

REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–27, were presented by Robert M. Wah, MD, Chair:

1. AUDITOR’S REPORT

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2011 and 2010 and the Independent Auditor’s report have been included in a separate booklet, titled “2011 Annual Report.” This booklet is included in the handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

2. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2011 THROUGH FEBRUARY 2012

Reference committee hearing: see report of [Reference Committee D](#).

HOUSE ACTION: RECOMMENDATION NOT ADOPTED REMAINDER OF REPORT FILED

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2011 through February 2012 and is written in response to AMA Policy D-490.983 (AMA Policy Database), “Annual Tobacco Report.”

TOBACCO USE IN THE UNITED STATES

Tobacco use continues to be the number one preventable cause of death and disease in the United States. The health consequences of tobacco use include heart disease, multiple types of cancer, pulmonary disease, adverse reproductive effects, and the exacerbation of chronic health conditions. (www.cdc.gov/tobacco/data_statistics/sgr/2010/index.htm) Each year, approximately 443,000 persons in the United States die from smoking-related illnesses. In addition, smoking has been estimated to cost the United States \$96 billion in direct medical expenses and \$97 billion in lost productivity each year. (www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm)

The Centers for Disease Control and Prevention’s (CDC) September 9, 2011, Morbidity and Mortality Weekly Report looked at adult smoking rates from 2005-2010. In 2010, an estimated 19.3 percent (45.3 million) of US adults were current cigarette smokers; of these, 78.2 percent (35.4 million) smoked every day, and 21.8 percent (9.9 million) smoked some days. Prevalence was higher among men (21.5 percent) than women (17.3 percent). Smoking prevalence generally decreased with increasing education and was higher among adults living below the poverty level (28.9 percent) than among those at or above the poverty level (18.3 percent).

During 2005-2010, the overall proportion of US adults who were current smokers declined from 20.9 percent to 19.3 percent, representing approximately 3 million fewer smokers in 2010 than would have existed had prevalence not declined since 2005. However, this decline in prevalence was not uniform across the population; statistically significant reductions were observed only among persons aged 18-24 years or 25-44 years. On average daily smokers consumed 17 cigarettes per day in 2005 but that number fell to 15 in 2010. However, the number of smokers who smoked one to nine cigarettes per day increased from 16 percent to 21.8 percent, whereas the proportion who smoked more cigarettes per day declined from 12.7 percent to 8 percent. It is believed that the increase in light smoking is a result of the increase in smoke-free laws and private places that prohibit tobacco use. Since there is no safe level of tobacco consumption, a significant decrease in health risks associated with tobacco use is not being seen.

Government Agencies

The Food and Drug Administration's (FDA) Center for Tobacco Products (CTP) is responsible for implementing the Family Smoking Prevention and Tobacco Control Act (Act). One of the first regulations implemented by the CTP was to prohibit the sale of flavored cigarettes. However, the Act did not include menthol as a banned flavoring additive despite recommendations from many in the public health community, including the AMA, which had concerns about the wide use of menthol cigarettes by minority populations. The issue of banning menthol is still before the FDA, which has been accepting public comments and input from the scientific community. Based on an independent review, the FDA evaluated all available science related to the impact of menthol in cigarettes on public health. FDA submitted its report to external review in July 2011, and the agency is revising its report based on the feedback. Once the report is released, public comments may provide additional evidence and the FDA will consider options related to addressing the public health impact of menthol in cigarettes.

In October 2011, the FDA and National Institutes of Health (NIH) announced a joint study on tobacco use and risk perceptions. The initiative, called the Tobacco Control Act National Longitudinal Study of Tobacco Users, is the first large-scale NIH/FDA collaboration on tobacco regulatory research since Congress granted FDA the authority to regulate tobacco products in 2009. Experts at NIH's National Institute on Drug Abuse and the FDA's CTP will coordinate the effort and will follow more than 40,000 users of tobacco-products and those at risk for tobacco use ages 12 and older. They will examine what makes people susceptible to tobacco use; evaluate use patterns and resulting health problems; study patterns of tobacco cessation and relapse in the era of tobacco regulation; evaluate the effects of regulatory changes on risk perceptions and other tobacco-related attitudes; and assess differences in attitudes, behaviors and key health outcomes in racial-ethnic, gender, and age subgroups.

The National Cancer Institute, in an effort to help teens and young adults quit smoking, launched a text messaging resource for smokers. SmokefreeTXT is a free mobile service created to provide 24/7 encouragement, advice, and tips to help smokers stop smoking without relapse. Once they sign up, smokers receive text messages timed according to their selected quit date. Following their quit date, they will continue receiving texts for up to six weeks. The service is an extension of the core smoking cessation website, www.smokefree.gov.

Two federal agencies are looking at paid advertising to help reduce tobacco use with an eye toward reducing the national adult smoking rate, which has been hovering around the 20 percent mark for the past several years. The CDC and the FDA are expected to spend a combined \$100 million over the next few years on the project.

Evidence supports the use of high profile counter marketing ads. In California, for example, the percentage of adults who smoke reached an all-time low. According to the California Department of Public Health data released in July 2011, 11.9 percent of California adults smoked last year, down from 13.1 percent of adults in 2009. Adults ages 25-44 accounted for the greatest decline in smoking rates. Among that population, smoking rates dropped from 15.2 percent in 2009 to 13.1 percent last year. California's health officials credit its aggressive media campaign and education efforts for the drastic decline. The new smoking rate makes California only the second state, after Utah, to meet a federal target smoking rate below 12 percent by 2020. In New York City, just 14 percent of adults said they were smokers in 2010, the lowest level since the city began tracking the smoking rate nearly two decades ago according to a survey released in September 2011. New York City, like California, invested in high profile, hard hitting advertising in a variety of media.

The CDC education effort is expected in the first half of 2012, while the FDA campaign is expected at the end of 2012 or early 2013. The FDA released information on its campaign, which is seeking advertising agencies for two campaigns. One campaign will be age-segmented while the other will be focused on at-risk and underserved populations. Since the FDA campaign includes input from the tobacco industry, the public health community is concerned that some highly effective messages with teens and young people that demonstrate the marketing tactics of the tobacco industry will not be utilized.

Tobacco and the Affordable Care Act

The Affordable Care Act (ACA) makes vital investments in disease prevention, including tobacco prevention and cessation programs. Specifically, ACA includes:

- New coverage under Medicaid to help beneficiaries quit smoking;

- Expanded private insurance coverage of treatments that help smokers quit; and
- Investments in proven prevention, wellness, and public health activities.

The Department of Health and Human Services (DHHS) announced in August 2011 that it was awarding \$137 million for programs to strengthen local programs, with much of the funding coming from the Prevention and Public Health Fund, which was created under the ACA. The new grant funding included:

- Nearly \$5 million to help states and territories enhance and expand the national network of tobacco cessation quit lines to increase the number of tobacco users who quit; and
- Up to \$75 million to fund nine Screening, Brief Intervention, Referral and Treatment program over the next five years to allow communities throughout the nation to provide more comprehensive substance abuse screening, secondary prevention, early intervention and referrals to treatment for people at higher risk for substance abuse.

AMA ACTIVITIES

Prevention and Healthy Lifestyles

The AMA received funding from the Respiratory Health Association of Metropolitan Chicago (RHA) to increase tobacco dependence treatment in clinical practices and to promote the US Public Health Service Guidelines for Treating Tobacco Dependence. The funds were part of the national CDC initiative, Communities Putting Prevention to Work, which provided grants to state and local health departments for obesity and tobacco prevention. RHA is the fiscal agent for the Chicago Department of Public Health and subcontracted with the AMA and others in Chicago on projects related to tobacco use and secondhand smoke exposure. The AMA focused its efforts on medical students attending Chicago-based medical colleges and on implementing system changes to foster cessation services at free clinics. Medical students volunteer at free clinics that treat low income patients. The AMA trained 185 medical students attending Northwestern University Feinberg School of Medicine, University of Chicago Pritzker School of Medicine, Loyola University Stritch School of Medicine, Rush Medical College, and University of Illinois College of Medicine. The project trained student-volunteers to screen for tobacco dependence and in use of motivational interviewing, treatment options, and referral resources. The free clinics, associated with the medical schools, were in diverse areas of Chicago reaching multi-ethnic patient populations. The AMA initiative recruited and trained medical students for six clinics with patient materials, access to the state's quit line, and free nicotine replacement therapy.

Clinic staff also received training in screening and treating tobacco dependence to ensure that patients would continue to receive counseling as medical students transitioned out of the clinics. To reinforce the quit smoking message, the AMA launched a three-part public transit ad campaign with ads appearing in buses with routes near each clinic. The message read: "Quitting is Hard, Not Quitting is Worse" and directed viewers to talk with their doctor or call the free quit line. The powerful image portrayed a man or woman in a hospital bed on oxygen. The ads ran during the summer, in the fall to coincide with the Great American Smokeout, and in January to coincide with the New Year and resolutions. Effectiveness of the ads was measured by reviewing call statistics to the quit line. The campaign was credited with increasing calls to the quit line from 3,200 the previous year to 6,700.

Throughout the year, the AMA has distributed media statements in support of national reports on tobacco. For example, in November the Campaign for Tobacco Free Kids (CTFK) released its annual report on funding for state tobacco prevention programs. A Broken Promise to Our Children reported on how states have allocated funds they receive annually from the Master Settlement Agreement with the major tobacco companies. In addition to the settlement funds, states also receive sales tax revenue. It is estimated that in fiscal year 2012, states will receive more than \$25 billion from tobacco taxes and settlement revenue combined. Despite this existing revenue stream, program funding in the past year has seen deep declines, with some states slashing funding by 12 percent. The AMA issued a statement expressing its concern for smokers and the difficulty they might face in finding cessation programs and calling on its members to take an active role in educating state elected officials on the importance of funding evidence-based programs at levels recommended by the CDC. The AMA statement became a blog post on several media outlet websites, including National Public Radio, Washington Post, LA Times, San Francisco Chronicle, Sacramento Bee, Houston Chronicle, and CBSnews.com.

The AMA also commented on the American Lung Association's (ALA) annual tobacco cessation report, Helping Smokers Quit. The report, released in December 2011, highlights which states provide comprehensive coverage for

tobacco cessation and identifies those states with gaps in coverage. The AMA's statement supported the ALA's call for comprehensive coverage and outlined the clinical resources the AMA has for physicians.

Collaborations

Eliminating tobacco use and its associated morbidity and mortality requires a multi-faceted strategy that includes clinical practice, legislative actions, policies, and public engagement. For this reason, the AMA regularly collaborates with Federation members, medical societies, and public health groups to reach tobacco users where they live, work, and play. In September, the AMA, a founding member of a tobacco control collaborative that includes the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists, and American College of Physicians, co-sponsored a leadership training course. The day and a half course, Protecting Children and Families from Tobacco: Leadership Advocacy Training, was held in Chicago and included 50 physicians from across the country. Physicians were recruited via an application process promoted by each sponsoring organization. The training provided networking opportunities and information on the latest trends in tobacco prevention, use, and cessation. Participants were tasked with creating advocacy plans and goals. Among the faculty were AMA members, Tom Houston, MD, and Richard Hurt, MD, who discussed physician involvement in the community and improving clinical practice policies. The five-association collaborative is looking for opportunities to offer a similar training program in other parts of the country.

The AMA and its public health partners recently scored two major victories. Prior to baseball spring training, the AMA joined with nine public health and medical groups, including AAP and the American Dental Association, in a campaign to ban smokeless tobacco from the nation's major league ballparks. While it had already been banned, along with all tobacco use, in minor league baseball in 1993, the major league had taken no action even after smoking cigarettes was prohibited. The campaign, Knock Tobacco Out of the Park, included letters to baseball commissioners, news releases, editorials, and social media. In November, Major League Baseball and the Major League Baseball Players Association (the union that represents the players) announced a historic first step in a total ban on smokeless tobacco products. Under the agreement, league players, managers, and coaches will no longer carry a tobacco tin or package in their uniforms at games, or any time that fans are in the ballpark. They are prohibited from using smokeless tobacco during televised interviews, at autograph signings, and other events where they meet fans, or at team-sponsored appearances. The restrictions take effect in the five-year contract in 2012; violators are subject to discipline. While Major League Baseball Commissioner Bud Selig favored a total immediate ban, the union did not support that measure. Baseball players have been using tobacco since the earliest days of the game and this agreement marked the first time that the league and the players have acknowledged the need to break this unhealthy addiction. The agreement also bolsters tobacco education programs for players and creates a new center on cessation to help players quit. The AMA and its partners will continue to support a complete prohibition of tobacco use by players at games and on camera.

Another sports-related victory involved the 2011 Orange Bowl. The Orange Bowl Committee had announced a three-year sponsorship agreement with Camacho Cigars that included a large presence at several game-day events, including on-site Camacho lounges with premium cigars. At the Game Day Fan Zone, the Bowl's largest pre-game event, VIP guests were to be treated to two Camacho Club Lounges located in the designated smoking areas. With just three weeks before the first game, the AMA was invited to provide input in a campaign that included grassroots activities by Miami-based health groups. The campaign included a sign-on letter to Orange Bowl officials and a press release that mentioned the AMA's involvement. Moreover, Senator Dick Durbin, a long time tobacco prevention advocate, reached out to Senate colleagues to contact the Bowl officials and local newspapers. Less than two weeks following the announcement, the Orange Bowl canceled the agreement when it was deemed inappropriate to go forward with the sponsorship.

Government Relations

The FDA CTP Act launched a discussion series in the fall of 2010 to establish a dialogue between CTP officials and stakeholders. Sessions focused on key topics specific to the primary stakeholder community. The AMA was invited to represent the medical community at the Public Health Stakeholder session in June 2011 and was given the opportunity to present on how the regulations would have an impact on physician practices and the role of the medical community in assisting CTP in its efforts. Fifty people attended with an estimated 100 participating via the telephone. A report summarizing the first round of stakeholder meetings will be available in early 2012.

In May 2011, the AMA sent a letter to the chair and ranking member of the House Appropriations Committee to express strong opposition to any legislative or report language, riders, or amendments that the Committee might consider during mark-up of the FY 2012 Agriculture, Rural Development, FDA and Related Agencies appropriations bill that would weaken the FDA's authority over tobacco products. The letter, co-signed by American Thoracic Society, AAP, and other health and medical groups, stressed that there had been bipartisan support for the FDA's authority over tobacco and that attempts to weaken that authority would put the public's health at risk.

In September 2011, the AMA was one of more than 35 public health and medical groups signing on to a letter to House members urging them to oppose H.R. 1639 that would exempt cigars from FDA regulation. The AMA is resolute in its belief that the FDA should retain authority over all tobacco products with no exemptions.

The US is negotiating a regional Asia-Pacific trade agreement known as the Trans-Pacific Partnership Agreement (TPP) with Australia, Brunei Darussalam, Chile, Malaysia, New Zealand, Peru, Singapore, and Vietnam with hopes to include Canada, Japan, and Mexico. Prior to the TPP meeting in Chicago, the AMA sent a letter to the US Trade Representative (USTR) urging exclusion of tobacco from all provisions of the TPP and any other free-trade agreements. If excluded, tobacco control measures would be exempted from trade rules protecting intellectual property, including trademarks. It would affect investor-state provisions that allow foreign corporations to be able to sue governments directly. The AMA further indicated that USTR should not ask any nation to weaken its current tobacco control strategies in the interest of promoting free-trade. The AMA letter also called for excluding alcohol.

The AAP, AAFP, American College of Preventive Medicine, and CTFK also presented formal comments to the USTR calling for exclusion of tobacco in the TPP. Negotiations for the TPP are continuing.

AMA/State Medical Society Litigation Center

Since the passage in June 2009 of the Family Smoking Prevention and Tobacco Control Act (Act), which granted regulatory rights to the FDA over tobacco, the tobacco industry has aggressively sought to halt regulations authorized by the Act. Many of these lawsuits are being decided by the courts. The Litigation Center of the AMA and State Medical Societies joined with several public health organizations and medical groups, including the AAP, American Cancer Society, ALA, and CTFK on amicus briefs in support of the provisions of the Act.

Federal Cases

A 2009 lawsuit filed by several tobacco companies moved for a preliminary injunction to bar enforcement of certain regulations of the Act. In particular, they challenged a requirement that tobacco companies obtain pre-approval from the FDA before they would be allowed to market newly developed tobacco products that allegedly carry less risk to health than currently marketed products. The AMA, the Kentucky Medical Association, and other public health groups filed an amicus brief arguing that this requirement was no different than what was being imposed on other FDA-regulated products. The court ruled that most of the provisions in the Act were constitutional but did strike down some of the advertising restrictions, agreeing with the tobacco companies that these infringed on the companies' First Amendment rights. Both sides appealed and oral arguments were heard in July 2011. This case, *Discount Tobacco/Commonwealth Brands v. United States*, is pending while regulations in question are being implemented.

In a separate but related case filed in 2011, R.J. Reynolds and other tobacco companies sought an injunction against an FDA regulation that requires tobacco companies to display graphic warning labels on cigarette packages. These required labels would include statements about tobacco's harms and emotionally-charged images. The regulation also mandated the placement and size of the warning label: it must occupy the top half of both sides of the package and the top fifth of any print advertisement. Arguing that the labeling requirement violated their First Amendment rights, the tobacco companies asked for a preliminary injunction that would stall implementation of the regulation. In addition, the companies asked for a summary judgment, and a permanent injunction. In September 2011, the AMA and public health and medical groups filed an amicus memorandum opposing a new industry motion for a preliminary injunction. They also filed a memorandum that argued against the summary judgment and permanent injunction.

In November 2011, the court ruled in *R.J. Reynolds v. FDA* that the graphic warnings would convey more than factual information and supported the tobacco companies' assertions that requiring them to advocate a government

anti-smoking policy would violate their First Amendment rights. The court entered a preliminary injunction which the FDA appealed. Another amicus brief, filed by the AMA and health groups in support of the FDA appeal, argued that the FDA regulation was a reasonable effort to curtail smoking, since most smokers have become insensitive to non-graphic warnings. In addition, the warnings would also deter smoking by youth.

Another lawsuit, *Lorillard v. FDA*, alleged bias by the agency when it formed the Tobacco Products Scientific Advisory Committee. The FDA moved to dismiss the lawsuit for failure to state a cause of action. The FDA argued that the advisory group meets the criteria established by Congress. In May 2011, the AMA and other public health and medical groups filed a trial level amicus brief to support the FDA motion.

The Office of the US Trade Representative asked public health and medical groups to submit an amicus brief supporting a United States law that bans importation of flavoring additives for cigarettes, including cloves. Indonesia brought a case against the US before a panel of the World Trade Organization (WTO), arguing that Section 101 (b) of the law, the section that bans flavored cigarettes (other than menthol), violated both the General Agreement on Tariffs and Trade and the Technical Barriers to Trade (TBT) Agreement. The WTO dispute panel ruled in *Indonesia v. United States* that the flavoring ban was justified from a public health standpoint and was not more extensive than necessary to protect public health but it also ruled that the TBT was violated because of the different treatment of cloves and menthol. In January 2012, the AMA joined with others, including the AAP and American Public Health Association, on an amicus brief, which argues that the Act does not violate any international trade agreements.

The New York City Board of Health appealed a lawsuit filed in 2010 against an ordinance requiring retail outlets selling tobacco products to post city-provided graphic warning signs. The court ruled that the ordinance was preempted by the 1965 Federal Cigarette Labeling and Advertising Act. The AMA and other public health and medical groups submitted an amicus brief in the appeals court in April 2011. The case, *23-34 94th St. Grocery Corp. v. New York City Board of Health*, is still pending.

State Case

The AMA, in its support of clean indoor air laws that protect people from the health risks associated with secondhand smoke exposure, signed on to an amicus brief with the Ohio State Medical Association, Ohio Osteopathic Association, Cleveland Clinic, and 12 other health and medical groups in August 2011. This was in response to an appeal by the plaintiff, Bartec, a Columbus, OH restaurant, to the Ohio Supreme Court. The issue in this case, *Bartec v. Wymyslo*, is whether businesses and their owners can be held liable for violations of the Ohio Smoke-Free Workplace Act and the regulations that implement it. The Ohio Department of Health (ODH) fined Bartec for ten violations of the Smoke-Free Act. ODH then sued Bartec to secure a legal judgment based on ten administratively imposed fines and for an injunction to prohibit future violations of the Smoke-Free Act. In defense, Bartec claimed that the Smoke-Free Act and its implementing regulations are unconstitutional. It contended that the law imposed liability on Bartec for smoking by its patrons, an activity beyond its control.

The trial court found in favor of Bartec. It vacated the fines and denied the requested injunction. ODH appealed to the Ohio Court of Appeals which reversed the decision because neither the language of the Smoke-Free Act nor that of the implementing regulations imposed strict liability on businesses. The laws written only require businesses to take reasonable steps to prohibit smoking. The Court of Appeals remanded the case to the trial court to reinstate the administrative fines and issue the injunction requested by ODH. Bartec appealed this decision to the Ohio Supreme Court, and oral arguments were heard in October 2011. The case is still pending.

SUMMARY

The health effects of tobacco use are cumulative and, despite drops in rates of tobacco use, the social, economic, and health consequences will continue to escalate for many years to come. The AMA has been engaged in a wide range of tobacco control activities, including promotion of member education, provision of cessation services, passage of local, state and federal policies, and education of the public regarding the dangers and impact of tobacco use. These activities involve staff at all levels of the organization and have included preparation of frequent public statements and provision of educational activities to members. An annual tobacco report has been routinely provided to the House of Delegates for the past two decades. However, the Board of Trustees believes that more direct, informal communication vehicles now should be used to highlight significant tobacco-related issues as they arise. As a result,

the Board recommends that a tobacco report to the House not be prepared annually, as is currently required under AMA Policy D-490.983 (AMA Policy Database). AMA staff will continue to monitor tobacco issues and provide the Board of Trustees with tobacco-related updates as new issues arise. Information on significant tobacco-related events will be provided to the Federation, and the Board will prepare reports to the House of Delegates on tobacco issues as necessary. For these reasons, the Board recommends that AMA Policy D-490.983 be rescinded.

RECOMMENDATION

The Board of Trustees recommends that the American Medical Association Policy D-490.983 be rescinded and the remainder of this report be filed. [Editor's note: This recommendation was not adopted.]

3. 2011 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2011.

