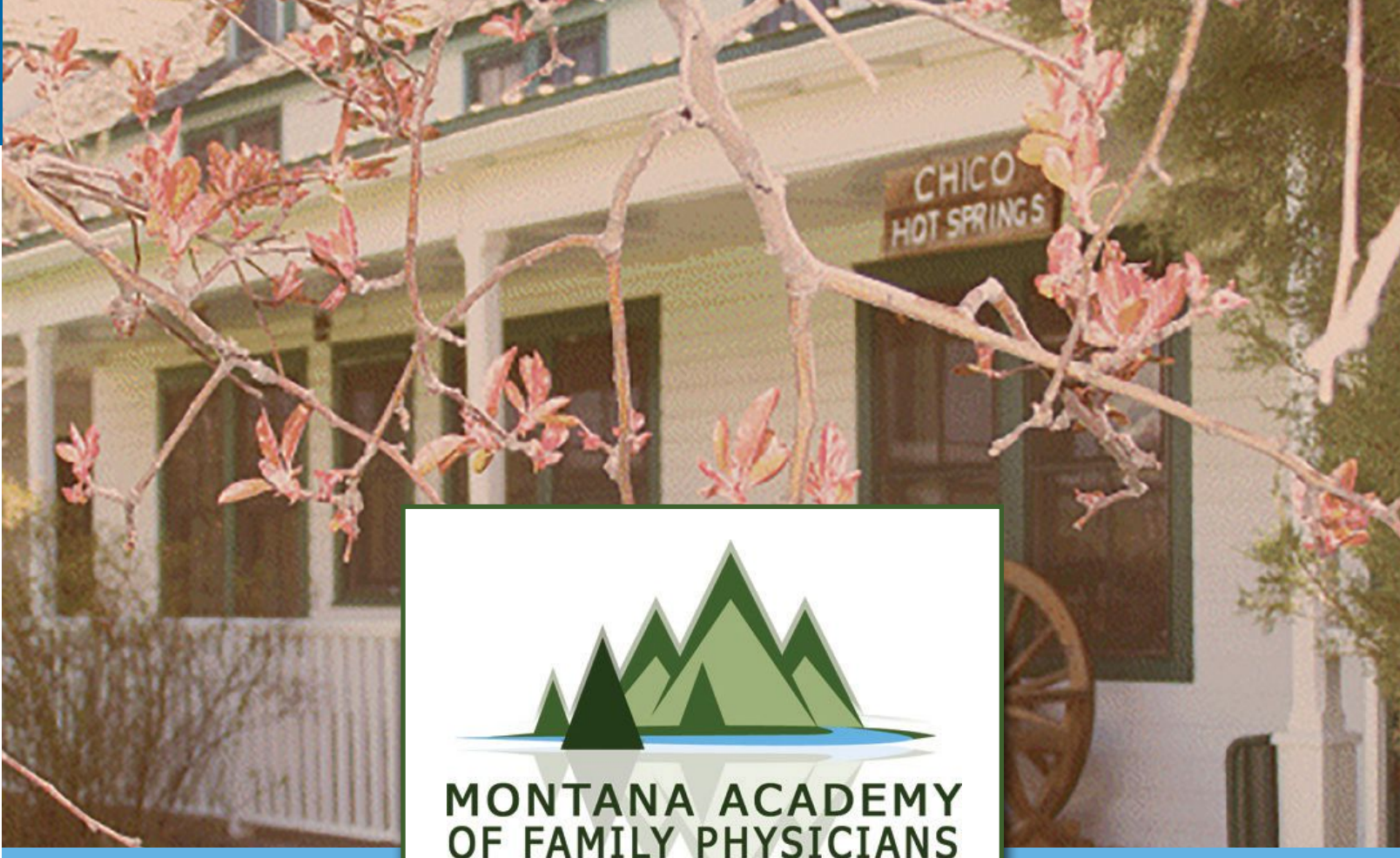
The Congress of Delegates (COD) is the Academy's policy-making body. Its membership consists of two delegates and two alternates from each constituent chapter and from the member constituencies including new physicians, residents, students, and other constituency groups represented at the National Conference of Constituency Leaders. The Montana Delegation who attended were Dr LeeAnna Musquiz and Dr Janice Gomersall as delegates, and Dr Janice Fordham and our President Dr Katrina Maher substituting for Dr Jason Sarisky, for alternate delegates. Our EVP Linda Edquest and Dr Heidi Duncan were also able to attend. Dr Jeff Zavala is a current AAFP Board Member as well.

During the two and one-half day meeting (held prior to AAFP Family Medicine Experience), the Congress agenda includes addresses from AAFP officers, resolutions from chapters, and reports from the Board of Directors and commissions. AAFP members are welcome to participate in hearings of the five reference committees: Advocacy, Education, Health of the Public and Science, Organization and Finance, and Practice Enhancement. Reference committees are committees of the COD that consider business (resolutions) items referred to them for recommendation to the COD for debate and action.