Grants & Donations For the Year Ended December 31, 2011 Amounts in thousands		
Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality	Patient Safety Organization Privacy Protection Center	\$42
Centers for Disease Control	Communications & Training Grant on Terrorism	30
Centers for Disease Control thru ASTHO	Enhancing Citizen Readiness for Radiation Disasters	22
Centers for Disease Control	Health Information Security Card	499
Department of Health & Human Services	Nuclear Preparedness Supplemental Journal	30
National Highway Transportation Safety Administration	Engage Physicians in Addressing Older Driver Safety	<u>176</u>
Government Funding		<u>799</u>
George Washington University	Bilingual Physicians Caring for LEP Patients	<u>51</u>
University Contributors		<u>51</u>
AstraZeneca Pharmaceuticals LP	Physician Advocates for Healthy Lifestyles	10
Janssen Scientific Affairs, LLC.	National Conference - Continuing Medical Education	3
Sanofi-Aventis US Inc.	National Conference - Continuing Medical Education	15
Pfizer, Inc.	Physician Advocates for Healthy Lifestyles	<u>85</u>
Pharma Funding		<u>113</u>

Grants & Donations
For the Year Ended December 31, 2011
Amounts in thousands

Funding Institution	Project	Amount Received
American Academy of Neurology	Imaging Measure Testing Project	10
Society of Nuclear Medicine	Imaging Measure Testing Project	10
American Academy of Pediatrics	Improving Tobacco Control thru Physician Leadership	19
American College of Cardiology Foundation	Clinical Quality Measures for Cardiovascular Disease	35
American College of Radiation Oncology	Oncology/Prostate Cancer Measures	28
American Society of Clinical Oncology	Oncology/Prostate Cancer Measures	23
National Quality Forum	Clinical Quality Measure Retooling Project	97
Respiratory Health Association of Metro Chicago	Chicago Tobacco Prevention Project	103
The MITRE Corporation	Ambulatory Quality Measure Test Data	74
The MITRE Corporation	Clinical Quality Measures - popHealth Software	80
The RAND Corporation	Advancing Clinical Decision Support	37
Contributions less than \$1,000	AMA International Medical Graduates Section Reception	<u>6</u>
Other Contributors		<u>522</u>
Total Grants and Donations		\$1,485

4. NEW SPECIALTY ORGANIZATION REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [D-600.984](#)

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the application of the Society of Cardiovascular Angiography and Interventions for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The application was first reviewed by the AMA SSS Credentials Committee and presented to the SSS Assembly for consideration.

The application was considered using criteria developed by the Council on Long Range Planning and Development and adopted by the House (Policy H-600.020, AMA Policy Database). A summary of the guidelines is attached under Exhibit A.

Organizations seeking admission are asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by the organization's explanation of how it meets each criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. The Society for Cardiovascular Angiography and Interventions was admitted to the SSS in 2008 and has been a member in good standing since.

Review of the materials and discussion during the SSS meeting at the 2011 Annual Meeting indicated that the Society of Cardiovascular Angiography and Interventions meets the criteria for representation in the HOD.

RECOMMENDATIONS

Therefore, the Board of Trustees recommends:

1. That the Society of Cardiovascular Angiography and Interventions be granted representation in the AMA House of Delegates.
2. That the remainder of this report be filed.

EXHIBIT A - Guidelines for Representation in & Admission to the House Of Delegates

1. The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
2. The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least 5 years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Criterion	Society of Cardiovascular Angiography and Interventions
1) Organization must not be in conflict with the Constitution and Bylaws of the AMA with regard to discrimination of membership	In compliance
2) Scientifically valid, not primarily focused on board certification	In compliance
3) Meets minimum AMA Membership thresholds	562 of 2,185 or 25%
4) Established longer than 5 years	Founded in 1978
5) Physicians comprise majority of voting membership	In compliance
6) Membership voluntary and society reported members who are current in dues payment, eligible to vote and hold office within their society	In compliance
7) Society is active and holds at least one meeting per year	In compliance
8) Society is national in scope and has members in the majority of states	In compliance
9) Application to HOD supported by official statement from organization's governing body	In compliance
10) US Chapter, if society is international	US based

5. AMA ACTIVITIES AS A PARTNER OF THE MILLION HEARTS INITIATIVE

Reference committee hearing: see report of [Reference Committee D](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Policy D-425.993 rescinded.

At the 2011 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-425.993 (AMA Policy Database), “AMA Partnership with Million Hearts,” which asked that the American Medical Association Board of Trustees (BOT) report back to the HOD at the 2012 Annual Meeting on the actions the AMA has taken as a partner in Million Hearts (a national collaborative project intended to prevent heart disease and stroke) to ensure its success.

The AMA has been a partner in the Million Hearts Initiative since its inception in September 2011 (<http://millionhearts.hhs.gov/index.html>) and was mentioned as a partner in the Department of Health and Human Services’ (DHHS) press release announcing the initiative. This campaign aims to prevent one million heart attacks and strokes over the next five years. Currently, cardiovascular disease costs \$444 billion every year in medical costs and lost productivity in Americans. Million Hearts is focused on two goals:

- Empowering Americans to make healthy choices such as preventing tobacco use and reducing sodium and trans fat consumption. This can reduce the number of people who need medical treatment such as blood pressure or cholesterol medications to prevent heart attacks and strokes.
- Improving care for people who do need treatment by encouraging a targeted focus on the “ABCS” – Aspirin for people at risk, Blood pressure control, Cholesterol management and Smoking cessation – which address major risk factors for cardiovascular disease and can help to prevent heart attacks and strokes.

By 2017, the Million Hearts Initiative strives to achieve the following specific measurable objectives:

- Increase aspirin use for people at high risk from the current baseline of 47% to 65%;
- Improve blood pressure control from the current baseline of 46% to 65%;
- Increase effective treatment of high cholesterol (LDL-C) from the current baseline of 33% to 65%;
- Reduce smoking prevalence from the current baseline of 19% to 17%;
- Reduce average sodium intake by 20% from the current baseline of 3.5g/day; and
- Reduce average artificial trans fat consumption by 50% from its current baseline of 1% of calories/day.

AMA Activities Undertaken as a Partner in the Million Hearts Initiative

Following its introduction, the Million Hearts Initiative had a face-to-face partner meeting at the American Public Health Association’s annual meeting on November 1, 2011. The AMA participated in this meeting and reiterated its interest and continuing partnership in the Million Hearts campaign.

The AMA has also maintained an active dialogue with several of the major federal agencies involved in moving the Million Hearts Initiative forward, including the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Service (CMS), and the Center for Medicare and Medicaid Innovation (CMMI).

As part of this dialogue, the AMA has agreed to work with Initiative staff in the federal government to improve and review the content of their Million Hearts website, specifically to help physicians understand that the Initiative does not place additional burden on practices, but instead serves as an opportunity to focus on the ABCS to get credit for participation in the Physician Quality Reporting System (PQRS) and meaningful use. The AMA also offered to help work with DHHS to improve how Million Hearts is communicated to the physician community and has asked that updates be provided that can be used in AMA publications such as *American Medical News*, *AMA Wire*, *Advocacy Update*, and AMA social media tools like Twitter and Facebook.

The AMA’s continued discussion of the Initiative with the federal agencies also focuses on understanding the implementation of the Million Hearts Initiative. The AMA has been told that the CDC is charged with the first focus

on empowering Americans to make healthy choices, that is, community prevention, and is now working on identifying best practices to help extend Million Hearts into communities. It is likely that much of this will be done through the existing “Community Transformation Grants.” These grants support community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke, and diabetes. By promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, it is hoped that these grants will help improve health, reduce health disparities, and control health care spending. As of January 2012, approximately \$103 million in prevention funding has been awarded to 61 states and communities serving approximately 120 million Americans. These awards are distributed among state and local government agencies, tribes and territories, and state and local non-profit organizations within 36 states, including seven tribes and one territory. At least 20 percent of grant funds will be directed to rural and frontier areas.

With regard to the area of clinical prevention, there are three foci:

1. ABCS measures, with the goal being alignment of these measures across HHS programs;
2. Health IT, with a goal of improving the relationship between health IT and population health, and how can HHS promote the use of health IT for improving adherence, and providing reminders for both physicians and patients around the existing ABCS measures; and
3. Care Innovations, looking at how to further embed the ABCS measures in bundled payments, Accountable Care Organizations, and team-based care.

The AMA has communicated to the federal agencies that the Million Hearts should help align existing programs around ABCS measurement for those physician specialties, where it is clinically relevant to do so, in practical and effective ways that do not add additional burden on physicians. The AMA has specified that health IT and care innovations topics are complicated. Since, the ABCS measures likely already exist in meaningful use programs, the AMA wishes to help physicians report on these measures as part of their participation in the programs.

However, if these measures are not clinically relevant to the physician practice, the AMA would want the meaningful use program to maintain and expand its flexibility of quality measure reporting. Similarly, for care innovations, helping identify the best way to embed ABCS-related measures in a way that is meaningful for the appropriate providers, without adding burden to the overall health care system, would be critical.

AMA Support of National Heart Month as a Partner in the Million Hearts Initiative

The AMA had two conversations with the federal staff for the Million Hearts Initiative to discuss promotion of not only the campaign, but also of heart health, during National Heart Month, which was February 2012. Notably, while the AMA planned many activities to coincide with National Heart Month, the AMA also planned activities for National Nutrition Month (March), as many aspects concerning nutrition and behavior surrounding nutrition play important roles towards maintaining a healthy heart.

The AMA’s Communications staff utilized several AMA communication vehicles to inform physicians about the importance of heart health, about the Million Hearts campaign, and also about National Nutrition Month during February and March 2012. These include:

- The February 8, 2012 *AMA Wire*, which provides news and information from the AMA to its members, featured an article on National Heart Month with mention of the AMA as a partner in the Million Hearts Initiative, and cites AMA resources related to cardiovascular disease prevention. The February 9, 2012 issue of the electronic newsletter, *Morning Rounds*, had a link to this *AMA Wire* story.
- The February 29, 2012 *AMA Wire* provided a special feature on Weigh What Matters (the AMA’s new national obesity prevention campaign, www.ama-assn.org/resources/weighwhatmatters/physicians.html) and on the AMA Healthier Life Steps™ program, a resource to help physicians help their patients improve their lifestyle behaviors (<http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/healthier-life-steps-program.page>). Since behavior change is fundamental to improving outcomes, including the ABCS, the feature will discuss the AMA’s involvement in, and how our programs support, the Million Hearts Initiative and the United States Department of Agriculture’s MyPlate effort (www.choosemyplate.gov/).

- The AMA has informed the Federation of Medicine of National Heart Month and of the AMA's involvement with the Million Hearts Initiative through the *Federation Newsletter*.
- AMA President, Peter Carmel, MD, blogged in his regular "Dr. Carmel's Blog" on the National Heart Month and the Million Hearts Initiative, the AMA's partnership in the effort, and our cardiovascular disease resources.
- The AMA activated its social media outreach on the National Heart Month and incorporated "hash tags" about the Million Hearts Initiative in our Twitter tweets as well as on the AMA's Facebook page.
- The AMA's AMA Healthier Life Steps™ web page linked to the Million Hearts website during National Health Month.
- Internally, the AMA's employee wellness program highlighted the Million Hearts Initiative in its ongoing comprehensive employee wellness activities during National Heart Month.

SUMMARY

The AMA believes strongly in the importance of heart health and the value of the Million Hearts Initiative. This is reflected in the breadth of the AMA's activities on this issue in just the first five months since its inception. The AMA continues to collaborate with the Initiative and remains in close communication with the different federal agencies leading the effort, such as the CDC, CMS, and the CMMI. The AMA stays abreast of developments in the Million Hearts Initiative and continues to explore ways that the AMA might contribute to achieving the ambitious but laudable goals of the campaign.

RECOMMENDATION

As this report fulfills the request of the House of Delegates, the Board of Trustees recommends that the Policy D-425.993 be rescinded and the remainder of this report be filed.

6. DEMOGRAPHIC REPORT OF THE HOUSE OF DELEGATES AND AMA MEMBERSHIP

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

This informational report, "Demographic Report of the House of Delegates and AMA Membership," is prepared pursuant to G-600.035 House of Delegates Demographic Report (AMA Policy Database), which was adopted at the 2010 Annual Meeting, which states:

A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to G-635.125, AMA Membership Demographics, which was adopted at the 2010 Annual Meeting, which states:

Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire AMA membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report, to remain consistent with the bi-annual Council on Long Range Planning and Development (CLRPD) report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA House of Delegates includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2011 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2011 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 521 allotted at the 2011 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 946 rather than the 1,042 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 16% of AMA members and approximately 22% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of AMA policy (see Policy D-630.972). Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the House of Delegates and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA Membership and Delegates along with corresponding figures for the entire physician and medical student population.

Data on physicians' and students' current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2011

2011	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates ^{1,2}
Total	217,490	1,163,294	946
Mean age (years) ³	49.3	50.8	55.8
Age distribution (percent)			
Under age 40	42.88%	29.81%	13.53%
40-49 years	11.53%	20.28%	14.27%
50-59 years	14.00%	20.61%	27.38%
60-69 years	10.77%	14.84%	31.82%
70 or more	20.81%	14.45%	13.00%
Gender (percent)			
Male	69.36%	68.62%	80.13%
Female	30.64%	31.38%	19.87%
Race/ethnicity (percent)			
White non-Hispanic	62.37%	54.04%	74.21%
Black non-Hispanic	4.03%	3.91%	3.49%
Hispanic	3.90%	4.79%	1.90%
Asian/Asian American	12.91%	13.93%	7.19%
Native American	0.30%	0.22%	0.32%
Other ⁴	0.90%	1.23%	1.06%
Unknown	15.59%	21.87%	11.84%

Education (percent)			
US or Canada	84.12%	77.71%	91.75%
IMG	15.88%	22.29%	8.25%

1. There were 96 vacancies as of year's end, most of which are unfilled alternate delegate slots.
2. Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
3. Age as of December 31. Mean age is the arithmetic average.
4. Includes other self-reported racial and ethnic groups.

Table 2. Life Stage, Present Employment and Self-Designated Specialty¹, December 2011

2011	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates
Life Stage (percent)			
Student ²	21.71%	8.09%	5.92%
Resident ²	16.71%	9.63%	4.02%
Young (under 40 or first 8 years in practice)	8.12%	17.08%	4.12%
Established (40-64)	28.06%	44.47%	59.20%
Senior (65+)	25.40%	20.73%	26.74%
Present Employment (percent)			
Self-employed solo practice	11.56%	11.16%	16.28%
Two physician practice	2.22%	2.14%	3.28%
Group practice	28.74%	41.86%	44.40%
HMO	0.13%	0.22%	0.42%
Medical school	1.88%	2.12%	8.03%
Non-government hospital	15.84%	11.06%	9.83%
State or local government hospital	3.07%	4.48%	3.07%
US government	1.40%	2.41%	3.38%
Locum Tenens	0.25%	0.22%	0.21%
Retired/Inactive	10.34%	9.30%	4.23%
Other/Unknown	2.85%	6.96%	0.95%
Student	21.71%	8.09%	5.92%
Specialty (percent)			
Family Medicine	9.76%	12.30%	12.26%
Internal Medicine	18.38%	22.69%	18.71%
Surgery	15.33%	13.96%	25.79%
Pediatrics	5.00%	8.50%	3.59%
OB/GYN	6.09%	4.92%	5.81%
Radiology	3.89%	4.57%	4.23%
Psychiatry	3.89%	5.56%	4.02%
Anesthesiology	4.07%	4.84%	4.76%
Pathology	1.98%	2.33%	2.43%
Other specialty	9.90%	12.24%	12.47%
Students	21.71%	8.09%	5.92%

1. See Appendix A for a listing of specialty classifications.
2. Students and residents are categorized without regard to age.

Appendix A - Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

7. AMA 2013 DUES

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

See Policy [G-635.130](#)

Our American Medical Association (AMA) last raised its dues in 1994. In recent years, the AMA has invested significantly in improving the value of AMA membership. As the AMA membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2013 Membership Year

The Board of Trustees recommends no change to the dues levels for 2013, and that the following be adopted, and that the remainder of this report be filed:

Regular Members	\$ 420
Physicians in Their Second Year of Practice	\$ 315
Physicians in Military Service	\$ 280
Physicians in Their First Year of Practice	\$ 210
Semi-Retired Physicians	\$ 210
Fully Retired Physicians	\$ 84
Physicians in Residency Training	\$ 45
Medical Students	\$ 20

8. ALTERNATIVE MEMBERSHIP MODEL PROJECT FINAL REPORT

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the American Medical Association's (AMA) 2011 Interim Meeting, Board of Trustees Report 12-I-11, Status Report on the Alternative Membership Models Project and AMA Organization and Governance, was adopted. A final report on the Alternative Membership Models Project (AMMP) was scheduled for June 2012. This report will conclude the AMMP and outline how future work will continue in conjunction with the AMA's new strategic direction and within the context of existing membership operations.

DISCUSSION

Background

In July 2010, the AMA Board Chair directed that a task force be convened to explore alternative membership structures that may better position the AMA to fulfill its mission in the 21st century. This task force was asked to address two key issues: 1) growth and stability in membership; and 2) validation of whom the AMA represents. In addition, any new structural option must account for the AMA's economic viability. The task force's initial work indicated that a hybrid membership concept with two distinct member types, Direct Membership and Society Membership, merited further study. As previously outlined in Board of Trustees Report 12-I-11:

- Direct Membership would be available to individual physicians or groups that establish membership through: (a) direct transactions with the AMA; (b) transactions with the AMA through their state or specialty societies; or (c) through a group, employer or institutional arrangement with the AMA.
- Society Membership would be available to state and specialty societies based on the existing eligibility requirements that are already in place for membership in the House of Delegates.

A structural concept for the hybrid model was developed and studied by utilizing available research and through an engagement strategy.

Engagement

Input was collected through face-to-face meetings and conference calls with state medical society presidents and executives, specialty society presidents and executives, the Advisory Committee to the Board of Trustees, the CLRPD, individual AMA members, the Board of Trustees and AMA management. The Advisory Committee to the Board of Trustees was comprised of members of the House who were appointed by the Board Chair in June 2011 to provide input and feedback on the hybrid concept.

Hybrid Concept Analysis

The concept was originally considered because, despite its risks, the Board of Trustees felt it was worth further exploration as a potential solution to grow membership. Upon study and analysis, it is clear that the hybrid noted

will not validate representation, grow or stabilize AMA membership or position the AMA to fulfill its mission in the 21st century.

Will not validate representation – The AMA will not be able to automatically count all individual society members as AMA members. This was clearly stated during the discussions with State and Specialty Society Executives and the Advisory Committee to the Board of Trustees. A portion of individual society members will actively object to being “counted.” The AMA can already credibly claim representation of almost all physicians through its House of Delegates. Creating a scenario where individuals might actively opt-out at the society level could erode rather than validate representation.

Non-participation by state and specialty societies is an additional risk. As stated above, the AMA already effectively represents all physicians through the members of the House of Delegates representing 187 state and specialty societies in addition to special groups.

Economically non-viable – State and specialty societies stated that they are not in a position to pay Society Membership Dues. This theme was present in all discussions, including those with the Advisory Committee to the Board of Trustees. Society dues would have to be at a very low level for them to be considered (and even then with a low probability of approval). The key reasons behind this theme included financial constraints and resistance to paying for benefits that they have been receiving for free.

A survey conducted at the time of the Committee on Organization of Organizations (COO) provides a similar result. Only 46% of specialty societies and only 67% of state societies indicated a willingness to commit to becoming a dues-paying member of an umbrella organization. Those who were willing to pay indicated that the dues would have to be low-cost.

Testimony on BOT Report 12-I-11 further indicated price-sensitivity – it was stated that it is already very costly for societies to participate in the AMA; and was requested that whatever recommendations come out should be budget-neutral for state and specialty societies.

In addition, political action committee and tax implications identified in the COO process remain problematic for a hybrid concept.

In light of the fact that a structural change such as a “hybrid” concept will not grow membership, the Board of Trustees directed management to realign all further efforts to a more viable plan that focuses on evidence-based, value enhanced recruitment and retention of aggregated and individual memberships. The Advisory Committee reconvened to discuss the findings and came to a consensus to support the new direction.

Current and Future Impact

The new direction and project focus will reach far beyond the AMMP and be integrated into our AMA’s new strategic direction. Individual membership is an essential component of the much larger AMA equation. The broader AMA equation best represents the comprehensive and robust engagement AMA has with individual physicians and the broader, complex universe of organizations engaged in the nation’s health care sector. The vital information already gathered on the proposed value of individual and group membership benefits, the desire for individual voice and how our AMA can better serve physicians will be used to support the AMA’s new organizational focus and direction.

When our AMA demonstrates strong value, it experiences growth in membership (Introduction to the Practice of Medicine is an example related to physicians-in-training). Implementation of new benefits for students, residents and young physicians were initiated in 2011 as a result of the information gathered and momentum created by AMMP. The enhanced benefits have contributed to AMA’s successful 2011 membership increase.

Our AMA will continue to learn through research what should be provided to our members, with a new focus on the needs of all categories of employed physicians, large systems and groups, academic physicians and institutions and a continued focus on critical career transition points. This will not be a one-time project. Evaluating ever-evolving physician needs will be a continuous process.

NEXT STEPS

Membership categories, enhanced membership benefits packages and alternate dues structures are being evaluated. Individual voice will be a critical component within all membership categories as our AMA has been told repeatedly that our members perceive a void in this regard.

Research

Quality research will be critical to ensure that high-impact benefits packages that align to a broad base of physicians will be developed for all membership categories. Realignment of AMA membership dues structures may be required. The research will be executed in a phased approach during 2012 and 2013.

- Student Membership – Research focused on enhanced benefits and alternate dues structures was launched in March 2012. Any changes to student dues structures, if indicated by the results, will be incorporated into future Board of Trustees reports for consideration by the House.
- Group Practice Membership – A focus on expanding existing, successful programs aimed at capturing multiple memberships from single entities has been identified as priority. To move this forward, a better understanding of large group needs is required. The research process has been started with a series of in-depth interviews with groups ranging in size from 40 to 3,900 physicians resulting in the identification of key opportunities. Follow-up research is being developed for evaluation and potential launch in late 2012.
- Physician Membership – Additional, comprehensive research is being outlined to focus on individual membership benefit package choices and dues levels. The information we gather may result in altered dues amounts, multi-year memberships or even new membership categories. This research is targeted for fall 2012.

Membership Focus for 2012 and 2013

The work done by management and the Board of Trustees will continue in 2012 and 2013 with a clear, focused, strategic approach to build on the successes of 2011. There will be continued work to execute effective, proven strategies to maintain the current membership base with an emphasis on career transition points, young physicians, practicing physicians and medical students. With the help of detailed analysis from the planned research, we will build and implement a strong group practice program including enhancing large group outreach targets. Existing relationships with individuals and groups will be leveraged. Our AMA will be engaged in expanding successful programs aimed at capturing multiple memberships from single entities. Finally, member and Group (IPM, Group Practices, and Academic Leadership) retention will remain a top priority.

CONCLUSION

The work of the AMMP has concluded with tangible results and a new direction. We have moved away from consideration of structural changes and have begun moving toward enhanced value and a greater focus on recruitment and retention of aggregated and individual memberships. The work to grow membership will be an ongoing process that will be fully integrated into the new AMA strategic direction, the broader AMA Equation and existing membership operations.

9. ELECTRONIC HEALTH RECORD “LEMON LAW” (RESOLUTION 823-I-11)

Reference committee hearing: see report of [Reference Committee G](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [D-478.978](#)

At the American Medical Association’s (AMA) 2011 Interim Meeting, the House of Delegates (HOD) referred Resolution 823, “Electronic Health Record.” Introduced by the California Delegation, Resolution 823 asks that our

AMA maintain a record of feedback and specific complaints by physicians about electronic health record (EHR) products and vendors, which all AMA members can access on the AMA website.

BACKGROUND

There was mixed testimony on this resolution. Some speakers supported the need for good information related to the functionality of EHRs, but felt that there might be an opportunity for our AMA to take a more active role in helping physicians select and implement EHR systems. The reference committee agreed with several speakers who suggested that this item be referred for thoughtful consideration of how to best achieve the intent and objectives identified in the resolution.

The United States has initiated the largest investment in health information technology (health IT) to date. The recent 2013 federal budget proposal allocates \$11.8 billion to health IT. This resolution is directly in line with the federal incentive programs that encourage the adoption and use of health IT, more specifically the EHR Medicare/Medicaid Incentives that encourage the “meaningful use” of health IT. Although federal incentive programs encourage the use of EHRs while advocating the benefits of implementation, physician participation is limited to date.

According to data released by the Centers for Medicare & Medicaid Services (CMS), 132,445 eligible professionals registered for the Medicare EHR incentive program, which includes 118,146 physicians and over 55,000 eligible professionals registered for the Medicaid EHR incentive program, consisting of over 40,000 physicians. The programs require the use of certified EHR technology. At present, there are over 1,700 EHR products certified by the Office of the National Coordinator (ONC) Authorized Testing and Certification Bodies. As the number of certified products increases, the need to establish an open forum to allow unbiased feedback related to these products and how they satisfy the needs of the provider becomes more apparent.

The Agency for Healthcare Research and Quality (AHRQ) funded a 2010 study on EHR Usability: Vendor Practices and Perspectives.¹ Included among the recommendations of the study is that there should exist an “increased diversity of users surveyed for pre-deployment feedback.”² The study encouraged vendors to survey a diverse group of end-users, as they continue to develop and fine-tune their EHR products. A free vendor rating system, available to providers would directly address the recommendation in the AHRQ study to solicit product feedback.

The 2010 Institute of Medicine (IOM) report entitled “Health IT and Patient Safety: Building Safer Systems for Better Care” addressed concerns related to patient safety and the use of health IT. The report reviewed multiple issues related to EHR usability including the need for testing and evaluating usability of EHRs throughout the product life cycle.³ The report cites several reasons that health IT related safety data is lacking including “the absence of measures and a central repository (or linkages among decentralized repositories) to collect, analyze, and act on information related to safety of this technology.”⁴ This statement supports the request of Resolution 823-I-11 in that it suggests the need for a central repository for data related to individual EHR products. Also listed as an obstacle to gathering safety data were contractual barriers such as nondisclosure agreements and confidentiality clauses “that can prevent users from sharing information about health IT-related adverse events.”⁵ One of the key findings in the IOM report was that “these barriers limit users’ abilities to share knowledge of risk-prone user interfaces, for instance through screenshots and descriptions of potentially unsafe processes.”⁶ The need for an open forum to expose the aforementioned barriers and potential pitfalls would properly align with the IOM findings.

At present, the AMA does not have such an open forum that allows providers to discuss their EHR product or rate a vendor. There are at least two companies that provide technology market research and opinion data, KLAS and Black Book. They provide detailed performance ratings on specific technology vendors; however, their information is only available at a significant cost. More comparable to the request of the resolution is the AmericanEHR vendor rating system, which provides ratings generated from verified physicians and contains an access comparison tool. Currently, AmericanEHR promotes this tool to physicians to assist in the effective integration of EHR/EMR systems into practices. The vendor rating tool is free, as is registration on the AmericanEHR website.

The American College of Physicians (ACP) and Cientis Technologies together manage the AmericanEHR Partners program through a joint governance and editorial process. Four advisory groups were established to provide feedback on the AmericanEHR Partners program: Clinical Advisory, Professional Society Advisory, EHR Vendor Advisory, and a Stakeholder Advisory that includes national organizations not represented in the first three advisory

groups. All partner societies automatically have a seat on the Professional Society Advisory group. The professional society advisory group provides guidance on education, collaborative initiatives and future development in relation to specialty and subspecialty clinician groups.

In an effort to allay concerns regarding the potential for liability, AmericanEHR states that the only liability that they have identified, and developed a process to address, is the management of user-generated content on the AmericanEHR Partners site. The AmericanEHR partner agreement provides assurance that AmericanEHR has sufficient internal controls to ensure users of the site will not be able to post libelous information due to the AmericanEHR's content review and approvals process that is jointly managed by Cientis and ACP. All content goes through an editorial review process before being published. In addition, the AmericanEHR governance structure with their clinical and society advisories provides a high level of accountability as new processes and services are developed through AmericanEHR that are presented to each group for input as part of the development process. Furthermore, should a partner decide no longer to participate, the AmericanEHR partner agreement can be cancelled at any time at the discretion of the partner.

The AMA has recently begun discussions with AmericanEHR to assess the potential for partnering with AMA to take advantage of the progress they have already made with vendor rating in lieu of allocating resources toward creating and developing a comparable tool. By working with AmericanEHR on their existing tool, the AMA can maximize physician input and ratings of vendors by encouraging the use of a single ratings system that is already established. The requisite AMA review process is being followed prior to committing to any agreement with AmericanEHR.

An alternative to the AmericanEHR tool is to revamp the AMA ePrescribing Learning Center to include reviews of EHRs. At present, the ePrescribing learning center allows physicians to share their experiences with ePrescribing, and assist their colleagues in making informed choices about their ePrescribing needs. This alternative would require significant financial investment in order to provide a record of feedback and specific complaints by physicians about EHR products and vendors which could be made available to AMA members and electronically accessible on the AMA website.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 823-I-11 and the remainder of the report filed:

That our American Medical Association (AMA) pursue possibilities, consistent with our strategic direction and existing guidelines for working with third parties, to develop tools, accessible to all AMA members, which can help physicians in the selection and evaluation of electronic health records.

REFERENCES

1. McDonnell C, Werner K, Wendel L. Electronic Health Record Usability: Vendor Practices and Perspectives. AHRQ Publication No. 09(10)-0091-3-EF. Rockville, MD: Agency for Healthcare Research and Quality. May 2010.
2. Id.
3. IOM (Institute of Medicine). 2012. Health IT and Patient Safety: Building Safer Systems for Better Care. Washington, DC: The National Academies Press.
4. Id.
5. Id.
6. Id.

10. ASSOCIATION SERVICES AND PHYSICIAN ORGANIZATIONS

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the American Medical Association's (AMA) 2011 Annual Meeting, Resolution 608-A-11, "Association Services and Physician Organizations" was introduced by the Oregon Delegation and adopted as Policy D-620.992 (AMA Policy Database).

Policy D-620.992 asks the AMA to:

1. Study and report back on emerging physician practice environments; how services that the AMA and state medical associations currently provide their members relate to those practice environments and what additional services should be provided in order to better serve the needs of all physicians.
2. Develop a comprehensive strategic plan to address those changes in federal laws and regulations that are necessary to support and safeguard physicians as they pursue new business models.

The AMA will continue to monitor these issues and make additional resources available as necessary.

The following report was prepared to fulfill the information requests of Policy D-620.992.

BACKGROUND

Antitrust and other laws and regulations may adversely impact physicians' ability to organize and play a leadership role in emerging delivery models. The AMA has identified several legal barriers associated with delivery and payment system reform¹ and believes these must be addressed in ways that accommodate the needs of independent and employed physicians as practice environments continue to evolve. This report provides an update of current AMA activity designed with the intent of assisting physicians in overcoming these legal barriers as well as addressing some of the logistical issues that impact physicians' ability to organize and participate in the aforementioned leadership roles.

EMERGING PHYSICIAN PRACTICE ENVIRONMENTS

Many departments within the AMA are involved in developing and implementing services and tools geared toward addressing the needs of physicians and the emerging practice environments.

Below is a summary of the current activity that addresses the tasks associated with Policy D-620.992(1).

AMA Council on Long Range Planning and Development

Biennially, the Council on Long Range Planning and Development (CLRPD) produces the Health Care Trends report, which provides significant insights into the health care environment. The Trends report is made publicly available through the CLRPD website, www.ama-assn.org/go/healthcaretrends. The report is readily accessible to sections of the AMA that use the document for guidance regarding focused development of tools and materials geared toward education and physician outreach. The information allows for the development of materials and services that are focused on specific practice environments. The following information on physician practice models of care is excerpted from the Health Care Resources chapter of the Trends report:

- Since 1980, the complement of office-based physicians grew 106 percent, and that in hospital-based practice did so by 81 percent. In 2009, the majority of US physicians (77.1 percent) remained in patient care. Of these patient-care physicians, 74.8 percent were in office-based practices and 25.2 percent were in hospital-based practices, which include residents, fellows, and full-time hospital staff. In 2009, 61 percent of physicians in the United States worked in practices with fewer than three physicians and hospitals employed 16 percent of physicians.²

- In 2009, nearly three-quarters of International Medical Graduates were in office-based practices, representing 24.7 percent of all office-based physicians in the United States and Possessions, and accounted for 29.3 percent of all hospital-based, full-time physician staff. The percentage of unique non-federal physicians who have affiliated to a group practice of three or more physicians is 42 percent of the total active physician population. The percentage of “truly independent” physicians has been declining by 2 percent annually and is projected to decline by 5 percent annually by 2013.³
- There is a growing movement, especially among young physicians, to choose the hospital employee model of practice. Increasing numbers of young physicians, burdened by medical school debts and seeking a regular work schedule, are deciding against opening private practices. Instead, they are accepting salaries at hospitals and health systems.⁴ The number of physicians who leave private practice to become hospital employees has increased from 22 percent to almost 50 percent in the last five years. According to 2010 data released by the Medical Group Management Association (MGMA), 65 percent of established physicians and 49 percent of those finishing residencies landed positions in hospital-based practices in 2009.⁵

Membership

To gain a better understanding of large group practice needs, a series of in-depth group practice interviews were conducted in December 2011 with groups ranging from 40 to 3,900 physicians, and key areas for further study have been identified. These interviews provide significant information regarding members' expectations of the AMA. The information collected provides the AMA with a better understanding of member expectations and provides guidance for offering services, tools, materials, and other products that align with those expectations.

Private Sector Advocacy

Continuing its commitment to provide physicians with expert resources, Private Sector Advocacy (PSA) has developed a “how-to” manual for physicians as they navigate health reform to help physicians evaluate, negotiate, and manage budget-based payment systems that are becoming alternatives to the predominant fee-for-service model for reimbursing physicians. *Evaluating and Negotiating Emerging Options* is available free to all physicians on the AMA's newly updated Practice Management Center website. Visit www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf. PSA is committed to the identification of emerging practice environments coupled with educational tools on emerging practice environments.

Finally, PSA has engaged in discussions with the Oregon State Medical Association on the development of a report card focused on employed physicians. The report card would, among other things, focus on working conditions, benefits and how integral employed physicians are to the organizations decision making process. The Advocacy Resource Center provides a coordinated effort related to state legislative and regulatory issues; they develop information resources and tools to keep members aware of state specific issues, such as a real-time legislative tracking, and state advocacy campaign toolkits, which are available at www.ama-assn.org/ama/pub/advocacy/centers-engaged-advocacy/advocacy-resource-center.

Health Information Technology Initiatives

The AMA Health Information Technology Initiatives (HIT) and Advocacy collaborated on several tools and information resources developed to assist physicians in understanding the ever-changing regulatory environment. These resources include summaries of current health IT related regulations, FAQs, and webinars. The AMA has crossed-branded health IT tip sheets and with state societies such as Connecticut. During the webinars the AMA has often surveyed the attendees to find out how AMA can improve our outreach methods.

In addition AMA HIT has education related online tools such as the CME online learning modules. This particular program provides information to physicians and practice staff on methodologies for successful adoption of health information technology solutions. The methodologies are presented in a series of 6 short video modules. The target audience for this program is physicians and practice staff in small practices faced with decisions regarding health IT.

Additionally, HIT conducted two physician surveys to better understand concerns and issues related to the Medicare/Medicaid EHR Incentive Programs as well as physician understanding of Health Information Exchanges (HIE). The EHR survey results indicated that physicians had a strong concern related to implementing EHRs and the

potential impact on their workflows. In response, HIT developed online workflow tutorials. These tutorials provide information to physicians about the link between workflow redesign and effective use of health IT. Utilizing these tutorials, practices can proceed with greater confidence and develop the skill set to prepare for integrating technology to transform care delivery and ultimately improve health outcomes. The HIE survey results indicated a need for additional information directed at physicians on HIE's. In response, the AMA added specific information related to HIE's on FAQ documents and health IT glossary.

AMA Organized Medical Staff Section

The Organized Medical Staff Section (OMSS) has developed a range of products and services to help physicians understand and manage employment and contractual relationships with hospitals, health systems, and other similar entities.

Annotated Model Physician Employment Agreements. The Annotated Model Physician-Hospital Employment Agreement addresses the specific needs of physicians who are preparing to negotiate employment contracts with hospitals or related entities. The Annotated Model Physician-Group Practice Employment Agreement addresses the needs of physicians who are preparing to negotiate employment contracts with established medical groups or group practices. These annotated model employment agreements provide a thorough description of basic contract terms typically found in such employment agreements, as well as in-depth explanations of the significance of such provisions and language that benefits the physician employee. In addition, these resources offer important examples of language that may be problematic to the physician employee.

Assistance for Physicians Navigating Relationships with Hospitals and Health Systems. As directed by AMA Policy D-215.990, the AMA provides assistance to individual physicians in matters pertaining to their employment and contractual relationships with hospitals, health systems, and similar entities. This member service, which is operated by the OMSS and the Office of the General Counsel, answers physician questions and provides advice on a range of physician-hospital/health system issues such as contracting, credentialing, peer review, due process, medical staff self governance, and more.

Principles for Physician Employment. As directed by AMA Policy D-215.990, the AMA through the OMSS is developing "Principles for Physician Employment" that address the relationships between and among employed physicians, hospitals, integrated delivery systems, and hospital medical staffs. It will provide a helpful cross-reference to the Annotated Model Physician-Hospital Employment Agreement.

While the AMA's annotated employment agreements are not substitutes for legal advice from qualified, health care counsel experienced in representing physician clients, they do provide a thorough description of basic contract terms typically found in such employment agreements, as well as in-depth explanations of the significance of such provisions and language that benefit the physician employee. In addition, these resources offer important examples of language that may be problematic to the physician employee.

Further, the AMA has established 2012 objectives specifically focused on the development and piloting of tools and resources to enable physician-led innovation in the area of delivery reform.

2012 STRATEGIC PLAN

With regard to the Policy D-620.992(2) various sections within the AMA are tasked with education and outreach related to changes in federal laws and regulations related to safeguarding physicians and their development of new business models. Such activity is reflected in the AMA Advocacy 2012 objectives specifically focused on achieving legislative and regulatory advances federally and in the states to promote physician-led innovation in health reform, and the newly formed AMA issue team on physician-led delivery innovation has focused on this as one of its three major objectives. AMA already has been very effective in influencing federal Medicare Accountable Care Organizations (ACO) rules and the removal of antitrust and fraud and abuse legal barriers with regard to ACO formation. Specifically:

- AMA advocacy led to the FTC and DOJ issuing a Joint Statement on Antitrust Enforcement and ACOs that incorporates many AMA recommendations, including Rule of Reason analysis for Medicare ACOs that want to jointly contract with private payers and a safety zone for ACOs that fall under a thirty percent market share

threshold. The Final FTC-DOJ Statement also included two important changes that the AMA had urged: 1) elimination of mandatory antitrust review of potential ACOs resulting in significant removal of burden and cost on potential ACOs; and 2) the statement applies to ALL collaborations among otherwise independent providers seeking to be a Medicare ACO. The draft statement had applied only to “newly formed” entities, defined as formed after March 23, 2010. This would have placed all collaborations that existed prior to March 23, 2010 under a separate antitrust review system for purposes of the Medicare ACO program. Newly formed entities may still seek a 90 day expedited, voluntary review.

- AMA advocacy led the United States Department of Health and Human Services (HHS) Office of Inspector General and Center for Medicare & Medicaid Services (CMS) to jointly issue waivers of certain self-referral, anti-kickback and gain sharing civil monetary penalties for ACOs. Further, in response to AMA comments, the final ACO rule included anti-kickback waivers that apply to the period of time when the organization is planning and putting together the ACO, and a waiver for what is called “beneficiary inducement” so that if an ACO provides extra benefits to patients like care coordination, that will clearly be legal. In direct response to AMA comments, the gain sharing and anti-kickback rule is an “interim” final rule so they can continue to refine these policies.

AMA-developed Material Available to Support MPEA Grassroots Advocacy

The AMA has launched a grassroots initiative to generate public support for Congressional passage of H.R. 1700 and S. 1042, the Medicare Patient Empowerment Act (MPEA), introduced by Rep. Tom Price (R-GA) and Sen. Lisa Murkowski (R-AK). This legislation, based on policy developed by the AMA House of Delegates, will create a new Medicare option to allow patients and physicians to enter into private contract arrangements without penalties for either party. The grassroots effort is focused on securing House and Senate co-sponsors for the bills, and assistance is being sought from Federation groups and individual physicians.

A range of resource material has been developed to support this work, including:

- An educational slide deck, with script, for physician audiences that can be personalized by the presenter.
- A physician-focused Frequently Asked Questions document.
- An educational slide deck, with script, for patient audiences that can be personalized by the presenter.
- A patient-focused Frequently Asked Questions document.
- A short educational video for patients.
- A downloadable patient flyer for physician offices.
- A web-based petition for patients and physicians, which provides access to educational material and enables patients to send email directly to their legislators. This can be accessed through a dedicated micro site at www.MyMedicare-MyChoice.org.

The resource material is available through the AMA website at www.ama-assn.org/go/privatecontracting. A patient brochure for distribution in physician offices is also being finalized. Copies will be available later this month, free of charge, in batches of 50 for physicians who order them through the My Medicare-My Choice microsite.

REFERENCES

1. “Pathways for Physician Success Under Healthcare Payment and Delivery Reforms, Harold D. Miller, June, 2010, www.ama-assn.org/resources/doc/washington/x-ama/payment-pathways.pdf.
2. Health Care Trends report, AMA Council on Long Range Planning and Development (CLRPD) www.ama-assn.org/go/healthcaretrends.
3. Health Care Trends report, AMA Council on Long Range Planning and Development (CLRPD) www.ama-assn.org/go/healthcaretrends.
4. Health Care Trends report, AMA Council on Long Range Planning and Development (CLRPD) www.ama-assn.org/go/healthcaretrends.
5. Health Care Trends report, AMA Council on Long Range Planning and Development (CLRPD) www.ama-assn.org/go/healthcaretrends.

11. DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of [Reference Committee F](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [G-600.021](#)

At the American Medical Association's (AMA) 2007 Annual Meeting, the recommendations in the Board of Trustees (BOT) Report 17-A-07 were adopted as amended and established a mechanism by which specialty society representation in the House of Delegates (HOD) would be determined from 2008 through 2012. BOT Report 17-A-07 also directed the preparation of annual reports, "describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations and recommending changes in strategies that be required to implement existing policy on representation of specialty societies." This report describes activities during 2011, provides the latest information on the level of designations, and recommends continuing the current system.

BACKGROUND

While it is a straightforward proposition to count the AMA members in a state using data on dues payments or members' addresses, enumerating individual members in specialty societies is considerably more difficult, because common data elements (other than name) in membership files of the AMA and most specialty societies are limited, which makes matching a complicated and time consuming process. In addition, an individual can belong to multiple specialty societies. Thus, when proportional representation for specialty societies was adopted in 1996, AMA members were to select, using a ballot, a specialty society to represent their interests in the HOD.

The number of delegates to which a specialty society is entitled depends on the number of AMA members who have designated that society for representation, but the designation (i.e., balloting) process has never functioned as well as planned; the proportion of AMA members who have designated any specialty society for representation has held steady at around thirty eight percent (38%). Using an extrapolation process described in BOT Report 17-A-07, the number of designations each specialty society has obtained will be adjusted annually through 2012 based on targeted levels of participation by AMA members. In BOT Report 17-A-07 the Board anticipated that by 2012 at least 80% of eligible AMA members would have designated a specialty society for representation. (Eligible members are those beyond their third year of medical school.)

RECENT ACTIVITIES

The primary focus to increase ballots cast has been on improving the online application, but the paper ballot continues to be used. Members continue to be encouraged through a variety of AMA publications, including *Morning Rounds*, *AMA Wire* and *AMNews*, to visit the ballot website and make their designation. All specialties were encouraged to use both electronic communications and their websites to promote the ballot to their members. The paper ballot continues to be included in the AMA Welcome Kits sent to all new and renewing members and ballots continued to be distributed at specialty society meetings where the AMA membership staff hosted "meet and greet events."

The most effective way to increase designations is through the specialty societies and their direct encouragement of their members to ballot while providing them with instructions and electronic links. The specialty society can more clearly articulate what it means to the society to increase the number of delegates that they are entitled to, while the AMA can merely point to the "generic" value of increased representation across specialties.

In December 2006, 76,588 ballots had been cast out of a possible 198,780 eligible to cast a ballot, meaning thirty-eight percent (38%) of eligible members had cast a ballot. Five years later, at the end of 2011, 63,407 ballots had been cast out of a possible 165,444, still only thirty-eight percent (38%) of those eligible. Despite strong efforts and a steady flow of ballots coming into the AMA, the numbers have failed to move and suggest that it may be time to examine the current system.

RECOMMENDATION

The Board of Trustees recommends that the current ballot system remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

12. THIRD PARTY PAYER QUANTITY LIMITS

Reference committee hearing: see report of [Reference Committee A](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
WITH TITLE CHANGE
IN LIEU OF RESOLUTION 113 AND
REMAINDER OF REPORT FILED**

See Policy [H-185.942](#)

INTRODUCTION

At the 2011 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-120.954 (AMA Policy Database), which asked our AMA to study the issue of insurers and pharmacy benefit managers (PBMs) interfering with dispensing medically appropriate quantities of formulary medications. This report outlines the various reasons that PBMs institute quantity limits for medications, the challenges that arise for physicians and patients as a result of these limits, and recommendations on this issue based on existing AMA policy.

BACKGROUND

Many, if not all, PBMs and other payers institute prescription drug quantity limits that dictate the number of dosage units of a particular drug product that will be covered by the plan for a specific period of time (typically 30 or 90 days). Quantity limits are usually based on the drug dose approved by the Food and Drug Administration (FDA), as listed in the product's prescribing information. If a patient attempts to refill a prescription too soon, or if physicians prescribe a dose higher than allowed by the payer, the drug claim will be rejected by the payer's pharmacy system. The patient may choose to fill the prescription for only the covered amount of medication or pay out of pocket for the quantity of medication not covered by the payer.

Some PBMs/payers allow physicians to request approval for medication quantities that exceed the specified limits. The process is often similar to that used for pharmacy prior authorization; physicians must submit information to the payer that supports the patient's need for a higher quantity of the particular medication. Unfortunately, the systemic problems that currently riddle the pharmacy prior authorization process also apply to receiving approval for higher quantities of medications. The quantity limitation is often not known by the physician or the patient until the prescription is presented to the pharmacy and the PBM/payer sends the reject message to the pharmacy. When the physician is alerted to the problem, he or she must find out what information and/or form is needed to request approval for an increased quantity of medication and where to send the information. This cumbersome process adds to the many administrative burdens already facing physicians and, more importantly, delays patients receiving the correct dose of their prescribed medication. If the exception request is granted by the PBM/payer, patients will sometimes be charged an additional co-payment for the additional quantity of medication.

While this approval process can be frustrating for physicians and patients, even more troublesome are those PBMs/payers that do not provide the opportunity to request an exception to prescription quantity limits. In some states, payers argue that quantity limits are business decisions that are ineligible for further review or appeal. Such policies offer no method for physicians to contest a quantity limit, and patients are forced to go without the needed dosage of their medication or pay for the extra drug expense out of pocket.