The 2025 COD was held in Anaheim California this year. Several resolutions were considered during this time, most notable included Standing up for evidence-based vaccine policies, Fair payment for annual wellness visits, Ensuring AI protects physicians' time and patients' health, Medicare coverage for obesity management and hearing loss, Medicare investment in primary care, Appropriate licensure for insurance physicians who do peer-to-peer evaluations, and IUD pain management training added to AAFP's Guidelines to Women's Health. We also referred to the Board resolutions on Filling gaps in CDC data by collaborating with other organizations, and Reducing burden of pharmacy auto refills.

At the COD, we elect new officers and three members to serve on the Board of Directors for the following 12 months. There are nine directors in total, each elected for a three year term. In 2025 we elected our new President Elect Dr Kisha Davis from Maryland, and new directors Dr Robyn Lui from Oregon, Dr Tracy Hendershot from West Virginia, and Dr Douglas Spotts from Pennsylvania. The President Elect from 2024 Dr Sarah Nosal from New York moves to President, and the President Dr Jen Brull moves to Board Chair. We did note that this is the first time ever that three women were in the 'president' roles - President elect, President, and Past President.

The 2026 COD will be in Nashville Tennessee October 19-21, with FMX to follow. Our own Montanan Dr Jeff Zavalla is currently an AAFP Board Director and will be running for President Elect in 2026.



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Application for CME credit has been filed with the AAFP.
Determination of credit is pending

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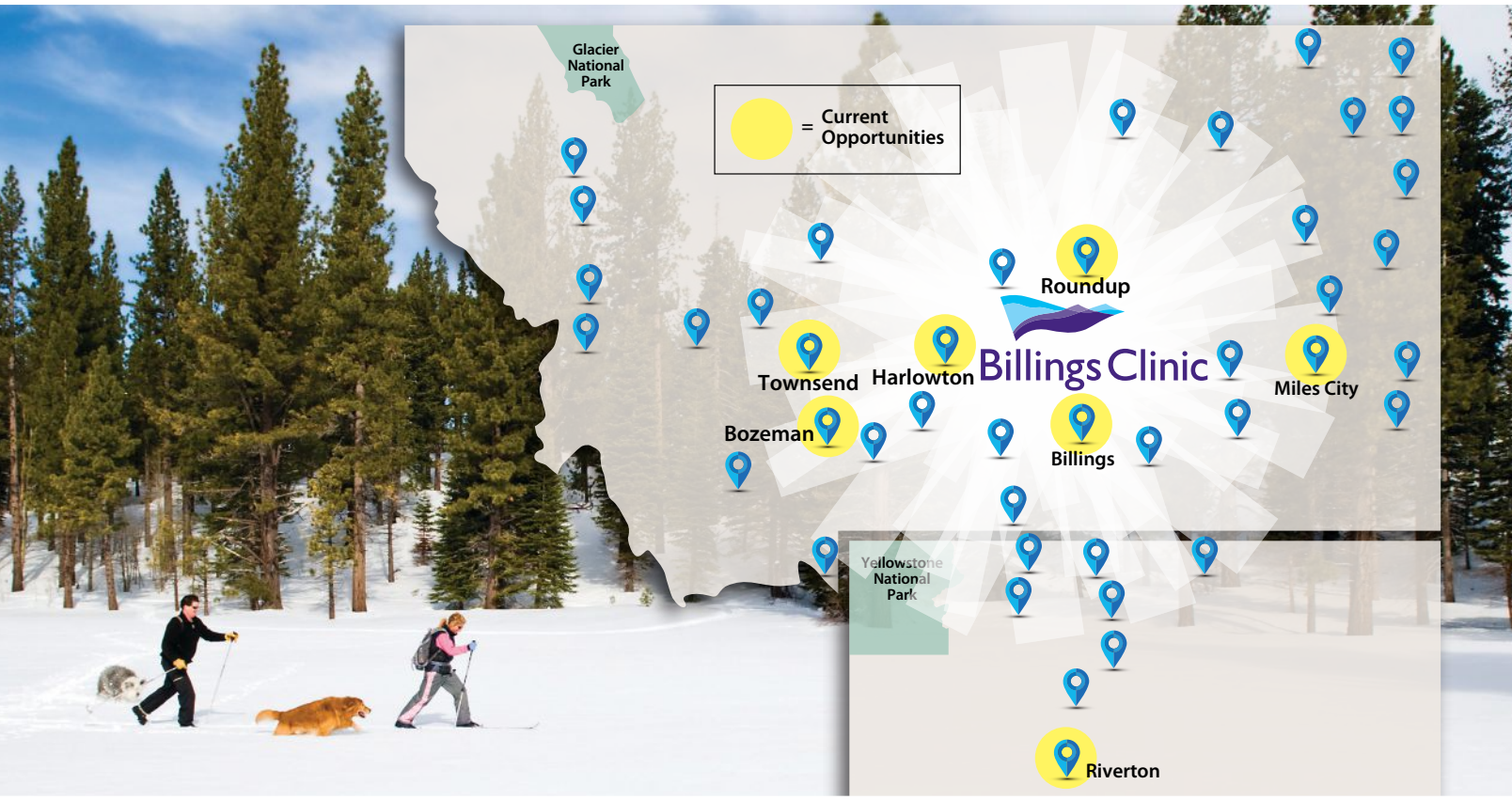

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