RATIONALE FOR MEDICATION QUANTITY LIMITS

Prescription drug costs are one of the fastest growing components of overall national health care spending. US prescription expenses increased from \$40.3 billion in 1990 to \$234.1 billion in 2008.¹ As such, PBMs/payers are

increasingly using tools such as prior authorization, step therapy, and quantity limits to control drug expenditures. One study showed that use of quantity limits for atypical antipsychotics in Medicaid prescription drug programs rose from 3.3% of states in 1999 to 63.3% of states in 2008; a similar trend was seen for antidepressants for these same years, with an increase from 3.3% to 53.3%.²

Quantity limits are viewed by PBMs and other payers as an effective way to reduce prescription drug costs. For example, an evaluation of drug-specific monthly quantity limits for migraine-abortive therapies (triptans and dihydroergotamine nasal spray) showed a 26.1% reduction in overall per-patient-per-month medical costs for migraine care, with direct drug costs declining by 28.8%.³ At the same time, utilization and costs of out-patient and in-patient migraine-related medical services fell 40%, suggesting that other types of medical costs were not negatively impacted by the quantity limits. Another study showed similar results after implementation of a triptan quantity limit, with annual spending for this drug class being \$872,718 lower following the utilization control; medical claims remained constant after the quantity limit was instituted.⁴ These data are for triptan use and are not necessarily generalizable to other medication classes.

While cost may be the primary reason that PBMs/payers utilize pharmacy quantity limits in their programs, there are other reasons for these types of restrictions that may, in some cases, justify their use. Quantity limits may support safe medication use and help ensure that patients are receiving prescription drugs in the doses deemed safe and effective by the FDA. Prescribing medications in dosages greater than those approved by the FDA may in some cases place patients at risk for adverse drug events and/or serious toxicities, which may in turn raise medical liability issues for physicians. Additionally, with the ever-growing concerns regarding prescription drug abuse, quantity limits on medications such as narcotic analgesics and benzodiazepines may offer one possible way to address issues of drug addiction and misuse. However, it is often very difficult for drug companies to calculate the proper medication dosing for rapid metabolizers, treatment-resistant patients, and slow metabolizers. In treating these challenging patient populations, physicians typically have more specialized knowledge in pharmacology and are better qualified to make dosage decisions than PBM staff.

Quantity limits may also help guide the appropriate use of medications and suggest a more appropriate course of therapy for a specific patient. In some cases, using dosages of a medication that exceed a PBM's quantity limit may indicate that a patient's condition could be better managed by selection of another medication or an alternative therapy approach, rather than continuing to increase the dose of a medication that might not be adequately controlling a patient's condition. For example, a patient's need for triptan medication quantities that exceed a plan's limit could suggest that the patient would benefit from initiation of, or change in, prophylactic migraine medication.⁵ It could also suggest that the patient is not initiating therapy soon enough after the onset of migraine symptoms, and is therefore requiring more triptan doses to achieve sufficient pain relief. Excessive use of triptans can also lead to medication overuse headaches; quantity limits again can help ensure appropriate use of this class of medications and prevent patients from experiencing negative effects from the overuse of therapy.

IMPACT OF QUANTITY LIMITS ON PHYSICIANS AND PATIENTS

Quantity limits may play a role in ensuring the safe and effective use of medications, as well as encourage the responsible use of valuable health care resources. However, too often these restrictions interfere with a physician's ability to prescribe the most effective and appropriate medication to meet the needs of an individual patient. Quantity limits can have serious clinical implications for affected patients and can result in negative health outcomes.

Psychiatry is an excellent example of a medical specialty where quantity limits can have dire consequences for patients. Dose titration is often a complicated, difficult process in this field of medicine, and physicians need the flexibility to prescribe medications in the doses and combinations required to meet the very individual needs of a particular patient. When patients receiving care for mental health conditions cannot receive the prescribed doses of their medications, the likelihood that their therapy will be effective and remission achieved is of course greatly reduced. There can obviously be grave consequences for patients with depression, bipolar disorder, or schizophrenia not being able to immediately and easily access required medications. However, there can be even longer-term implications, as the inadequate results achieved with sub-therapeutic doses may discourage patient compliance with future regimens; in effect, patients may lose trust in the ability of medications to treat their conditions if they do not respond to therapy due to the suboptimal doses imposed by quantity limits.

Insulin prescribing provides another excellent example of the possibly dangerous effects of quantity limits. A patient may require 40 units of insulin daily to control her diabetes, meaning that she must receive 1.2 vials per 30-day period (and the pharmacy must dispense 2 insulin vials). However, the PBM may only authorize payment for one vial of insulin for a 30-day period. The patient will thus run out of insulin after 25 days and will have to pay an additional co-pay (or even the retail cost out of pocket) for the additional vial of insulin. If she cannot afford the cost of the additional vial, she may choose to cut back on her insulin dose throughout the month or simply stop using insulin for a few days. The health consequences for a patient with diabetes not receiving the dosage of insulin required to control her condition are obviously grave; the AMA has received anecdotal reports from physicians indicating that the A1C values of their patients have risen due to problems receiving adequate amounts of insulin. In the most extreme examples, patients with type 1 diabetes have been admitted to the hospital with diabetic ketoacidosis after stopping their insulin injections due to payer quantity limits.

Quantity limits also pose problems for physicians and patients when they are applied to medications that are dosed on an “as needed” basis. Arbitrary quantity limits may prevent optimal therapy with medications used as needed for acute conditions, such as triptan therapy for the treatment of acute migraine. PBMs/payers may set an arbitrary quantity limit of eight triptan doses per month for patients, assuming that patients on average will suffer four migraines per month and will need two doses per headache to achieve adequate pain relief. However, if a patient’s migraine headache frequency exceeds the payer’s expectation, he or she will be left without needed pharmacotherapy due to the quantity limit policy.

Finally, medication quantity limits may pose problems for all stakeholders in the equation—physicians, patients, and insurers—if they impede the optimal treatment of a particular patient and consequently result in an increase in overall health care costs. In the example above regarding insulin quantity limitations resulting in hospitalization for diabetic ketoacidosis, any health care costs saved on prescriptions would be far outweighed by inpatient care costs. Similarly, while limiting triptan therapy to eight doses monthly could reduce short-term prescription expenses, patients who run out of medication and visit the emergency room for acute migraine will obviously drive up overall health care costs. If medication quantity limits interfere with the ability of physicians to prescribe, and patients to receive, optimal pharmacotherapy, they can easily increase, rather than control, overall health care spending.

AMA POLICY

AMA policies relevant to the discussion of medication quantity limits include H-120.988 Patient Access to Treatments Prescribed by Their Physicians, H-110.990 Cost Sharing Arrangements for Prescription Drugs, and H-110.997 Cost of Prescription Drugs. As stated in H-120.988, the AMA strongly supports the autonomous clinical decision-making and prescribing authority of a physician and the obligation of third-party payers to cover a drug that represents safe and effective therapy, irrespective of drug labeling. As indicated in H-110.990 and H-110.997, the AMA believes that payers’ prescription drug programs should not unduly shift costs to patients, should support quality in care, should allow physicians the freedom to prescribe the most appropriate drugs for their patients, and should provide patients with adequate access to the medications needed to manage their medical conditions. Finally, D-125.997, Interference in the Practice of Medicine, directs the AMA to initiate action to bring a halt to the interference in medical practice by PBMs and others.

CONCLUSIONS

The AMA strongly objects to the interference in the patient-physician relationship by payers via various utilization control mechanisms, to include medication quantity limits. However, the AMA recognizes that PBMs/payers may continue to use quantity limits and other cost control tools to manage resource use. If payers use quantity limits in their prescription drug programs, an exceptions process must be in place to ensure that patients can access higher quantities of a drug if medically necessary. Any such process should place the minimum amount of burden upon physicians and their staff.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of this report be filed.

1. That our American Medical Association support the protection of the physician-patient relationship from interference by payers via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. That our AMA work with third party payers to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. That our AMA support interested state legislative efforts, federal action and develop model state legislation to ensure that third party payers that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
 - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants);
 - physicians can appeal adverse determinations regarding quantity limitations;
 - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's website;
 - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
 - physicians with specialized qualifications may not be subject to quantity limits;
 - payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
 - payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in nonurgent situations and one working day in urgent cases; and,
 - physicians or patients can submit any denied appeals to an independent review body for a final, binding decision.
4. That Policy D-120.954 be rescinded, having been accomplished by preparation of this report.

REFERENCES

1. Kaiser Family Foundation. Prescription Drug Trends. May 2010. Available at:<http://www.kff.org/rxdrugs/upload/3057-08.pdf>.
2. Vogt WB, Joyce G, Xia J, Dirani R, Wan G, Goldman DP. Medicaid cost control measures aimed at second-generation antipsychotics led to less use of all antipsychotics. *Health Aff (Millwood)*. 2011;30:2346-2354.
3. Hoffman L, Mayzell G, Pedan A, Farrell M, Gilbert T. Evaluation of a monthly coverage maximum (drug-specific quantity limit) on the 5-HT₁ agonists (triptans) and dihydroergotamine nasal spray. *J Managed Care Pharm*. 2003;9:335-345.
4. Dunn JD, Cannon HE. Effects of a polypharmacy edit and reduced quantity limits on the utilization of triptans and overall costs in an integrated health system. *Managed Care Interface*. 2006;19:46-51.
5. Silberstein SD, Dodick D, Kesslick J. Removing barriers to appropriate migraine treatment: formulary limitations and triptan package size. *Headache*. 2005;45:1250-1254.

13. NEED TO INCLUDE ASSESSMENT OF ECONOMIC IMPACT IN PRACTICE GUIDELINES (RESOLUTION 121-A-11)

Reference committee hearing: see report of [Reference Committee A](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 121-A-11 AND
REMAINDER OF REPORT FILED**
See Policy [D-410.993](#)

INTRODUCTION

At the 2011 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 121 to the Board of Trustees for the development of a report back to the House at the 2012 Annual Meeting. Introduced by the Maryland Delegation, the Resolution asks that:

Our AMA study the need to include an assessment of economic impact in practice guidelines and try to determine the fiscal impact of these changes on the overall cost of health care and whether changes in guidelines and diagnostic disorders should be accompanied by a fiscal impact statement.

Testimony on this resolution was mixed, with the concern raised by several speakers that adding an economic or cost component to developing practice guidelines would make an already difficult and complex process even more difficult and diminish the focus on patient safety and evidence-based medicine. Several speakers suggested that this resolution be referred so that all aspects of the issue could be thoroughly considered.

This report summarizes briefly the existing literature on assessing the economic impact of practice guidelines and the limitations of studying the impact of these changes on the overall cost of health care.

SUMMARY OF SELECTED STUDIES ASSESSING THE COST OF ADHERING TO NEWLY IMPLEMENTED PRACTICE GUIDELINES

The health care and clinical practice evaluation literature contains a number of studies assessing the costs of care for treating patients in adherence with newly implemented practice guidelines. These studies include the assessments of strategies to increase the implementation of physiotherapy clinical guidelines,¹ the impact of asthma guidelines on use of metered-dose bronchial inhalers,² the economic implications of changes in hand hygiene guidelines,³ cost reports on implementing National Institute for Health and Clinical Excellence (NICE) guidance in England for diagnosis and treatment of lung cancer,⁴ and the clinical diagnosis and management of tuberculosis.⁵

None of those studies, however, include an assessment of overall cost of health care or a fiscal impact statement. Several additional studies examine methodological issues in performing economic assessment of the implementation of guideline changes that shed some light on the analytical requirement for determining the fiscal impact of changes in guidelines and diagnostic disorders on the overall cost of health care. For example, Hoomans and co-authors performed a meta-analysis of 24 studies evaluating the economics of guideline implementation.⁶ The studies involved varying settings, targeted professionals, targeted behaviors, clinical guidelines, and implementation strategies. The authors' systematic review of these empirical studies in general found them lacking in methodological rigor. The authors found it difficult to determine the quality of study designs owing to poor reporting and flaws in methodology, in particular, failure to follow guidelines for evaluation design, data collection and data analysis. The authors conclude that there are gaps in economic methodology of guideline implementation evaluation.

In another study Hoomans and co-authors present a total net benefit approach to economic evaluation and illustrate how that approach can be used to inform decision making about guidelines and specific implementation strategies.⁷ The total net benefit approach incorporates consideration of the current (or future) use of guidelines or guideline recommendations, the cost of implementation and the scope of clinical practice. The authors present results from an assessment of implementing guidelines aimed at improving diabetes care in the U.K. that indicate the total net benefit of guideline use and value of implementation can vary substantially. Variation was driven by the clinical

intervention evaluated, the health system where the intervention is implemented and the specific implementation strategies.

LIMITATIONS FOR ASSESSING THE OVERALL COST OF HEALTH CARE

The results of these studies suggest that guideline implementation process and strategies are drivers of the cost impact of implementing new guidelines. Others have proposed that important contributors to the success and the cost of guideline implementation processes are the structures of national organization strategies, payer/health-plan organization strategies, purchaser strategies, and regional cooperative strategies.⁸ Quantifying the elements of these strategies for an economic impact assessment of guideline implementation on overall health care costs would be extremely challenging given the variation in interventions and organizational structures and strategies that may arise at the local and regional levels.⁹

Consequently, the evaluations of guideline changes on overall health care costs would require a different level of data and analysis than that used to analyze the direct cost of care for patients in the guideline target population for a specific guideline implementation effort. Given the pertinent literature for guideline development generally has little information on relevant costs or effects to include in evaluations, requiring an economic assessment would add significantly to the costs of guideline development. The availability of cost information aside, there is no widely accepted model or approach available to estimate these cost impacts, and significant gaps exist in the economic methodology of guideline implementation evaluation. Finally, the requirement would invariably slow down the already lamentably slow process of translating scientific understanding into practice and thereby hurt patients.

AMA POLICY

Policy H-155.998[2] (AMA Policy Database) advocates that physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 121-A-11, and that the remainder of this report be filed:

That our American Medical Association continue to monitor the methodological guidance, data collection, and data synthesis applied to evaluating the economic impact of implementing guidelines into clinical practice.

REFERENCES

1. Wees PJ, Jamtvedt G, Rebbeck T, de Bie RA, et al. Multifaceted strategies to increase the implementation of physiotherapy clinical guidelines: a systematic review. *Aus J Physiotherapy*. 2008;54:233-241.
2. Bailey R, Weingarten S, Lewis M, et al. Impact of clinical pathways and practice guidelines on management of acute exacerbations of bronchial asthma. *Chest*. 1998;118: 40S-46S.
3. Stone PW, Hasan S, Quiros D, et al. Effects of guideline implementation on costs of hand hygiene. *Nurs Econ*. 2007;25(5):279-284.
4. NICE. Lung cancer: the diagnosis and treatment of lung cancer (update): costing report, implementing NICE guidance, April 2011.
5. NICE. Tuberculosis: clinical diagnosis and management of tuberculosis, and measures of prevention and control: costing report, implementing NICE guidance in England, March 2006); and the treatment of depression NICE. Costing clinical guidelines: depression (England and Wales), November, 2004.
6. Hoomans T, Evers SM, Ament AJ, et al. The methodological quality of economic evaluations of guideline implementation into clinical practice: a systematic review of empiric studies. *Value Health*. 2007 Jul-Aug;10(4):305-16.
7. Hoomans T, Ament AJ, Evers SM, et al. Implementing guidelines into clinical practice: what is the value? *J Eval Clin Pract*. 2011 Aug;17(4):606-14.
8. Curry SJ. Organizational interventions to encourage guideline implementation. *Chest*. 2000;118:40S-46S.
9. Bailey R, Weingarten S, Lewis M, et al. Impact of clinical pathways and practice guidelines on management of acute exacerbations of bronchial asthma. *Chest*. 1998;118:40S-46S.

14. BEERS OR SIMILAR CRITERIA AND THIRD PARTY PAYER COMPLIANCE ACTIVITIES

Reference committee hearing: see report of [Reference Committee G](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

See Policy [H-185.940](#)

INTRODUCTION

At the 2011 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-185.987 (AMA Policy Database), asking the AMA to evaluate the problem of insurance industry efforts to limit access to medications based on Beers Criteria or similar criteria. Because, at the time of adoption, it was known that the American Geriatrics Society (AGS) was in the process of revising the Beers Criteria, the AMA was asked to report back to the House of Delegates upon the release of the revised criteria. The revised Beers Criteria were released in March 2012.

BACKGROUND ON THE BEERS CRITERIA AND OTHER SIMILAR LISTS

The Beers Criteria were first developed in 1991 by Mark Beers, MD, along with an expert panel, with the goal of addressing inappropriate drug prescribing in nursing homes. The original Beers Criteria identified drugs that may have had harmful side effects when taken by older adults. The Beers Criteria were first updated in 1997 and again in 2003, expanding its scope to include medications that were potentially inappropriate for all adults aged 65 and older.

Most recently, the AGS assembled the 2012 Beers Criteria Update Expert Panel (the Panel). The Panel consisted of experts in geriatrics and pharmacology and used an enhanced, evidence-based methodology to develop the 2012 updated Beers Criteria. The Panel divided the targeted medications into three categories: (1) medications that are potentially inappropriate for older adults because they either pose high risks of adverse effects or appear to have limited effectiveness in older patients and there are alternatives to these medications; (2) medications that are potentially inappropriate for older adults who have certain diseases or disorders because these drugs may exacerbate the specified health problems; and (3) medications to be used with caution in older adults. The AGS panel is also considering more frequent updates to the list to reflect continual changes in the prescription drug market.

There are other similar lists that have been developed to complement or replace the Beers Criteria. One such list is the Screening Tool of Older Persons Potentially Inappropriate Prescriptions (STOPP) criteria. The STOPP criteria address commonly encountered “potentially inappropriate medications” and are listed according to physiological systems. The Zhan list is another tool addressing medications in older adults. It was created in 2001 and also offers a compilation of potentially inappropriate medications. This list recognizes that some potentially inappropriate medications are necessary in certain clinical situations and is, therefore, more narrow than the Beers Criteria.

USES OF BEERS CRITERIA AND OTHER SIMILAR LISTS

Coverage Decisions

The Beers Criteria, and other similar evidence-based criteria, are regularly used as educational tools by physicians and other clinicians to inform their prescribing practices and help monitor prescription drug use in older patients. In this capacity, these lists serve as positive and effective tools for physicians.

However, the AMA is concerned that rather than the Beers Criteria being used as an educational tool for physicians, it may be used by payers to definitively determine drugs that should not be prescribed by physicians to older adults. For example, a payer may remove the identified drugs from its formulary or refuse to reimburse for these prescriptions when given to an older adult. In either scenario, the payer is intervening into the patient-physician relationship and failing to recognize that the prescribing physician should make a final determination regarding the appropriateness of a drug for a patient. Until recently, Medicare Part D employed such an inappropriate policy by excluding all benzodiazepines, a category of drugs that is considered potentially inappropriate for older adults under the Beers Criteria, from reimbursement.

These types of coverage and reimbursement restrictions are contrary to the goals of the AGS Panel that was charged with revising the list. The Panel states that the intentions of the criteria include “improving the selection of prescription drugs by clinicians and patients, evaluating patterns of drug use within populations, educating clinicians and patients on proper drug usage, and evaluating health-outcome, quality of care, cost, and utilization data.” The panel emphasizes that “the list is not meant to supersede clinical judgment or an individual patient’s values and needs.”

The Panel recognizes that there may be cases where the healthcare provider determines that a drug on the Beers list is the only reasonable alternative. The most commonly cited example of appropriate deviation from the Beers Criteria is when a patient is being provided end-of-life or palliative care. In such a situation, the benefits of providing an identified drug to an older patient may far outweigh the risks associated with prescribing it, and the drug should be available to the patient through his or her insurer.

Quality Measures

In addition to the Beers Criteria being used to determine coverage and reimbursement, the list, along with other similar lists, has also been used in the development of quality measures. For example, in 2007, NCQA developed a HEDIS quality measure, Drugs to Be Avoided in the Elderly, which is largely based on the Beers Criteria. Many health plans utilize this HEDIS measure and the Centers for Medicare and Medicaid Services (CMS) has also adopted the measure, including as part of its star ratings for Medicare Part D plans. The 2012 AGS panel supports the use of the criteria for the purposes of quality measurement development, but recommends that the proper use of any such quality measures be clearly defined and easily applied.

Although the development of quality measures with the Beers Criteria is an established practice, it is important that any such measure not be used punitively against physicians, given that it is often appropriate for physicians to deviate from the criteria. Problems can arise with these quality measures when payers develop policies or procedures to encourage adherence to the measures that may restrict the physician’s and patient’s individual decisions. For example, some health plans, including some Medicare Part D plans and combined Medicare Advantage and prescription drug plans, have considered formulary restrictions as a means of curtailing utilization of drugs excluded under the quality measures. Other payers have put in place onerous prior authorization procedures to manage the prescribing of potentially inappropriate medications under the quality measures.

The Panel appears to concur that neither the patient nor the physician should be harmed, penalized or excessively burdened by restrictions or procedures that payers put into place to adhere to quality measures based on the Beers list. The Panel states in its final report that “the criteria is not meant to be applied in a punitive manner....prescribing decisions are not always clear cut and clinicians must consider multiple factors.” The Panel also acknowledges the difficulties in the development of quality measures that would recognize the subgroups of individuals who should be exempt from the criteria and for whom only a specific criterion applies.

CONCLUSION

The Beers Criteria, and other similar lists, can be powerful tools in a physician’s clinical practice, and these types of evidence-based guidelines are effective in guiding physicians and other providers in making decisions about appropriate medications for older adults. However, it is imperative that these types of lists and/or criteria not be used by insurers, benefit managers, and other payers to make coverage determinations or penalize physicians that prescribe outside the criteria when appropriate.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and the remainder of the report filed:

1. That our American Medical Association (AMA) adopt policy discouraging health insurers, benefit managers, and other payers from using the Beers Criteria and other similar lists to definitively determine coverage and/or reimbursement, and inform health insurers and other payers of this policy.

2. That our AMA adopt policy clarifying that while it is appropriate for the Beers Criteria and appropriate use guidelines to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy.
3. That Policy D-185.987 be rescinded, having been accomplished by this report.

**15. REMOVING FINANCIAL BARRIERS TO LIVING ORGAN DONATION
(RESOLUTION 6-I-11)**

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 6-I-11 AND
REMAINDER OF REPORT FILED**

See Policy [H-370.965](#)

At the 2011 Interim Meeting, the House of Delegates (HOD) referred Resolution 6, which was introduced by the Resident and Fellow Section. Resolution 6, "Removing Financial Barriers to Living Organ Donation," asked that our American Medical Association (AMA) work with legislators to remove financial barriers to living organ donation to pass laws which include (1) provisions for expenses involved in the donation incurred by the organ donor; (2) providing access to health care coverage for any medical expense or disability related to the donation; (3) prohibiting employment discrimination on the basis of living donor status; and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage. While some testimony in support was presented before the Reference Committee on Amendments to Constitution and Bylaws, the majority of both virtual and onsite testimony was in favor of referral. The reference committee therefore recommended referral of Resolution 6, and the HOD concurred with this recommendation.

BACKGROUND

The number of patients who are candidates for organ transplants far exceeds the number of organs available. As of March 9, 2012, there were more than 113,000 waiting list candidates in the United States, according to the United Network for Organ Sharing (UNOS), but there were only 14,144 donors and 28,535 transplants in 2011.¹ Over the past two decades, the gap between the number of patients waiting for a transplant and the number receiving a transplant has continued to widen. Last year, over 7,000 candidates died waiting for an organ donor match.²

While most solid organ and tissue donations occur after the donor has died, some organs and tissues can be donated while the donor is alive. Living organ donation dates back to 1954, when a kidney from one twin was successfully transplanted into his identical brother. As a result of the growing need for organs for transplantation, living donation has increased as an alternative to cadaveric donation. Today, there are more than 6,000 living organ donors per year, with the majority donating kidneys, but living donors can also donate liver segments, lung lobes, and parts of other organs.³ The number of living organ donors has matched or exceeded the number of cadaveric donors since 2001, mostly through directed donations by family members, but some living donations take place between strangers.⁴

Living donors may incur considerable financial losses if they bear the expenses of travel, lodging, meals, lost wages, and the medical care associated with donation. The out-of-pocket costs associated with medical evaluations, testing, pre- and perioperative care, and travel have been estimated to range from \$550 to \$20,000, but the actual financial impact is difficult to fully ascertain.⁵ Lack of insurance is believed to be a deterrent to donation. In 2007, for example, 12-18 percent of living donors did not have health insurance at the time of donation.⁶ Other insurance issues, such as inadequate coverage for death and disability and risk for uninsurability or increased cost of insurance if loss of a vital organ is considered to be a pre-existing condition, are also often cited as disincentives to organ donation.⁷

Medical expenses incurred by a living organ donor, from evaluation and testing to the actual extraction of the organ, generally are considered part of the recipient's overall procedure and covered by the eventual organ recipient's insurance.⁸ The transplant center will charge a recipient's insurance an acquisition fee when he or she receives an

organ. The medical costs related to the donation procedure and required postoperative care are also covered by this fee. Medicare will pay the full cost of care for a kidney donor: section 1881 of the Social Security Act provides that “any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this title with respect to such donation.” Such benefits include evaluation, testing, hospital stay, and any medical or surgical complications.⁹

However, additional costs incurred as a result of unexpected complications or adverse long-term effects may not be covered by the recipient’s insurance. Despite the relatively low incidence of post-surgical complications for most living organ donors, health problems related to but following the actual donation are usually the donor’s responsibility. In addition, the cost of non-medical expenses involved with donation, such as travel, lodging, and lost wages are not covered by the recipient’s insurance, although these costs may be covered by the recipient.¹⁰ Living donors are typically responsible for any time lost from work, unless their employer is able to provide paid leave or allow the donor to use short-term disability. For example, federal employees may use up to seven days of paid leave each calendar year to donate bone marrow, and may use up to 30 days of paid leave each calendar year to serve as a living organ donor.¹¹ A number of states also allow state employees leave (paid and unpaid) for serving as a living organ donor or allow a leave of absence for private sector employees regarding organ donation.¹²

A number of public policy changes have been proposed to try to alleviate the organ shortage, including the use of financial incentives to encourage more living organ donation. However, such proposals must comply with the National Organ Transplant Act (NOTA), which prohibits the sale of human organs in the United States: “It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”¹³ However, NOTA expressly permits “reasonable payments associated with the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.”¹⁴

The Organ Donation Recovery and Improvement Act (ODRIA), enacted in 2004, established the authority and legislative parameters to provide reimbursement for travel and subsistence expenses incurred towards living organ donation for living organ donors with low incomes.¹⁵ Pursuant to ODRIA, the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) awarded a cooperative agreement to the Regents of the University of Michigan, which partnered with the American Society of Transplant Surgeons (ASTS) to establish the National Living Donor Assistance Center (NLDAC) to operate this program. The HRSA grant, renewed in 2010, is funded through August 31, 2014, and provides up to \$2 million annually for four years. The NLDAC is intended to provide reimbursement only in those circumstances when payment is not otherwise available. Accordingly, the program cannot provide reimbursement to a living organ donor for travel and other qualifying expenses if reimbursement is available from any state compensation program, an insurance policy, any federal or state health benefits program, an entity that provides health services on a prepaid basis, or the organ recipient. Program eligibility is based on recipient and donor household income, with priority given to donors and recipients with incomes below 300 percent of the federal poverty level. Preference is given to prospective living donors who are the most likely to not be able to cover their travel and qualified expenses. Qualifying expenses presently include only travel, lodging, and meals and incidental expenses incurred by the donor and/or his/her accompanying person(s) as part of: (1) Donor evaluation; and/or (2) hospitalization for the living donor surgical procedure; and/or (3) Medical or surgical follow-up, clinic visits, or hospitalization within two calendar years following the living donation procedure (or beyond the two-year period if exceptional circumstances exist). The total federal reimbursement for qualified expenses during the donation process for the donor and accompanying individuals cannot exceed \$6,000, although the average expense for travel and lodging has been around \$2,900. Since the program began, over 2,000 applications have been reviewed. In FY 2011, the program received on average 62.1 applications per month, with over 90 percent approved for funding; 95 percent of the applicants were kidney donors and 5 percent were liver donors.¹⁶

Private programs are also available that help to provide insurance to living donors. For example, the American Foundation for Donation & Transplantation (AFDT), an association of transplant-related professional organizations and one of the oldest transplant groups in the country, operates the Living Organ Donor Network (LODN) for living kidney donors. LODN collects data on living donors’ quality of life post-transplant, and offers life, disability, and health insurance as a safety net for complications which might result from being a living kidney donor. The coverage is underwritten by AIG Insurance.¹⁷

AMA POLICY

Our AMA has longstanding policy recognizing the need to increase organ donation, supporting public education and awareness campaigns on organ donation, and encouraging patients and their families to consider organ donation. For example, Policy H-370.971 recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care (AMA Policy Database). Policy H-370.977 calls on our AMA to develop model legislation to create provisions for organ donation within living wills and other health care advance directives, and encourages physicians to discuss advance directives and organ donation as a part of the ongoing physician-patient relationship. In addition, Policy H-370.981 directs our AMA to develop model legislation requiring individuals to declare their organ donor status when issued a driver's license or state identification, and for such information to be printed on the license or identification. AMA policy also supports educational materials for the medical community and the public to raise awareness about the need for organ donors, the importance of organ donation, and the exploration of methods to greatly increase organ donation (H-370.995, H-370.996, H-370.998, D-370.992, D-370.993, and D-370.997).

With respect to financial incentives for organ donation, our AMA supports modification of NOTA to rescind prohibition of "valuable consideration" for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out (D-370.987). Policy H-370.982, "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," states that physicians "should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them," and that physicians "should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means." Specifically related to living organ donation, AMA ethical policy states that "Living donors should not receive payment for any of their solid organs. However, donors should be treated fairly; reimbursement for travel, lodging, meals, lost wages, and the medical care associated with donation is ethically appropriate" (E-2.15).

DISCUSSION

Resolution 6 reflects the frustration felt by both the transplant patient and medical communities about the continuing shortage of organs available for transplantation. Even with steady increases in organ donation rates, primarily from living donors, the need for organs for transplantation continues to far outweigh availability. However, providing financial incentives for living donors has been controversial in the past: opponents argue such incentives can exploit lower income individuals and that human body parts should not be treated as commodities. Moreover, it can be argued that financial incentives undermine the altruistic and charitable motives underlying living organ donation. Another argument raised against removing financial barriers is concern over increasing medical costs (e.g., by requiring either the recipient's or the donor's insurance to cover medical expenses), and imposing unfunded mandates on employers with respect to paid leave and disability coverage.

Proponents of reimbursing living donation-related costs, including the National Kidney Foundation, NATCO (the organization for transplant professionals), and the American Society of Transplant Surgeons, argue that removing financial barriers is an equitable way to encourage charity and altruism. While removing financial barriers may not by itself end the organ shortage, it might help to reduce waiting times. One can argue that removing financial barriers by reimbursing donation-related expenses simply makes the donor "whole" again, at least with respect to objective criteria. An argument can also be made that, given the specific prohibition in US law on paying for organs but the recognition that reasonable payments related to the donation (e.g., travel, housing, and lost wages) are allowed, creative initiatives are necessary if any headway is to be made in increasing the supply of transplantable organs.

Pending federal legislation would help to remove financial disincentives to living organ donation through tax credits. The "Share Your Spare Act of 2011" (H.R. 2755), introduced by Representative Larry Kissell (D-NC), would amend the Internal Revenue Code to allow a nonrefundable, one-time tax credit for a donation of a qualified life-saving organ for transplantation by a living donor. The annual amount of the tax credit would be limited to \$10,000 of the unreimbursed costs and lost wages incurred by an organ donor in connection with an organ transplant. The bill also amends NOTA to provide that any such tax credit shall not be deemed "valuable consideration" for purposes of the ban against organ purchases.

Concerns about insurance discrimination toward living organ donors in terms of uninsurability due to pre-existing conditions or being charged higher premiums should be alleviated by AMA-supported health insurance market reforms included as part of the Patient Protection and Affordability Act (ACA). Beginning in 2014, the ACA prohibits denial of health insurance coverage for pre-existing conditions or discrimination in terms of premiums based on health status. The ACA will also help by expanding health insurance coverage to millions of individuals through private coverage and expanded eligibility for Medicaid.

CONCLUSION

In summary, support for reducing financial barriers with respect to expenses involved in the donation incurred by the organ donor, providing access to health care coverage for any medical expense related to the donation, and protecting organ donors against employment discrimination is consistent with our AMA ethical and health policies to encourage organ donation, as summarized above. Therefore, the Board of Trustees recommends adoption of the substance of Resolution 6-I-11, with a minor modification to make the resolution House of Delegates policy in lieu of a directive.

RECOMMENDATION

The Board of Trustees recommends that, in lieu of Resolution 6-I-11, our AMA adopt new policy to read as follows, and that the remainder of the report be filed:

Removing Financial Barriers to Living Organ Donation

It is the policy of the American Medical Association to support federal and state laws that remove financial barriers to living organ donation, such as: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing access to health care coverage for any medical expense related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage.

REFERENCES

1. United Network for Organ Sharing, <http://www.unos.org> (last visited March 12, 2012)
2. Organ Procurement and Transplantation Network, <http://optn.transplant.hrsa.gov> (visited March 11, 2012)
3. US Department of Health and Human Services, Health Resources and Services Administration, www.organdonor.gov/about/livedonation.html (last visited March 11, 2012).
4. UNOS website, <http://www.transplantliving.org>
5. Carey Business School paper prepared for American Society of Transplant Surgeons, "Living Kidney Donation in the U.S.," November 29, 2011, citing 2005 statistics (ASTS paper)
6. ASTS paper
7. ASTS paper; CEJA Report 5-A-05, Transplantation of Organs from Living Donors.
8. UNOS, <http://www.transplantliving.org>
9. 42 U.S.C. 1395rr(d)
10. UNOS, <http://www.transplantliving.org>
11. 5 U.S.C. 6327
12. http://www.kidney.org/transplantation/livingDonors/pdf/LDTaxDed_Leave.pdf
13. 42 U.S.C. 274e
14. 42 U.S.C. 274e(c)
15. 42 U.S.C. 274f
16. NLDAC Advisory Group Program Update slide deck, October 27, 2011, provided by ASTS.
17. www.seopf.org/lodn_info.htm

16. ENHANCING THE FUNCTION OF THE LIAISON COMMITTEE ON MEDICAL EDUCATION

Reference committee hearing: see report of [Reference Committee C](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [H-295.882](#)

BACKGROUND

The Liaison Committee on Medical Education (LCME) was formed in 1942 by the Council on Medical Education of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) for the purpose of accrediting programs of medical education that lead to the Medical Doctor (MD) degree in the United States and Canada. The LCME is recognized by the United States Department of Education (USDE) as an accrediting entity and follows the regulatory guidelines of the USDE. From the 1970s, the Council on Medical Education has had delegated responsibility for the LCME from the AMA House of Delegates. In 2003, based on a proposal to create a single office of the LCME, the House of Delegates adopted Policy H-295.882 (AMA Policy Database):

2. That any proposed changes in the role of the AMA in the organization or structure of the LCME should be considered matters of AMA policy.

LCME – Current Status and New Challenges

The creation of the LCME in 1942 was based on the mutual recognition of its sponsors of the need to have a single, strong medical education accreditation process for programs leading to the MD degree. Preceding the creation of the USDE by 37 years and recognized worldwide for its work as an accrediting body, the LCME has been sponsored for almost seventy years by informal agreement between the AMA and the AAMC (the sponsors). This sponsorship includes sharing the costs of supporting the LCME staff and LCME activities, including meetings, surveys, site visits, administrative functions, office space, and legal counsel.

While this relationship and system have worked well in the past, the current model has come under increased stress due to a number of factors. Issues related to governance, composition of the LCME, budgeting, operations, and communication are impacting the LCME's ability to keep pace with the increased accreditation demands in undergraduate medical education and medical schools.

Formation of the LCME Joint Task Force (Task Force)

The LCME Joint Task Force (Task Force) was convened by the AMA and the AAMC to explore a broad range of issues and strategies relevant to the current structure, function, and work processes of the LCME. The Task Force was established in early 2011 and included representatives from the AMA, the AAMC and the LCME. The Task Force was charged with:

Developing recommendations for optimizing the effectiveness and integrity of the LCME; and integrating a robust accreditation process through strong and deep connections with the medical practice and academic communities.

The Task Force accomplished its work through a series of meetings and conference calls of the full Task Force and subcommittees; interviews with the LCME Secretariat and legal counsel of the three organizations; interviews and correspondence with accrediting agencies of other health professions organizations; and consultation with special counsel retained by the AMA and the AAMC on the USDE regulations for accrediting agencies. A thorough review of the current governance, membership, and operations of the LCME was conducted. Final recommendations from the Task Force were completed for consideration by the AMA and the AAMC Boards in November 2011 and were endorsed in principle by both Boards. Senior management was charged with developing an implementation plan and memorandum of understanding (MOU) between the AMA, the AAMC and the LCME in order to operationalize the recommendations of the Task Force. The major recommendations of the Task Force are described below:

LCME TASK FORCE RECOMMENDATIONS

Relationship with Sponsoring Organizations

The organizational relationships among the AMA, the AAMC, and the LCME should be clarified through a formal agreement, such as a memorandum of understanding.

The LCME has existed as a joint effort between the AMA and the AAMC throughout its history without anything more formal in terms of an agreement or memorandum of understanding (MOU) than a “Statement of Cooperation” between the sponsors with respect to medical school accreditation. That this arrangement has effectively served the medical education community for so long is both a credit to the relationship between the sponsors and the efforts of the highly respected LCME Secretariat. To address some of the current and future issues facing the LCME, however, a formal agreement between the sponsors is needed. A MOU should be structured to formally recognize the respective roles, responsibilities, and authority of the sponsors and the LCME.

LCME Accreditation of Programs in Medical Education

Consistent with USDE guidelines and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree. In addition, the LCME should have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards. While final decisions on standards should rest with the LCME, the sponsors should have an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or amended standards proposed by the LCME via a defined process. This recommendation supports the importance of the peer review process for standards and, through peer review, the acceptance and inculcation of the standards by the peer institutions.

Create a “Council” to Facilitate Communication, Flexibility and Planning among the AMA, AAMC and LCME

The LCME is managed by two offices and two LCME Secretariats – one supported by the AMA and one by the AAMC. In 2003, consideration was given to forming a single consolidated LCME office. The AMA Council on Medical Education considered this issue and affirmed the desirability of the dual office format. The recommendations of the Council on Medical Education were incorporated into AMA Policy H-295.882, Proposed Consolidation of Liaison Committee on Medical Education. The recent LCME Task Force report affirms the desirability of the two-office system for the foreseeable future.

While the two LCME Secretaries and the respective offices have worked well together, the increasing workload of the LCME, including an increase in the number of medical schools, as well as increases in class size and the proliferation of branch campuses, has caused new challenges in keeping the LCME running smoothly. A mechanism to support collaborative decision-making would facilitate the process of working within the operational systems of the two sponsoring organizations.

The Task Force carefully re-examined the structure/governance and practices of the LCME. They established goals to guide any recommended changes, which included (i) enhancing communication among the LCME and its sponsors; (ii) establishing greater functional autonomy for the LCME, particularly in connection with accreditation standards; (iii) allowing the LCME to engage in more effective budget development, financial management, and strategic planning; (iv) ensuring diversity and quality in the composition of LCME membership; and (v) providing for strategic planning. The practices of other accrediting agencies surveyed provide some guidance for the LCME in this process.

The Task Force considered the option of a fully independent LCME incorporated separately from its sponsors as a mechanism to meet the goals above. The current governance structure, in which the LCME functions as a committee with joint AMA and AAMC sponsorship, however, is consistent with the organizational structure of many of the association-sponsored accrediting agencies reviewed. Most of these accrediting agencies are internal components (usually called councils or commissions) of the sponsoring associations, rather than separate/independently incorporated entities.

The Task Force recommended an intermediate approach to meeting the goals set forth above: to create a new council which would be placed organizationally between the LCME and its sponsors. The new council would receive and synthesize input from the AMA, the AAMC and the LCME and would become a vehicle for communication between these organizations. The function of the council would be to approve LCME policies (other than accreditation policies, standards, and decisions), business initiatives, and the proposed use of LCME resources. The council would also work with the sponsors to nominate new members to the LCME. The council will have no role in specific accreditation decisions or the setting of accreditation policy of the LCME.

The role and responsibilities of the LCME would remain focused on the policies and procedures for accrediting educational programs leading to the MD degree. The LCME would remain the entity that conducts primary reviews for all aspects of the medical school accreditation process, including but not limited to: reviews of undergraduate medical education programs; selections of survey teams; taking accreditation actions; and appeals of negative decisions. The LCME and its Secretariat would continue to hold responsibility for staffing, operations, and the work of accreditation, including establishing committee structures that enable the review and accreditation of undergraduate medical education programs.

The new council should facilitate budgetary and strategic planning for the LCME among the three organizational bodies (the two sponsors and the LCME itself). The LCME should propose its own budget, subject to review by the council, with final approval by the sponsors.

Composition and Size of the New Council

The new council will provide the sponsors with a consolidated structure to interact on their behalf with the LCME, while providing the LCME with a single entity for discussion and resolution of issues needing sponsor input. The members of the new council for each entity should be selected and appointed by each sponsor and by the LCME, through a mechanism that supports these goals. The new council should have nine members: three selected by the AAMC, three selected by the AMA, and three from the LCME (the chairs and the designees). Members appointed by the sponsors should have fixed terms, defined lengths of service and staggered starting dates to enhance continuity of the council membership. A senior executive leader from each of the AMA and the AAMC should be among those council members appointed by the sponsors as member liaisons.

Role of the AMA Council on Medical Education

The Council on Medical Education has historically and does currently play a significant role with respect to the consideration and review of proposed actions and function of the LCME. No other constituted body of the AMA serves this function. AMA Policy H-295.882 "Proposed Consolidation of Liaison Committee on Medical Education", provides in relevant part: "(2) [a]ny proposed changes in the role of the AMA in the organization or structure of the LCME should be considered matters of AMA policy." Given that the CME has been, and continues to be the primary body overseeing the activities, functions, and actions of the LCME for the AMA, it makes sense and is a natural progression that the CME would be the entity within the AMA to consider "any changes to the role of the AMA in the organization and structure of the AMA," and would make recommendations regarding such to the AMA Board of Trustees for final action.

SUMMARY AND RECOMMENDATIONS

In keeping with the historic precedent that the AMA House of Delegates assigns to the Council on Medical Education responsibility for oversight of the LCME, the Board of Trustees recommends that the following recommendations be adopted and that the remainder of this report be filed:

1. That our American Medical Association support a formal recognition of the organizational relationships among the AMA, the AAMC, and the LCME through a memorandum of understanding.
2. That, consistent with United States Department of Education regulations and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree.

3. That the LCME have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards, through a defined process that allows the sponsors an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or amended standards proposed by the LCME.
4. That a new entity be formed to support communications, flexibility and planning among the AMA, the AAMC and the LCME on medical school accreditation, with membership, authority and additional parameters to be defined within the new memorandum of understanding.
5. That AMA Council on Medical Education be the entity within the AMA to determine policy relating to the organization or structure of the LCME.
6. That AMA Policy H-295.882, "Proposed Consolidation of Liaison Committee on Medical Education" be modified to read as follows:
 - (1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education.
 - ~~(2) Any proposed changes in the role of the AMA in the organization or structure of the LCME should be considered matters of AMA policy.~~

**17. HOSPITAL ELECTRONIC MEDICAL RECORDS AND COMPUTERIZED
PHYSICIAN ORDER ENTRY PROBLEM
(RESOLUTION 711-A-11)**

Reference committee hearing: see report of [Reference Committee G](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 711-A-11 AND 721 AND
REMAINDER OF REPORT FILED**

See Policy [D-478.995](#)

At the 2011 Annual Meeting, Resolution 711-A-11, "Hospital Electronic Medical Records and Computerized Physician Order Entry Problem," was referred to the Board of Trustees (BOT) for a report back at the 2012 Annual Meeting. Introduced by the Oklahoma Delegation, Resolution 711-A-11 asks the American Medical Association (AMA) to: (1) encourage local, state, and federal regulatory agencies to slow the transition to Electronic Medical Records (EMR) and Computerized Physician Order Entry (CPOE) for all hospitals; (2) lobby for research to demonstrate the efficacy of EMR and CPOE in all elements of hospitalized patient care before requiring incentivizing implementation; and (3) lobby the federal government to place responsibility for the efficacy and effectiveness of EMR and CPOE systems and their implementation on healthcare vendors. Penalties currently focused on the provider community should be passed onto the vendors who are most responsible for delays and increased risk to patient safety that result from use of their systems.

BACKGROUND

In order to increase electronic health record (EHR) adoption rates, the US Congress included a provision in the American Recovery and Reinvestment Act of 2009, (ARRA: P.L. 111-5), which became law on February 17, 2009, that provides Medicare and Medicaid financial incentives for the adoption and meaningful use of certified EHRs by hospitals and physicians. The meaningful use program also includes financial penalties that are scheduled to begin in 2015 against hospitals and physicians who fail to meet EHR meaningful use measures. The Centers for Medicare and Medicaid Services (CMS) have indicated that there will be three stages under the meaningful use incentive program.

One of the EHR meaningful use measures that physicians are required to meet is the use of CPOE. CPOE entails the physician's use of computer assistance to directly enter orders (e.g., medication, laboratory) from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization. For Stage 1 of the EHR meaningful use incentive program, the use of CPOE for

medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines, is a required measure. In order to meet this measure, a physician must use CPOE for at least one medication order for more than 30 percent of all unique patients the physician treats during the applicable reporting period. The only physicians who are exempt from the CPOE requirement during Stage 1 are physicians who write fewer than 100 prescriptions during the applicable reporting period. CMS released the proposed measures for Stage 2 of the incentive program in February 2012. The proposed CPOE measure would require a physician to use CPOE for medication, laboratory, and radiology orders, and the threshold would increase from 30 to 60 percent. Resolution 711-A-11 asks the AMA to advocate for slowing the transition to EHR and CPOE use, calling for more research on these systems prior to the issuance of incentives, and holding vendors accountable for ensuring the efficacy, effectiveness, and safety of EHR and CPOE systems.

AMA POLICY

The AMA has extensive policy on health IT and EHRs. Policy D-478.995 (2 C) indicates that the AMA will advocate for continued research and physician education on EMR user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care. In addition, Policy H-405.971 indicates that the AMA supports the need for cooperation among all sectors of the health care industry to design, carry out, and analyze the results of scientifically rigorous studies to measure the benefits (in effectiveness and quality of care, and in efficiency and costs of its provision) and the costs (in time use, behavioral, and organizational change, as well as in monetary costs) of physician use of computers in all health care settings. Policy D-478.996 indicates that the AMA will continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. Policy D-478.994 further highlights that the AMA will support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); and support initiatives to ensure interoperability among all HIT systems.

AMA ADVOCACY EFFORTS

AMA's extensive policy on health IT and EHRs has provided a strong basis for AMA's advocacy efforts. In January 2010, CMS proposed measures that physicians have to meet in order to receive incentives under Stage 1 of the EHR meaningful use incentive program. On March 15, 2010, the AMA issued extensive comments on the proposed Stage 1 measures, including the proposed required measure on CPOE. Ninety-five state and specialty medical societies signed onto AMA's comment letter. The AMA recommended a number of key improvements including significant modifications to the CPOE requirement for Stage 1. As a result of AMA's advocacy efforts to improve the Stage 1 measures, CMS' final rule on Stage 1 of the meaningful use program included significant modifications to the CPOE measure. Due to AMA's advocacy efforts, CMS reduced the threshold requirement for CPOE from 80 to 30 percent and removed the requirement that CPOE be performed on all orders and just required CPOE on one order—medication orders.

On April 21, 2011, the AMA submitted a statement to the Health IT Policy Advisory Committee on issues relevant to the usability of EHRs. The AMA recommended that EHR vendors be held responsible to ensure that the systems they develop are able to meet the clinical and administrative needs of EHR users. In addition, vendors should be required to establish a formal reporting process that specifically addresses patient safety issues and reporting of potential events associated with use of EHR products, and that the Office of the National Coordinator (ONC) should track patient safety issues raised to vendors on a nationwide basis through reporting processes. The AMA further recommended that the information gained from these processes should then be used both within and outside the certification process to improve patient safety and the usability of EHRs. The AMA also called for a careful study and the monitoring of the effects of health IT on patient safety as well as other important outcomes. Along with identifying EHR usability challenges, the AMA also addressed the fact that physicians are facing potential new liabilities with the increased use of EHRs, and recommended that the Certification and Adoption Workgroup of the Health IT Policy Advisory Committee further explore liabilities associated with the use of EHRs and recommend solutions for minimizing legal risks.

On June 29, 2011, the AMA solicited input from specialty medical societies and shared the results of the survey with the Department of Health and Human Services (HHS), CMS, ONC, and the Health IT Policy Advisory Committee on the challenges a number of physician specialists faced in meeting the Stage 1 meaningful use measures, including

challenges associated with the Stage 1 CPOE measure and the Policy Committee's proposed CPOE measure for Stage 2. On March 1, 2012, the AMA issued comments to the ONC and the Agency for Healthcare Research and Quality (AHRQ) indicating the AMA's commitment to work collaboratively with ONC, AHRQ, and other respective stakeholders to increase our understanding of safety risks associated with health IT and use this knowledge to improve the safe design, implementation, and use of health IT systems.

AMA leadership and staff have met on a regular basis with policymakers to ensure that adequate flexibility is built into the EHR meaningful use incentive program to accommodate all specialists and their varying practice patterns and patient populations and that the EHR measures are reasonable and achievable and can improve the quality, safety, and efficiency of health care. The AMA has been a strong advocate for ensuring that health IT systems are available for rural physicians. Physicians in rural communities face several barriers to implementing health IT systems including lack of: broadband internet access; access to IT personnel; and financial resources to help defray the EHR adoption and implementation costs. Resources are available today for rural physicians. Regional Extension Centers are organizations that have been established across the country including rural areas to assist health care providers, including physicians, with the selection and implementation of EHR technology. In addition, the Health Resources and Services Administration's Office of Rural Health Policy is available to help rural physicians with implementing EHRs into their practices. The AMA also has resources available to aid physicians throughout the country with their questions on EHR products.

DISCUSSION

Resolution 711-A-11 asks the AMA to advocate for slowing the transition to EHR and CPOE use, calling for more research on these systems prior to the issuance of incentives, and holding vendors accountable for ensuring the efficacy, effectiveness, and safety of EHR and CPOE systems. Recent surveys on EHR adoption rates and CPOE use reflect challenges that hospitals and physicians are facing as they transition to EHR and CPOE systems. A November 2010 survey by the College of Healthcare Information Management Executives (CHIME) found that 15 percent of CHIME's 191 members believed that their hospitals would have everything in place during the first six months of fiscal year 2011 in order to successfully participate in the EHR meaningful use incentive program.¹ The CHIME survey results also indicated that 62 percent of respondents anticipated challenges with the implementation of CPOE meaningful use measure.² According to the survey, the greatest barrier to CPOE use identified by over half of the Chief Information Officer (CIO) participants is actually getting health care providers to enter orders into the hospital's CPOE system.³

While EHR adoption and use rates are increasing, the rate of adoption varies across the country. A 2011 National Ambulatory Medical Care Survey, conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics indicated that between 2010 and 2011, the percentage of physicians who reported having systems meeting the criteria for a basic EHR system increased by 36 percent.⁴ Adoption of EHR systems varied greatly by state. For example, in 2011, the percentage of physicians using any EHR system ranged from 40 percent in Louisiana to 84 percent in North Dakota.⁵ Compared with the national average, three states had a significantly lower percentage of office-based physicians using an EHR system, and eleven states had a significantly higher percentage.⁶ The percentage of physicians having a system that met the criteria for a basic system ranged from 16 percent in New Jersey to 61 percent in Minnesota.⁷ Compared with the national average, five states had a significantly lower percentage of office-based physicians with a basic system, and eight states had a significantly higher percentage.⁸ CMS' January 2012 meaningful use incentive program report indicated that 20,912 eligible physicians, and 712 eligible hospitals and critical access hospitals (CAHs) received Medicare EHR meaningful use incentives through January 2012.⁹

Surveys have also been performed on health IT and patient safety that reflect the need for additional research on the safety risks of health IT and EHR systems. "Research in Ambulatory Patient Safety 2000-2010: A 10-year review" provides an analysis of patient safety in hospitals. The report's findings indicate that major gaps continue to exist regarding patient safety and there are almost no credible studies showing how to make improvements.¹⁰ The report also provides a number of recommendations, including the need to further research the role of information technology to improve ambulatory patient safety, including CPOE and EHR systems, and that these technologies should be evaluated within the larger contexts where they are implemented.¹¹

A 2011 Institute of Medicine (IOM) report that was commissioned by ONC also recommends the need for greater oversight related to the safety of health IT. Although the IOM report supports the use of health IT and the potential

long-term positive impact of health IT use, the report indicates that there is “little published evidence to quantify the magnitude of the risk.”¹² Key recommendations in the IOM report include the need for more research on the impact of health IT on patient safety, the development of a new Health IT Safety Council to evaluate criteria for assessing and monitoring the safe use of health IT, a required registration process for health IT vendors along with quality and risk management requirements that health IT vendors must adopt, and the creation of a mechanism for health IT vendors and users to report patient safety events related to health IT.¹³

The Board of Trustees believes that the results and recommendations of these recent health IT surveys and reports are consistent with AMA policy and advocacy efforts in that they identify increased adoption and use of EHRs by hospitals and physicians and the importance of incentives to minimize the financial burden to physician practices of adopting and maintaining EHRs. The Board of Trustees believes that the trends show an increased level of EHR adoption by physicians and hospitals and the important role that incentives play in increasing adoption rates. Therefore, slowing this adoption trend and not providing incentives for EHR and CPOE use, which is what Resolution 711-A-11 is calling for, is not advisable and highly unlikely given that the above-mentioned survey and report findings reflect the continued rise of EHR adoption rates. AMA policy and advocacy efforts also support continued research on EHR and CPOE systems to identify barriers to and solutions for physician EHR use and physician participation in the meaningful use incentive program. The AMA will continue with efforts to ensure that EHR and CPOE systems support the evolving payment and delivery structures expected under health care reform, physician practice workflow, clinical decision-making, and enhance processes aimed to improve health outcomes. The Board of Trustees also agrees with the above-mentioned survey and reports findings that further research is needed to increase our understanding of safety risks associated with health IT to enable solutions to improve the safe design, implementation, and use of health IT systems. In addition, the Board of Trustees agrees that vendors of EHR and CPOE systems should be accountable for ensuring the efficacy, effectiveness, and safety of their systems. The Board of Trustees believes that existing AMA policy should be modified to support AMA advocacy efforts on calling for more research on EHR and CPOE systems and for vendor accountability.

RECOMMENDATIONS

The Board of Trustees recommends that, in lieu of Resolution 711-A-11, our AMA amend Policy D-478.995 by insertion and deletion and addition of a new clause 2(d) to read as follows, and that the remainder of the report be filed:

D-478.995 National Health Information Technology

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (a) advocates for standardization of key elements of EMR electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (b) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (c) advocates for continued research and physician education on EMR EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (d) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

REFERENCES

1. College of Healthcare Information Management Executives survey on readiness for meaningful use, November 2010 (www.cio-chime.org/chime/press/surveys/pdf/chime_mu2_survey_report.pdf).
2. Id.
3. Id.
4. Hsiao CJ, Hing E, Socey TC, Cai B. *Electronic Health Record Systems and Intent to Apply for Meaningful Use Incentives Among Office-based Physician Practices: United States, 2001–2011*. Health E-Stats. National Center for Health Statistics. 2010. Available at: <http://www.cdc.gov/nchs/data/databriefs/DB79.pdf>.
5. Id.
6. Id.
7. Id.
8. Id.
9. http://www.cms.gov/EHRIncentivePrograms/Downloads/Monthly_Payment_Registration_Report_Updated.pdf.

10. Lorincz CY, Drazen E, Sokol, PE, Neerukanda KV, Metzger J, Toepp MC, Maul L, Classen DC, Wynia MK. *Research in Ambulatory Patient Safety 2000-2010: A 10-Year Review*. American Medical Association, Chicago, IL 2011. Available at: www.ama-assn.org/go/patientsafety.
11. Id.
12. Institute of Medicine (IOM). 2012. *Health IT and Patient Safety: Building Safer Systems for Better Care*. Washington, DC. The National Academies Press.
13. Id.

**18. PHYSICIAN PROTECTION FROM RISK WITH ACCOUNTABLE
CARE ORGANIZATIONS (ACOs)
(RESOLUTION 123-A-11)**

Reference committee hearing: see report of [Reference Committee B](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 123-A-11 AND
REMAINDER OF REPORT FILED**
See Policy [D-385.963](#)

At the 2011 Annual Meeting, Resolution 123-A-11, “Physician Protection from Risk with Accountable Care Organizations (ACOs),” was referred to the Board of Trustees (BOT) for a report back at the 2012 Annual Meeting. Introduced by the New Jersey Delegation, Resolution 123-A-11 asks the American Medical Association (AMA) to: seek federal legislation to establish a legal framework that indemnifies physicians from medical malpractice for participation in Accountable Care Organization (ACO) work from day one; and work with the Centers for Medicare & Medicaid Services (CMS) to absolve individual physicians from financial risk in ACOs to the extent possible.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA), which became law on March 23, 2010, establishes several demonstration programs to test and evaluate new Medicare health care delivery and payment models. This is in an effort to improve care coordination and quality while reducing the rate of spending growth. These models include ACOs. The Medicare ACO program is a voluntary, three-year program to further develop the ACO model of health care delivery reform. To qualify, an ACO must agree to be accountable for the quality, cost, and overall care for the Medicare fee-for-service beneficiaries assigned to it. An ACO must have at least 5,000 assigned Medicare beneficiaries and have in place, among other things, the following: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments will continue to be made to physicians and other ACO participants under the usual Medicare payment structure (e.g., the Medicare fee schedule). Additionally, ACOs would share among their provider participants a portion of any savings achieved in excess of a threshold benchmark. Resolution 123-A-11 asks the AMA to seek federal legislative and regulatory action to protect physicians from legal and financial liabilities and risks that could arise from their participation in an ACO.

AMA POLICY

The AMA has extensive policy on ACOs. Policy H-160.915 outlines detailed principles for ACOs. In addition, Policy D-385.963 (1) indicates that the AMA will provide physician members with access to legal, financial, and ethical information, tools, and other resources to enable physicians to play a meaningful role in systems like ACOs. Policy D-385.963 (2) indicates that the AMA will advise physicians so that they can make informed decisions prior to starting, joining, or affiliating with an ACO, including legal and financial advice. Policy D-385.963 (3) indicates that the AMA will develop a toolkit to aid physicians in making decisions about starting, operating, and participating in ACOs. The AMA also has extensive policy on liability protections for physicians. Policy H-435.978 indicates that the AMA will advocate for comprehensive medical liability reforms, including caps on non-economic damages, that do not undermine state liability reforms. Policy D-435.974 indicates that the AMA will press for effective liability reform as part of federal health system reform, including support for traditional comprehensive reforms and the testing of alternative reform models.

AMA ADVOCACY EFFORTS

The ACO principles outlined in Policy H-160.915 along with AMA's commitment to aid physicians in their decision-making efforts to start, operate, and/or participate in ACOs specified in Policy D-385.963 have provided a strong basis for AMA advocacy efforts. On March 31, 2011, the Obama Administration released proposed regulations to implement the ACO program. The AMA issued extensive comments in June 2011, on the proposed rule and urged the CMS to make significant changes to the proposed rule to allow all interested physicians to lead and participate in ACOs. The AMA offered constructive changes to the proposed ACO rule to enable physicians to participate in a well-developed ACO model that can be an effective tool to improve quality, manage care coordination, reduce health care costs, and create a supportive environment for practicing physicians. One specific recommendation was for CMS to provide a payment option that includes shared savings only ("one-sided risk") without the mandatory shared loss provision. This option would allow ACOs to receive shared savings, without the down-side risk, which would not only encourage participation by a greater variety of physician practices but would minimize financial risk to the ACO and to the ACO's participating physicians. On October 20, 2011, CMS issued the final rule on the ACO program, which incorporated numerous improvements many of which were a direct result of AMA's significant advocacy efforts, including CMS' decision to allow ACOs the option to receive shared savings without having to share in the losses. CMS also responded positively to comments from the AMA of the importance of an advance payment program and established one to assist physicians with the ability to obtain and recoup the start-up and first-year operating costs needed to successfully participate in an ACO. It is also important to note that there will be ACOs formed in the private sector and Medicaid ACOs.

The AMA has also pursued an aggressive federal and state advocacy campaign to bring about meaningful liability protections for physicians. The AMA has called on federal lawmakers to pass H.R. 5, the "Help Efficient, Accessible, Low-cost Timely Health Care (HEALTH) Act," which includes comprehensive liability reforms similar to those enacted in California and Texas. The HEALTH Act provides the right balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting non-economic damages to a quarter million dollars. In addition, the HEALTH Act protects medical liability reforms at the state level. On March 22, 2012, the US House of Representatives passed H.R. 5, re-named the "Protecting Access to Healthcare Act," which combined the HEALTH Act and a provision to eliminate the Independent Payment Advisory Board (IPAB). The AMA has also pressed for the passage of H.R. 816, the "Provider Shield Act." This federal bill prohibits the use of any guideline or standard specified in the ACA, including the provision on ACOs, to establish the standard of care owed by a health care provider to a patient in a medical liability claim or lawsuit. In addition, the bill protects state rights for establishing legal standards or procedures used in medical liability cases. In addition to these federal bills, the ACA authorizes a program of demonstration grants to states to develop, implement, and evaluate alternatives to the current medical liability system for resolving medical liability disputes over injuries allegedly caused by health care providers. The AMA continues to urge for federal funding for states to pursue alternative liability reform models including safe harbors for the practice of evidence-based medicine, early disclosure and compensation programs, and health courts. As a result of significant AMA advocacy on federal liability reform, in 2009, the Obama Administration issued \$25 million in grants for 20 states and health systems to test a variety of liability reform models. The AMA also continues to support efforts to enact comprehensive reforms at the state level.

AMA EDUCATIONAL EFFORTS

Since the enactment of the ACA in March 2010, the AMA has undertaken efforts to educate physicians on ACOs, including the production and distribution of "Pathways for Physician Success under the Health Care Payment and Delivery Reforms," by Harold Miller of the Center for Healthcare Quality and Payment Reform. This extensive resource also includes helpful information to address physician concerns regarding financial and legal risks in the context of ACO participation. The AMA has also created a web page (www.ama-assn.org/go/paymentpathways) that provides up-to-date resources for physicians on ACOs, and has developed and sponsored regional seminars in 2010 and 2011 to educate physicians on ACO participation. In December 2010, the AMA released *ACOs, CO-Ops and Other Options: A "How-To" Manual for Physicians Navigating a Post-Health Reform World* (www.ama-assn.org/go/ACO). This resource is specifically designed to help physicians maximize the likelihood of success, while minimizing the risk of failure. Upon issuance of the final ACO Rule, the AMA hosted a free webinar in November 2011, that outlined the major provisions of CMS' final rule on ACOs, including changes from the proposed rule designed to encourage physician-led organizations. The timelines and application information for various ACO programs were also addressed.

DISCUSSION

Resolution 123-A-11 asks the AMA to seek federal legislative and regulatory action to protect physicians from legal and financial liabilities and risks that could arise from their participation in an ACO. The BOT believes that the provision in Resolution 123-A-11 asking the AMA to work with CMS to protect physicians from financial risk in ACOs is already covered by existing AMA policy and advocacy efforts. Existing policy requires the AMA to provide physician members with access to financial information, tools, and other resources to enable physicians to effectively participate in ACOs. The AMA also developed resources to address physician concerns regarding financial risks in the context of ACO participation. In addition, the AMA urged CMS to make significant changes to the proposed ACO requirements which CMS did. The final ACO rule allows more flexibility for ACOs to pursue payment options that would encourage participation by a greater variety of physician practices and that would minimize financial risk to the ACO and to the ACO's participating physicians.

The BOT believes that the provision in Resolution 123-A-11 calling for federal legislation to protect physicians who participate in ACOs from medical liability is already covered under extensive, broad AMA policy and advocacy efforts that support comprehensive medical liability reform for physicians, irrespective of whether or not the physician participates in an ACO. The AMA is working at the federal and state levels to reform the medical liability system by advocating for proven reforms, such as the caps on non-economic damages that have stabilized the liability climates in California, Texas, and other states. In addition, the AMA continues to actively advocate for the passage of a federal bill, the "Provider Shield Act," which would protect physicians from legal loopholes that could arise from any guideline or standard specified in the ACA, including the provision on ACOs. This federal bill would help shield physicians from liability in this era of testing ACOs and other new ways to improve the quality and efficiencies of care. The AMA is also calling for federal funding for the testing and evaluation of innovative liability reform models such as safe harbors for the practice of evidence-based medicine, early disclosure and compensation models, and health courts, to determine if these innovations can improve the medical liability system for patients and physicians. Rather than diverting AMA's federal advocacy resources to pursue liability protections solely for physicians participating in ACOs, the Board of Trustees believes that the AMA's federal advocacy resources should remain focused on continued efforts to pursue federal medical liability reforms that would protect physicians who participate in a variety of health care payment and delivery reform models, and not limit protections to just those physicians who participate in the ACO model. This strategy is also consistent with the advocacy efforts of other liability reform coalitions.

At the state level, the AMA has developed model legislation ("Enabling Coordinated Care Organizations with Medical Integrity Act") to assist states with the implementation of Coordinated Care Organizations (CCO), which are defined to include ACOs. The model bill addresses numerous issues involved in the establishment of CCOs. One section in the model bill addresses medical liability issues for CCOs and physicians participating in them. It states that any and all rights, privileges, immunities, and protections with respect to liability, including but not limited to, professional or commercial liability, that apply to physician organizations or institutional health providers also apply to the fullest extent to CCOs and physicians and institutional providers participating in CCOs. Extending current state liability protections to CCOs and the physicians participating in them should be a priority for states considering ACO bills, and the model bill language is helpful in this regard. The model bill also refers to a resource that the AMA has developed to assist states interested in creating liability protections for physicians based on their use of an evidence-based guideline. With ACOs likely to increase the use of evidence-based guidelines, establishing immunity, an affirmative defense, or other level of liability protection for physicians participating in ACOs could help to limit their potential liability exposure. Further, at least one state has discussed including physicians participating in ACOs under the purview of the state tort claims act to address any liability issues that may arise. The AMA will continue to work with states and produce materials to assist them in this regard.

The Board of Trustees believes that AMA policy should be modified so that our AMA works with states to ensure that current state liability reform laws protect physicians from claims or lawsuits that could arise from participation in a variety of health care payment and delivery reform models, including ACOs. Existing AMA policy and advocacy efforts are consistent with and do address Resolution 123-A-11, which seeks federal legislative and regulatory action to protect physicians from legal and financial liabilities and risks that could arise from their participation in an ACO. However, adding a further recommendation to current policy to cover AMA state level activities would strengthen AMA policy on this issue. The Board of Trustees recommends adding the following recommendation to Policy D-385.963: "Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability

exposure for physicians participating in ACOs or other delivery reform models.” In addition, the Board of Trustees believes that existing AMA policy on a toolkit to aid physicians participating in ACOs should be modified to include the development of indemnification provisions that should be included in contracts between physicians and ACOs in order to further protect physicians from legal and financial liabilities that could arise from participation with ACOs.

RECOMMENDATIONS

The Board of Trustees recommends that, in lieu of Resolution 123-A-11, our AMA amend Policy D-385.963 by addition to read as follows, and that the remainder of the report be filed:

D-385.963 Health Care Reform Physician Payment Models

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians; and (e) update the House of Delegates on these issues at the 2011 Annual Meeting. 2. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services. 3. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities. 4. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs. 5. 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. 6. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.

19. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2002 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee B](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - RECOMMENDED ACTIONS ON 2002 HOUSE POLICIES

Policy Number	Title	Text	Recommendation
H-175.985	Kennedy-Kassebaum: Fraud and Abuse	<p>Our AMA:</p> <p>(1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);</p> <p>(2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians;</p> <p>(3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of “willfully and knowingly” to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard;</p> <p>(4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services;</p> <p>(5) continues its efforts to educate the entire Federation about the AMA’s successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be prosecuted or fined for inadvertent billing errors, absent an intent to “knowingly and willfully” defraud;</p> <p>(6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and</p> <p>(7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse.</p> <p>(Sub. Res. 222, A-97; Appended: Res. 202, I-98; Reaffirmation A-99; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02)</p>	Retain – This policy remains relevant.

<p>H-175.989</p>	<p>Health Care Fraud Legislation</p>	<p>Our AMA:</p> <ol style="list-style-type: none"> (1) should continue to scrutinize current and future key legislation regarding health care fraud and abuse; (2) should use all appropriate resources available to ensure that any proposed sanctions, penalties, or sentences be commensurate with the offense committed, especially regarding the imposition of criminal penalties in measures that fail even to define the boundaries of a “health care offense” or to establish the requisite intent necessary for conviction; (3) should work with appropriate federal agencies and congressional committees in studying the extent to which health care fraud pervades the current environment; (4) should continue to support legislative measures such as HR 5120, which would establish a national commission to investigate the nature, magnitude, and cost of health care fraud and abuse; (5) should conduct surveys and research in order to develop data on possible abuses in the system; (6) should continue to support the Principles of Medical Ethics concerning fraud by encouraging physicians to accept the responsibility to expose those engaged in fraud and deception; (7) should continue to pursue recent initiatives, including providing assistance to the FBI in a cooperative endeavor as it attempts to identify and prosecute health care fraud, and continue ongoing efforts with the FTC to remove the current legal barriers to professional self-regulatory activity that would assist in the elimination of fraud and abuse; (8) should pursue legislative efforts to enact a program that would award grants to medical societies for the creation of programs specifically targeted at fraud and abuse; and (9) continue to make the relief of oppressive and overzealous application of fraud and abuse regulations a high priority and take whatever action is necessary to challenge improprieties in the application of fraud and abuse laws against physicians. <p>(BOT Rep. Z, I-92; Reaffirmed: Sub. Res. 232, A-96; Reaffirmation A-99; Appended: Sub. Res. 244, A-00; Reaffirmed: Res. 201, I-00; Reaffirmation I-00; Reaffirmation A-02)</p>	<p>Retain – This policy remains relevant.</p>
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H-270.969	Equitable Tax Treatment of Expenditures Made for Health Care Purposes	<p>Our AMA:</p> <p>(1) will prepare a model state legislative resolution concerning the equitable tax treatment of expenditures made for health care purposes, patterned after the current Colorado Senate Joint Resolution 96-11 which provides that: the state is desirous of federal legislation that affords equal tax treatment for the costs of health care insurance by employers, by employees and individuals who are self-employed and by individuals who are not self-employed; that the state supports federal legislation that affords equal tax treatment for the management of health care costs through the use of medical savings accounts; that the state calls on the United States Congress to establish a plan for tax equity in the treatment of contributions, expenses, and costs associated with employer-based health care insurance, individually-paid health care insurance, health care not covered by Medicare and the use of individual medical savings accounts; and that the state will send copies of the resolution to the President of the United States, the President of the Senate and the Speaker of the House of Representatives of the Congress of the United States and to each member of the state's Congressional delegation; and</p> <p>(2) will provide the model state legislative resolution to all members of the federation for consideration to be introduced into their next legislative session.</p> <p>(Res. 220, A-96; Reaffirmation I-98; Reaffirmation A-02)</p>	Rescind - Reference to the Colorado bill is obsolete and we have policy that supersedes this policy.
H-290.983	Support of Health Care to Legal Immigrants	<p>Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.</p> <p>(Res. 211, A-97; Reaffirmation A-02)</p>	Retain - This policy remains relevant.
H-330.969	Medicare Program	<p>Our AMA:</p> <p>(1) urges the taking of all actions possible to repeal Public Law 101-239 and the restoration of the rights of physicians to privately contract with Medicare beneficiaries for the provision of health care services outside of the Medicare program, and</p> <p>(2) supports making its position known to the US Congress.</p> <p>(Res. 30, A-91; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02)</p>	Rescind - We have extensive policy that supersedes this policy.
H-345.985	Outpatient Psychiatric Services	<p>Our AMA will sponsor legislation to repeal Section 1833(c) of the Social Security Amendments of 1965, which limits Medicare payment for outpatient psychiatric services to 62.5 percent of approved charges.</p> <p>(Res. 214, A-92; Reaffirmation A-00; Reaffirmation A-02)</p>	Rescind – This policy has been accomplished through the Medicare Improvements for Patients and Providers Act of 2008, P.L. 110-275.
H-440.903	Public Health Care Benefits	<p>Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants.</p> <p>(Res. 219, A-98; Reaffirmation A-02)</p>	Retain - This policy remains relevant.

APPENDIX 2 - AMA Policies Superseding Policies Recommended for Rescission

H-270.969 Equitable Tax Treatment of Expenditures Made for Health Care Purposes

Our AMA: (1) will prepare a model state legislative resolution concerning the equitable tax treatment of expenditures made for health care purposes, patterned after the current Colorado Senate Joint Resolution 96-11 which provides that: the state is desirous of federal legislation that affords equal tax treatment for the costs of health care insurance by employers, by employees and individuals who are self-employed and by individuals who are not self-employed; that the state supports federal legislation that affords equal tax treatment for the management of health care costs through the use of medical savings accounts; that the state calls on the United States Congress to establish a plan for tax equity in the treatment of contributions, expenses, and costs associated with employer-based health care insurance, individually-paid health care insurance, health care not covered by Medicare and the use of individual medical savings accounts; and that the state will send copies of the resolution to the President of the United States, the President of the Senate and the Speaker of the House of Representatives of the Congress of the United States and to each member of the state's Congressional delegation; and (2) will provide the model state legislative resolution to all members of the federation for consideration to be introduced into their next legislative session. (Res. 220, A-96; Reaffirmation I-98; Reaffirmation A-02)

H-165.920 Individual Health Insurance

Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax

credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax; (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11)

H-165.852 Health Savings Accounts

It is the policy of the AMA that: (1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies; (2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; (3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform; (4) activities to educate patients about the advantages and opportunities of HSAs be enhanced; (5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged; (6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and (7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. (CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11)

H-330.969 Medicare Program

Our AMA: (1) urges the taking of all actions possible to repeal Public Law 101-239 and the restoration of the rights of physicians to privately contract with Medicare beneficiaries for the provision of health care services outside of the Medicare program, and (2) supports making its position known to the US Congress. (Res. 30, A-91; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02)

D-390.957 A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act

Our AMA will now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the 2010 Interim Meeting of the House of Delegates through AMA Policy D-390.960. (Res. 203, I-11)

D-390.960 Assuring Patients' Continued Access to Physician Services

1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010. 2. Our AMA is

committed to a well funded and priority legislative and grassroots campaign to ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's "Medicare Patient Empowerment Act" as the centerpiece legislation the AMA supports. 3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation. (Sub. Res. 204, A-10; Appended: Res. 202, I-10)

H-165.838 Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11)

H-165.916 Government Controlled Medicine

Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with

the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference. (Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-07; Reaffirmation A-09)

H-383.991 Right to Privately Contract

Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; (2) the restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans. (Res. 203, A-09)

H-385.961 Medicare Private Contracting

Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries' freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08)

H-380.989 Patient and Physician Right to Privately Contract for Health Care

It is the policy of the AMA: (1) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (2) to pursue appropriate legislative and legal means to permanently preserve the patient's basic right to privately contract with physicians for wanted or needed health care services; (3) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/ patient relationship; and (4) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry. (Sub. Res. 20, A-90; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmed: CMS Rep. 7, A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05)

H-330.932 Cuts in Medicare and Medicaid Reimbursement

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05)

**20. ENHANCING ANTIBIOTIC STEWARDSHIP TO IMPROVE PATIENT OUTCOMES
IN THE INPATIENT SETTING
(RESOLUTION 226-A-11)**

Reference committee hearing: see report of [Reference Committee E](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 226-A-11 AND
REMAINDER OF REPORT FILED**

See Policy [H-100.952](#)

At the 2011 Annual Meeting, the House of Delegates (HOD) referred Resolution 226-A-11 introduced by the Infectious Diseases Society of America (IDSA). The resolution asked our American Medical Association (AMA): (1) to urge the Centers for Medicare & Medicaid Services (CMS) to require antimicrobial stewardship and infection prevention programs, which are overseen by qualified physicians, as Medicare and Medicaid Conditions of Participation for health care facilities; (2) to urge CMS to allot a portion of the payment withhold used to fund the Hospital Value-Based Purchasing Program to reimburse health care facilities for implementation and maintenance of antimicrobial stewardship and infection prevention programs; (3) to urge CMS to allow flexibility in the establishment of such programs so that adherence to national requirements does not limit the ability of providers to design programs based on local variables, such as facility size, and to address local antimicrobial stewardship and infection prevention challenges; and (4) regardless of Medicare and Medicaid Conditions of Participation, to state that it is the fiduciary duty of each health care facility's governing body to promote and support robust antimicrobial stewardship and infection prevention programs as critical components of assuring safe patient care.

INTRODUCTION

Antibiotic resistance has continued to increase even as pharmaceutical companies are reducing their research and development efforts to create new antibiotic agents that have novel mechanisms of action. The impact of antibiotic resistance on patient mortality, length of hospitalization, and cost to the healthcare system is substantial, and it is now well documented that inappropriate use of antibiotics is a primary driver of resistance in bacteria. In the IDSA/Society for Healthcare Epidemiology of America (SHEA) guidelines for antibiotic stewardship programs, it is reported that up to 50% of inpatient antimicrobial use is inappropriate.¹ Inappropriate use includes: (1) the prescribing of antibiotics when they are not indicated; (2) continuation of antibiotic therapy when no longer necessary; (3) incorrect dosing; (4) use of broad spectrum agents to treat very susceptible pathogens; and (5) use of the wrong antibiotic to treat an infection. Antibiotic exposure is also the single most important risk factor for the development of Clostridium difficile associated disease (CDAD), and the emergence of the NAP-1/BI or "epidemic" strain of C. difficile has intensified the risks associated with antibiotic exposure.²

This report is not a systematic review of the literature on antibiotic stewardship, which is the responsible use of antibiotics by healthcare professionals, particularly with respect to selection of the most appropriate agent, its dosage, its duration of use, and its route of administration. Instead, it provides an introduction to the concept of antibiotic stewardship within a healthcare facility and describes recommended elements for such an antibiotic stewardship program. The report also discusses process-related and outcome-related measurements that can be used to evaluate antibiotic stewardship programs. Recommendations supporting increased use of antibiotic stewardship programs are proposed. Significantly, these recommendations suggest that before unfunded mandates imposing new regulatory burdens are used to improve utilization of antibiotic stewardship programs, systematic adoption of voluntary approaches should be explored.

The continuing problem of antibiotic resistance

Antibiotic resistance remains a growing healthcare problem that kills tens of thousands of people in the United States and across the world each year, significantly increasing the length of hospital stays and increasing costs to the healthcare system.³ Beyond the implications of antibiotic exposure for CDAD, a meta-analysis indicates a significant increase in mortality associated with methicillin resistant Staphylococcus aureus (MRSA) bacteremia compared to methicillin-susceptible S. aureus (MSSA) bacteremia.⁴ Additionally, studies indicate that methicillin resistance in Staphylococcus aureus has been associated with significant increases in length of hospitalization and hospital costs.⁵ This is true not just for MRSA but also for vancomycin resistant enterococci, penicillin- and

cephalosporin-resistant *Streptococcus pneumoniae*, and also with various resistant gram-negative organisms such as *Enterobacter* spp. and *Klebsiella*.⁶ In 1995, the Congressional Office of Technology Assessment calculated that resistance in just six types of bacteria increased hospital treatment costs by \$1.3 billion.⁷ Resistance continues to develop despite significant efforts by not only the AMA, but also by many leading national healthcare organizations and by federal agencies, to institute appropriate antibiotic use guidelines. A significant percentage of inappropriate use of antibiotics occurs in animal agriculture,⁸ and the AMA has remained very active in efforts to rein in inappropriate use of antibiotics in animal agriculture, consistent with existing AMA HOD Policy H-440.895, Antimicrobial Use and Resistance (AMA Policy Database).

The negative outcomes of resistance are particularly harsh on vulnerable populations, such as the pediatric and the older adult population, those who are immunocompromised, and those with chronic health conditions. Young children and infants are at increased risk of developing extraintestinal focal disease and disseminated disease from enteric pathogens, and when the bacteria are multi-drug resistant, there is increased risk of adverse outcomes, including fatality.⁹ Pneumonia is the major infection-related cause of death in older persons, and urinary tract infection is the most common bacterial infection seen in geriatric patients.¹⁰ The emergence of highly resistant pathogens among geriatric patients for which no effective antibiotics will be available will result in significant morbidity and mortality in this vulnerable population.¹⁰ In those infected with HIV, bacterial pneumonia infections are particularly common, and when caused by penicillin-resistant bacteria, the mortality rate for AIDS patients is approximately 7.8 times higher compared to infections caused by bacteria that are fully or even partially sensitive to penicillin.¹¹ The loss of effective antibiotics as a result of resistance will have far-reaching implications for the treatment of bacterial infections in these vulnerable populations.

It is important to recognize that 53% of antibiotic use occurs in the outpatient setting.¹² Additionally, data from a recent meta-analysis by Costelloe, et al. indicate that antibiotics prescribed to an individual in primary care were consistently found to be associated with the development of resistance to those antibiotics in urinary and respiratory bacteria in that individual.¹³ Thus, while not a topic of this report, appropriate management of antibiotic use within the primary care outpatient setting is also important.

Finally, major pharmaceutical companies are losing interest in the antibiotics market because these drugs simply are not as profitable as drugs that treat chronic conditions and lifestyle issues. Additionally, drug research and development is expensive and risky. In 2002, out of 89 new drugs, no new antibiotics were approved. Thus, IDSA has issued a monograph titled “Bad Bugs, No Drugs” highlighting in detail the issues that are causing the pharmaceutical pipeline for new antibiotics to dry up.¹⁴ This monograph was then followed by a call to action titled the “10 x ‘20” initiative to spur development of new antibiotics.¹⁵ The AMA has endorsed these two IDSA initiatives to incentivize research and development within major pharmaceutical companies.

What is an antibiotic stewardship program?

Antibiotic stewardship is the multi-faceted approach to optimize antibiotic prescribing. In particular, an antibiotic stewardship program should encompass components such as policy, guidelines, surveillance, education, epidemiology of current resistance, and process measurement. Such a multidisciplinary approach requires the participation of all members within the healthcare facility including infection control staff, pharmacists, physicians, administrators, laboratory technicians, a member of the IT department, nurses, and other allied health professionals. A successful antibiotic stewardship program monitors and directs antimicrobial use, providing a standard, evidence-based approach to judicious antibiotic use in a healthcare facility.^{1,16}

More specifically, the goals of an antibiotic stewardship program are to:

- Optimize dose, antimicrobial selection and duration of treatment;
- Prevent and/or reduce the emergence of antibiotic resistance;
- Reduce adverse drug events (including CDAD);
- Reduce length of patient stay;
- Reduce healthcare costs; and
- Reduce patient morbidity and mortality.

Thus antibiotic stewardship programs include not only limiting inappropriate use, they also optimize antibiotic selection, dosing, route of administration, and length of treatment in order to limit unintended consequences

(resistance, cost, adverse reactions) while improving patient outcomes and patient safety.^{1,16} According to the IDSA/SHEA guidelines for developing an institutional program to enhance antibiotic stewardship, there are 11 recommendations that should be considered to create a comprehensive antibiotic stewardship program. Depending on the needs and resources of the institution, as well as the epidemiology of local resistance, elements can be chosen from these recommendations.¹ These 11 recommendations are summarized in the appendix of this report. Of increasing interest, and not mentioned in the IDSA/SHEA recommendations, is the use of new rapid molecular diagnostic testing that would allow earlier identification of the causative pathogen, leading to improved decision making with regards to antibiotic therapy.¹⁷

Measuring antibiotic stewardship programs

It is important to recognize that there are two ways that the success of antibiotic stewardship programs can be measured: by process measures, which are easier to accomplish; or by outcome measures, which are far more difficult.¹⁷ As is often the case, once a process is established at an institution and process measurement is in place, the incentive to actually measure the impact on health outcomes is diminished. Additionally, measuring outcomes such as reduction in the incidence of specific types of infections, reduction in the emergence of antibiotic resistance, or other similar patient-focused health outcomes, is very time consuming and often confounded by other environmental factors. Thus, data remain limited on these outcome measurements.

Process outcomes on the other hand, are fairly easy to measure, and much data exist on the steps necessary to implement a successful antibiotic stewardship program. Three different outcome measures are summarized below, all of which are associated with improving the quality of patient care and patient outcomes.

Impact of antibiotic stewardship programs on antibiotic resistance

Data remain limited on the impact of antibiotic stewardship programs on reducing the emergence of resistance. There have been several studies that have shown reduction in resistance in gram negative bacteria following the implementation of antibiotic stewardship programs. Busing, et al. describe a program featuring the implementation of a computerized antimicrobial approval system for ordering restricted antibiotics, limiting duration of dispensing, and facilitating communication with pharmacy, infection control staff, and prescribers. This program improved susceptibility of *Pseudomonas* to many antibiotics studied.¹⁸ Rahal et al. noted that a 80.1% reduction in hospital-wide cephalosporin use correlated with a 44% reduction in the incidence of ceftazidime-resistant *Klebsiella* infection and colonization throughout the medical center.¹⁹ Bantar and coworkers, using a four-intervention, multidisciplinary approach, demonstrated significant reduction in resistance to different agents in *Proteus*, *Enterobacter cloacae*, and *Pseudomonas*.²⁰ Finally, Pakyz and colleagues demonstrated in a consortium of 22 university teaching hospitals that carbapenem-resistant *P. aeruginosa* incidence was lower in hospitals that restricted carbapenem use than those that did not.²¹

There are also limited data with respect to gram positive organisms. The Busing study described above showed improved susceptibility of *S. aureus* to methicillin when an antibiotic stewardship program was implemented.¹⁸ Cook, et al. showed that active monitoring of oral and IV ciprofloxacin use led to a 31% reduction in ciprofloxacin use and was significantly correlated with an almost 6% reduction in prevalence of MRSA.²² The Bantar study detailed above demonstrated a significant reduction in the prevalence of MRSA following implementation of the stewardship program.²⁰

Impact of antibiotic stewardship programs on cost

The implementation of antibiotic stewardship programs that successfully reduce antibiotic misuse corresponds with decreased cost to the institution by an average of \$200,000 to \$900,000, without a negative impact on the quality of clinical care.^{1,16} For example, Maswoswe and coworkers demonstrated that, in a 580-bed, county teaching hospital, restricting antibiotic use resulted in a savings of more than \$300,235 over a nine-month period.²³ Agwu et al. utilizing a web-based program to provide automated clinical decision support and facilitate approval and real-time communication with prescribers related to antibiotics, showed a reduction of \$370,069 in projected, annual cost associated with antimicrobial use, and an 11.6% reduction in doses of restricted antibiotics over one year.²⁴ These direct savings likely pale when compared to potential decreases in overall healthcare costs that can be achieved with effective implementation of an antibiotic stewardship program.

While indirect cost savings are more difficult to document, extrapolation is possible. Since reduced antibiotic resistance, adverse outcomes, and secondary unintended infections are linked with increased patient mortality and morbidity, longer hospital stays, and increased healthcare costs,^{6,25-26} proper antibiotic stewardship should optimize patient care and consequently lower these costs. Indeed, a large study in a tertiary care academic center estimated more than \$4.25 million in total healthcare savings over one year when an antibiotic stewardship program using both pre-authorization and prospective audit and feedback was implemented.¹⁷

In a University of Maryland study, implementation of one antibiotic stewardship program saved a total of \$17 million over 8 years at one institution, and when the program was discontinued, antibiotic costs increased over \$1 million in the first year (an increase of 23 percent) and continued to increase the following year.²⁷ Finally, a study of cost-effectiveness of antibiotic stewardship on the reduction of morbidity and mortality associated with nosocomial bacteremia demonstrated a cost of \$2,367 per quality-adjusted life year (QALY) gained for the stewardship interventions. This compares favorably with many currently funded healthcare interventions and services.²⁸

Impact of antibiotic stewardship programs on appropriate antibiotic use

Antimicrobial stewardship programs have been shown to increase the likelihood that hospitalized patients receive the right antibiotic, at the right dose, at the right time, and for the right duration.^{1,16} As a result, there is reduced mortality, reduced risks of CDAD, reduced length of hospital stays, and reduced overall antimicrobial resistance within the facility, which will also contribute to reduced costs for the institution. One arena where appropriate and targeted use of antibiotics has been successful is in CDAD. For example, Valiquette and coworkers demonstrated in a secondary/tertiary-care hospital that the implementation of an antimicrobial stewardship program to optimize antibiotic usage resulted in a 60% decrease in the incidence of CDAD.²⁹ Additionally, studies indicate that optimization of antibiotic use also optimizes patient safety. Thus, a study by Singh et al. showed that an antibiotic stewardship program reduced overtreatment with antibiotics of patients with pulmonary infiltrates in the ICU.³⁰ This resulted in significant reductions in antibiotic resistance and superinfections in the patients. Fishman and colleagues have reported that an antibiotic stewardship program implemented at the Hospital of the University of Pennsylvania resulted in a significant increase in appropriate therapy that correlated with a significant increase in cure rates and a significant decrease in treatment failures.³¹ Finally, a meta-analysis of 14 studies of the application of antimicrobial stewardship principles to the management of community-acquired pneumonia showed improvement in physician awareness of guidelines, improved appropriate antibiotic use, and a reduction in unnecessary prescribing. This improved utilization led to decreased 30-day mortality and in-hospital mortality rates, reduced length of hospital stay, reduced treatment failure rates and reduced healthcare costs.³²

Policy Statement from the IDSA, SHEA, and the Pediatric Infectious Diseases Society (PIDS)

In April 2012, the IDSA, SHEA, and PIDS released a joint policy statement with regards to antibiotic stewardship programs.³³ The five recommendations from this policy statement are presented here.

1. Antimicrobial stewardship programs should be required through regulatory mechanisms;
2. Antimicrobial stewardship should be monitored in ambulatory healthcare settings;
3. Education about antimicrobial resistance and antimicrobial stewardship must be accomplished;
4. Antimicrobial use data should be collected and readily available for both inpatient and outpatient settings; and
5. Research on antimicrobial stewardship is needed.

CONCLUSION

Well designed and properly implemented antibiotic stewardship programs will reduce inappropriate use of antibiotics, can optimize outcomes for patients, and may preserve the effectiveness of currently available antibiotics. Additionally, an effective program will generally reduce overall healthcare costs for the facility.

More data are still needed to confirm the impact of antibiotic stewardship programs on different patient-centered outcomes in order to provide impetus for continued implementation of effective antibiotic stewardship programs. As a result of the multifaceted approaches of an antibiotic stewardship program, individual medical facilities will need to adapt more standardized recommendations to fit with the needs of their institution.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 226-A-11 and the remainder of this report be filed:

1. That our American Medical Association (AMA) support antimicrobial stewardship programs, overseen by qualified physicians, as an effective way to ensure appropriate antibiotic use, to optimize patient outcomes, and to reduce overall costs for a healthcare facility. Antibiotic stewardship programs are multi-faceted approaches to optimize antibiotic prescribing, encompassing components such as policy, guidelines, surveillance, education, epidemiology of current resistance, and process measurement. Successful antibiotic stewardship programs monitor and direct antimicrobial use, providing a standard, evidence-based approach to judicious antibiotic use in a healthcare facility.
2. That our AMA support the development of antibiotic stewardship programs that allow flexibility so that adherence to national requirements does not limit the ability of providers to design programs based on local variables, such as healthcare facility size, and to address local antimicrobial stewardship and infection prevention challenges.
3. That our AMA urge each healthcare facility's governing body to promote and support robust antimicrobial stewardship and infection prevention programs as critical components of assuring safe patient care.
4. That our AMA support continued research into the impact of antibiotic stewardship programs on process outcomes, and encourage increased research on the impact of such programs on patient-centered outcomes.

APPENDIX - IDSA/SHEA Guidelines for Developing an Institutional Program to Enhance Antibiotic Stewardship Recommendations

1. Core members of a multidisciplinary antimicrobial stewardship team include an infectious diseases physician and a clinical pharmacist with infectious diseases training (A-II*) who should be compensated for their time (A-III), with the inclusion of a clinical microbiologist, an information system specialist, an infection control professional, and hospital epidemiologist being optimal (A-III). Because antimicrobial stewardship, an important component of patient safety, is considered to be a medical staff function, the program is usually directed by an infectious diseases physician or codirected by an infectious diseases physician and a clinical pharmacist with infectious diseases training (A-III).
2. Collaboration between the antimicrobial stewardship team and the hospital infection control and pharmacy and therapeutics committees or their equivalents is essential (A-III).
3. The support and collaboration of hospital administration, medical staff leadership, and local providers in the development and maintenance of antimicrobial stewardship programs is essential (A-III). It is desirable that antimicrobial stewardship programs function under the auspices of quality assurance and patient safety (A-III).
4. The infectious diseases physician and the head of pharmacy, as appropriate, should negotiate with hospital administration to obtain adequate authority, compensation, and expected outcomes for the program (A-III).
5. Hospital administrative support for the necessary infrastructure to measure antimicrobial use and to track use on an ongoing basis is essential (A-III).
6. There are 2 core strategies, both proactive, that provide the foundation for an antimicrobial stewardship program. These strategies are not mutually exclusive.
 - a. Prospective audit with intervention and feedback. Prospective audit of antimicrobial use with direct interaction and feedback to the prescriber, performed by either an infectious diseases physician or a clinical pharmacist with infectious diseases training, can result in reduced inappropriate use of antimicrobials (A-I).
 - b. Formulary restriction and preauthorization. Formulary restriction and preauthorization requirements can lead to immediate and significant reductions in antimicrobial use and cost (A-II) and may be beneficial as part of a multifaceted response to a nosocomial outbreak of infection (B-II). The use of preauthorization requirements as a means of controlling antimicrobial resistance is less clear, because a long-term beneficial impact on resistance has not been established, and in some circumstances, use may simply shift to an alternative agent with resulting increased resistance (B-II). In institutions that use preauthorization to limit the use of selected antimicrobials, monitoring overall trends in antimicrobial use is necessary to assess and respond to such shifts in use (B-III).

7. The following elements may be considered and prioritized as supplements to the core active antimicrobial stewardship strategies based on local practice patterns and resources.
 - a. Education. Education is considered to be an essential element of any program designed to influence prescribing behavior and can provide a foundation of knowledge that will enhance and increase the acceptance of stewardship strategies (A-III). However, education alone, without incorporation of active intervention, is only marginally effective in changing antimicrobial prescribing practices and has not demonstrated a sustained impact (B-II).
 - b. Guidelines and clinical pathways. Multidisciplinary development of evidence-based practice guidelines incorporating local microbiology and resistance patterns can improve antimicrobial utilization (A-I). Guideline implementation can be facilitated through provider education and feedback on antimicrobial use and patient outcomes (A-III).
 - c. Antimicrobial cycling. There are insufficient data to recommend the routine use of antimicrobial cycling as a means of preventing or reducing antimicrobial resistance over a prolonged period of time (C-II). Substituting one antimicrobial for another may transiently decrease selection pressure and reduce resistance to the restricted agent. Unless the resistance determinant has been eliminated from the bacterial population, however, reintroduction of the original antimicrobial is again likely to select for the expression of the resistance determinant in the exposed bacterial population.
 - d. Antimicrobial order forms. Antimicrobial order forms can be an effective component of antimicrobial stewardship (B-II) and can facilitate implementation of practice guidelines.
 - e. Combination therapy. There are insufficient data to recommend the routine use of combination therapy to prevent the emergence of resistance (C-II). Combination therapy does have a role in certain clinical contexts, including use for empirical therapy for critically ill patients at risk of infection with multidrug-resistant pathogens, to increase the breadth of coverage and the likelihood of adequate initial therapy (A-II).
 - f. Streamlining or de-escalation of therapy. Streamlining or de-escalation of empirical antimicrobial therapy on the basis of culture results and elimination of redundant combination therapy can more effectively target the causative pathogen, resulting in decreased antimicrobial exposure and substantial cost savings (A-II).
 - g. Dose optimization. Optimization of antimicrobial dosing based on individual patient characteristics, causative organism, site of infection, and pharmacokinetic and pharmacodynamic characteristics of the drug is an important part of antimicrobial stewardship (A-II).
 - h. Parenteral to oral conversion. A systematic plan for parenteral to oral conversion of antimicrobials with excellent bioavailability, when the patient's condition allows, can decrease the length of hospital stay and health care costs (A-I). Development of clinical criteria and guidelines allowing switch to use of oral agents can facilitate implementation at the institutional level (A-III).
8. Health care information technology in the form of electronic medical records (A-III), computer physician order entry (B-II), and clinical decision support (B-II) can improve antimicrobial decisions through the incorporation of data on patient-specific microbiology cultures and susceptibilities, hepatic and renal function, drug-drug interactions, allergies, and cost. However, implementation of these features has been slow, and conformation of the technology to the clinical environment remains a challenge.
9. Computer-based surveillance can facilitate good stewardship by more efficient targeting of antimicrobial interventions, tracking of antimicrobial resistance patterns, and identification of nosocomial infections and adverse drug events (B-II).
10. The clinical microbiology laboratory plays a critical role in antimicrobial stewardship by providing patient-specific culture and susceptibility data to optimize individual antimicrobial management and by assisting infection control efforts in the surveillance of resistant organisms and in the molecular epidemiologic investigation of outbreaks (A-III).
11. Both process measures (did the intervention result in the desired change in antimicrobial use?) and outcome measures (did the process implemented reduce or prevent resistance or other unintended consequences of antimicrobial use?) are useful in determining the impact of antimicrobial stewardship on antimicrobial use and resistance patterns (B-III).

* Infectious Diseases Society of America–United States Public Health Service grading system for ranking recommendations in clinical guidelines.

Category, grade	Definition
<i>Strength of recommendation</i>	
A	Good evidence to support a recommendation for use
B	Moderate evidence to support a recommendation for use
C	Poor evidence to support a recommendation for use
<i>Quality of evidence</i>	
I	Evidence from ≥ 1 properly randomized, controlled trial
II	Evidence from ≥ 1 well-designed clinical trial, without randomization; from cohort or case-controlled analytic studies (preferably from >1 center); from multiple time-series; or from dramatic results from uncontrolled experiments
III	Evidence from opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

REFERENCES

1. Dellit TH, Owens RC, McGowan JE, Jr., Gerding DN, Weinstein RA, Burke JP et al. Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America guidelines for developing an institutional program to enhance antimicrobial stewardship. *Clin Infect Dis* 2007; 44(2):159-177.
2. Chang HT, Krezolek D, Johnson S, Parada JP, Evans CT, Gerding DN. Onset of symptoms and time to diagnosis of *Clostridium difficile*-associated disease following discharge from an acute care hospital. *Infect Control Hosp Epidemiol* 2007; 28(8):926-931.
3. Goff DA. Antimicrobial stewardship: bridging the gap between quality care and cost. *Curr Opin Infect Dis* 2011; 24 Suppl 1:S11-20.:S11-S20.
4. Cosgrove SE, Sakoulas G, Perencevich EN, Schwaber MJ, Karchmer AW, Carmeli Y. Comparison of mortality associated with methicillin-resistant and methicillin-susceptible *Staphylococcus aureus* bacteremia: a meta-analysis. *Clin Infect Dis* 2003; 36(1):53-59.
5. Cosgrove SE, Qi Y, Kaye KS, Harbarth S, Karchmer AW, Carmeli Y. The impact of methicillin resistance in *Staphylococcus aureus* bacteremia on patient outcomes: mortality, length of stay, and hospital charges. *Infect Control Hosp Epidemiol* 2005; 26(2):166-174.
6. Cosgrove SE. The relationship between antimicrobial resistance and patient outcomes: mortality, length of hospital stay, and health care costs. *Clin Infect Dis* 2006; 42 Suppl 2:S82-9.:S82-S89.
7. Office of Technology Assessment USC. Impacts of antibiotic-resistant bacteria. 1995. Washington, DC, Government Printing Office.
8. Food and Drug Administration. Summary Report on Antimicrobials Sold or Distributed for Use in Food-Producing Animals. 2010. Washington, DC, Food and Drug Administration.
9. Shea KM. Antibiotic Resistance: What Is the Impact of Agricultural Uses of Antibiotics on Children's Health? *Pediatrics* 2003; 112(Suppl. 1): 253-258.
10. Yoshikawa, TT. Antimicrobial Resistance and Aging: Beginning of the End of the Antibiotic Era? *J Am Geriatr Soc* 2003; 50(Suppl. s7): 226-229.
11. Keep Antibiotics Working Coalition. Antibiotic Resistance and its Impact on Persons Living With HIV/AIDS. Available at: http://www.keepantibioticsworking.com/new/Library/UploadedFiles/Antibiotic_Resistance_and_its_Impact_on_Per_2.pdf. Last Accessed: 3-16-2012.
12. Polk RE, Fox C, Mahoney A, Letcavage J, MacDougall C. Measurement of adult antibacterial drug use in 130 US hospitals: comparison of defined daily dose and days of therapy. *Clin Infect Dis* 2007; 44(5):664-670.
13. Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD. Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. *BMJ* 2010; 340:c2096.
14. Boucher HW, Talbot GH, Bradley JS, Edwards JE, Gilbert D, Rice LB et al. Bad bugs, no drugs: no ESKAPE! An update from the Infectious Diseases Society of America. *Clin Infect Dis* 2009; 48(1):1-12.
15. Infectious Diseases Society of America. The 10 X '20 Initiative: Pursuing a Global Commitment to Develop 10 New Antibacterial Drugs by 2020. *Clin Infect Dis* 2010; 50:1081-1083.
16. Tamma PD, Cosgrove SE. Antimicrobial stewardship. *Infect Dis Clin North Am* 2011; 25(1):245-260.
17. Ohl CA, Luther VP. Antimicrobial stewardship for inpatient facilities. *J Hosp Med* 2011; 6 Suppl 1:S4-15. doi: 10.1002/jhm.881.:S4-15.
18. Buising KL, Thursky KA, Robertson MB, Black JF, Street AC, Richards MJ et al. Electronic antibiotic stewardship--reduced consumption of broad-spectrum antibiotics using a computerized antimicrobial approval system in a hospital setting. *J Antimicrob Chemother* 2008; 62(3):608-616.
19. Rahal JJ, Urban C, Horn D, Freeman K, Segal-Maurer S, Maurer J et al. Class restriction of cephalosporin use to control total cephalosporin resistance in nosocomial *Klebsiella*. *JAMA* 1998; 280(14):1233-1237.
20. Bantar C, Sartori B, Vesco E, Heft C, Saul M, Salamone F et al. A hospital wide intervention program to optimize the quality of antibiotic use: impact on prescribing practice, antibiotic consumption, cost savings, and bacterial resistance. *Clin Infect Dis* 2003; 37(2):180-186.
21. Pakyz AL, Oinonen M, Polk RE. Relationship of carbapenem restriction in 22 university teaching hospitals to carbapenem use and carbapenem-resistant *Pseudomonas aeruginosa*. *Antimicrob Agents Chemother* 2009; 53(5):1983-1986.
22. Cook PP, Catrou P, Gooch M, Holbert D. Effect of reduction in ciprofloxacin use on prevalence of methicillin-resistant *Staphylococcus aureus* rates within individual units of a tertiary care hospital. *J Hosp Infect* 2006; 64(4):348-351.
23. Maswoswe JJ, Okpara AU. Enforcing a policy for restricting antimicrobial drug use. *Am J Health Syst Pharm* 1995; 52(13):1433-1435.
24. Agwu AL, Lee CK, Jain SK, Murray KL, Topolski J, Miller RE et al. A World Wide Web-based antimicrobial stewardship program improves efficiency, communication, and user satisfaction and reduces cost in a tertiary care pediatric medical center. *Clin Infect Dis* 2008; 47(6):747-753.
25. Maragakis LL, Perencevich EN, Cosgrove SE. Clinical and economic burden of antimicrobial resistance. *Expert Rev Anti Infect Ther* 2008; 6(5):751-763.
26. Roberts RR, Hota B, Ahmad I, Scott RD, Foster SD, Abbasi F et al. Hospital and societal costs of antimicrobial-resistant infections in a Chicago teaching hospital: implications for antibiotic stewardship. *Clin Infect Dis* 2009; 49(8):1175-1184.
27. Centers for Disease Control and Prevention. Antibiotic stewardship — the ultimate return on investment. Available at: <http://www.cdc.gov/getsmart/healthcare/learn-from-others/factsheets/antibiotic-use.html>. Last Accessed: 3-16-2012.

28. Scheetz MH, Bolon MK, Postelnick M, Noskin GA, Lee TA. Cost-effectiveness analysis of an antimicrobial stewardship team on bloodstream infections: a probabilistic analysis. *J Antimicrob Chemother* 2009; 63(4):816-825.
29. Valiquette L, Cossette B, Garant MP, Diab H, Pepin J. Impact of a reduction in the use of high-risk antibiotics on the course of an epidemic of *Clostridium difficile*-associated disease caused by the hypervirulent NAP1/027 strain. *Clin Infect Dis* 2007; 45 Suppl 2:S112-21.:S112-S121.
30. Singh N, Rogers P, Atwood CW, Wagener MM, Yu VL. Short-course empiric antibiotic therapy for patients with pulmonary infiltrates in the intensive care unit. A proposed solution for indiscriminate antibiotic prescription. *Am J Respir Crit Care Med* 2000; 162(2 Pt 1):505-511.
31. Fishman N. Antimicrobial stewardship. *Am J Med* 2006; 119(6 Suppl 1):S53-S61.
32. Bosso JA, Drew RH. Application of antimicrobial stewardship to optimise management of community acquired pneumonia. *Int J Clin Pract* 2011; 65(7):775-783.
33. Policy Statement on Antimicrobial Stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society (PIDS). *Infect Control Hosp Epidemiol* 2012; 33(4):322-327.

21. COMBATING OBESITY WITH PHYSICAL EDUCATION REQUIREMENTS (RESOLUTION 412-A-11)

Reference committee hearing: see report of [Reference Committee D](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 412-A-11 AND REMAINDER OF REPORT FILED

See Policies [H-170.999](#), [H-470.975](#), [H-470.989](#), [H-470.990](#), [H-470.996](#) and [D-440.971](#)

Resolution 412 A-11, which was introduced by the Medical Student Section and referred to the Board of Trustees (BOT), asks our American Medical Association to advocate that schools require a health care professional's recommendation for students to opt out of physical education programs in order to stress the importance of physical wellness among children and to promote healthy lifestyle choices that extend into adulthood.

INTRODUCTION

Today, about one in three, or 2.5 million American children and teens, is overweight or obese, nearly triple the rate in 1963.¹ Decreased physical activity and increases in high fat, high calorie diets have been associated with the obesity epidemic in adults, as well as in children and adolescents. Addressing this requires a comprehensive strategy that includes policies and programs that provide opportunities to be more physically active, access to healthier food options, and address cultural biases. According to the Centers for Disease Control and Prevention (CDC), the amount of vigorous exercise students get declines as grade levels increase. In 2009, the proportion of students who met recommended levels of physical activity dropped from 40 percent to 32 percent between ninth and twelfth grade. The difference was most pronounced among females where the decline was from 31 percent in ninth grade to 22 percent by twelfth grade. While state requirements to provide physical education are high, requirements for student participation are lower in the higher grades. Forty percent of elementary schools require students to participate in physical education, but only 5.4% of high schools require that seniors enroll.²

Schools are a fertile environment to teach, model, and engage students in healthier lifestyles that include better nutrition and physical activity. In school settings, physical education is the foundation of comprehensive physical activity programs and defined as a "school-based instructional opportunity for students to gain the necessary skills and knowledge for lifelong participation in physical activity."³ Program curricula include cognitive and physical activities.

In contrast to physical health education, school-based physical activity includes classroom-incorporated physical activity, recess, intramural and interscholastic sports and activity clubs, and physical education.⁴ Physical activity classes, such as dance or strength training class, in schools are not interchangeable with physical health education; they lack the cognitive component of physical health education.

Physical Education/Physical Activity and Opt Out Provisions

The health and quality of life benefits of daily physical activity are well-established and beneficial for any age. Some of the benefits specific to children include increase in bone, muscular, and cardio-respiratory health, and decrease in body fat and depression.⁵ Demetriou and Höner⁶ evaluated the effectiveness of 129 studies on school-based physical activity interventions and concluded that most interventions significantly improved motor performance, physical activity, and knowledge of physical activity.

Despite this growing body of evidence about the health benefits of daily physical activity in school-based settings, physical activity participation continues to decrease nationally in high schools. In high schools, participation decreased nationally from 42 percent in 1991 to 29 percent over a 10 year period.⁷ The decrease is due to school, district, and state policies that allow exemptions and waivers, but also from school budget cuts that force schools to eliminate physical education staff and funding. In addition, students are commonly exempted and granted waivers from physical education courses for participating in interscholastic sports, ROTC, and precollege academic courses. However, the alarming trends in obesity among children are switching the focus from traditional sports in physical education classes to one on health and physical activity.

Due to the aforementioned trends, policy initiatives in the United States include private and public sector initiatives at various levels. Healthy People 2020 includes new goals for increasing physical activity in children and youth, which target childcare settings, recess, and physical education in public and private grammar schools.⁵ The objectives include increasing the proportion of: (1) public and private schools (elementary to senior high school) that provide daily, physical education for all students; (2) youth participating in daily physical education; and (3) states and school districts that recommend and require elementary recess. As of 2006, studies indicate that only 11.8 percent of states required, and only 25.5 percent recommended, that elementary schools provide students with regularly scheduled recess.⁸

Various national health agencies and associations, including the American Diabetes Association, American Cancer Society, American Heart Association, American Stroke Association, Institute of Medicine, and National Association for Sport and Physical Education (NASPE) recommend a minimum of 30 minutes of moderate to vigorous physical activity during every school day.⁹⁻¹⁰ In addition to daily physical activity, the CDC advocates that elementary recess be required and that states support efforts on obesity-prevention by requiring “schools and school districts to eliminate exemptions and waivers from physical education.”¹¹ Similarly, NASPE opposes exemptions, substitutions, and waivers for physical education and recommends that adapted classes be created for students with permanent physical or cognitive impairments or religious reasons.¹²

Provisions vary by school, district, and state, but there are commonalities. For example, Illinois is the only state that as of 2010 requires daily physical education in all K-12 grades; however many schools are exempted from this requirement. The majority of opt-out provisions nationwide exempt only students that that are permanently physically or cognitively impaired, or for religious reasons.⁸ This provision is most prevalent in elementary and middle school.⁸ Exemptions increase in high school allowing for the previously mentioned reasons, and for “participation in school activities other than sports, participation in school sports, and religious reasons.”⁸ The percent of schools that require physical education in every grade level decreases at higher grade levels. Nationally, the percent is 49.75% in kindergarten, peaks at 68.1% in sixth grade, then decreases to 20.4% by 12th grade.⁸ Thus, the greater issue is not students opting out of physical education classes, but rather schools requiring physical education. Although, Resolution MSS 3 (A-11) intends to foster physical wellness in school-age children by requiring that a healthcare provider recommendation be necessary for students to opt out of physical education programs, the primary cause of student decreased participation in physical education will not be effectively addressed. In addition, unintended consequences and barriers as a result of the provision will outweigh the resolution’s good intentions. These unintended consequences include: increase in primary healthcare provider visits; financial consequences for students and their families; academic concerns; and a disincentive for wellness policies.

Adoption of the proposed resolution would unnecessarily increase primary healthcare provider visits, resulting in extra office visits and increased time and cost clinical practice implications. This office visit might be reimbursed by Medicaid, but Medicaid and SCHIP payments and reimbursements are projected to decrease with proposed budget cuts. Aside from the cost considerations, primary care physicians already have heavy workloads; specifically, general and family medicine, along with pediatrics, account for 37 percent of all physician visits. In addition, the

demand for primary care is projected to increase due to a growing population, increase in healthcare coverage with Affordable Care Act implementation, and a decrease in physician supply due to retirement.¹³

Financial consequences for students and their families result from opt-out provisions. A financial burden will be placed on families whose parents work and have to miss a day to take the child to the doctor. This results in loss of income for the missed day(s) of work. There are also the associated costs of visiting a healthcare provider. For those on federal insurance programs, given projected Medicaid and CHIP budget cuts, it remains questionable whether office visits for opt-out notes will be covered or subsidized. Current service fees for a visit of this nature vary by states.¹⁴ For students with private insurance, the parents or guardians will absorb the associated costs.

In addition to financial concerns, there are also academic ones. The Recommendation may increase absenteeism; students may have to miss a day of school to obtain a physician's recommendation note. Absenteeism can negatively impact academic performance and in low socioeconomic and at-risk populations, students struggling academically cannot afford to miss any class(es).¹⁵⁻¹⁷

The resolution's provision may become a disincentive for the development and implementation of wellness policies that are required by the Child Nutrition and WIC Reauthorization Act of 2004. Currently, students most at risk for obesity (based on economic status, race, and ethnicity) attend schools and districts that do not have a wellness policy. Furthermore, schools with written policies have vague or nonexistent provisions on physical activity goals.¹⁸ It is essential for better nutrition and physical activity in the school systems to be envisioned and planned through wellness policies.

Existing AMA Policies

The AMA has several policies that capture the intent of this resolution, which is to improve children and adolescent health by ensuring access to physical education and increased opportunity to be physically active. Four of these policies: H-170.999; H-470.990; H-470.975; and H-470.989 (AMA Policy Database) deal directly with physical fitness and physical education. H-470.989, Physical Fitness and Physical Education, which was first introduced in 1979 as a Council on Scientific Affairs report, was reaffirmed three times, most recently in 2007. It urges school board and administrators to provide physical education programs at all levels and that these programs be conducted by qualified staff. The other three policies, which were also reaffirmed in 2007, align with the proposed resolution. They articulate the benefits of physical education and physical activity for children and adolescents and the importance of advancing policies that promote and encourage programs that are implemented by trained professionals. The AMA's policy on obesity (D.440.971) adopted in 2005 and reaffirmed in 2010 goes further than just stating AMA's commitment. It outlines specific recommendations for physician involvement and collaboration with communities to address health issues associated with obesity and unhealthy weight. This policy also lays out a strategy for the AMA to partner with CDC and other government agencies to work with parents, physicians, health care providers and educators to demonstrate the benefits of physical education and physical activity programs. It takes a positive approach to ensuring adoption of these programs across the educational spectrum.

CONCLUSION

Current AMA policies recognize the growing obesity epidemic in children and the important role that schools play in fostering long-term healthy lifestyles via quality, comprehensive physical education. While noble in intent, Resolution 412 A-11 has such a unintended consequences that outweigh the benefits. The opt-out provision that would require a parent to get a note from a health professional does not address the barriers to implementing evidence based physical education and activity programs in schools, especially high schools, and places an undue burden on families and the health care provider.

RECOMMENDATIONS

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 412 A-11 and the remainder of the report be filed:

1. That the following AMA policies be reaffirmed:

H-170.999 Health Instruction and Physical Education in Schools

H-470.996 School and College Physical Education
 H-470.990 Promotion of Exercise Within Medicine and Society
 H-470.989 Physical Fitness and Physical Education
 D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity

2. That Policy H-470.975, Mandatory Physical Education, be amended by insertion and deletion to read as follows:

The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including the handicapped those with physical, developmental, or intellectual challenges or other special needs, in grades kindergarten through twelve, including ungraded classes.

3. That Policy H-470.975 be adopted as amended.

REFERENCES

1. Ogden CL, Carroll MD, Kit BK, and Flegal KM. Prevalence of obesity in the United States, 2009-2010. NCHS data brief, no 82. Hyattsville, MD: National Center for Health Statistics. 2012.
2. Pate R., et al, Promoting Physical Activity in Children and Youth, American Heart Association Position Statement, Circulation. 2006; 114: 1214-1224
3. Centers for Disease Control and Prevention (CDC). Components of coordinated school health. 2012. <http://www.cdc.gov/healthyyouth/cshp/components.htm> Accessed February 20, 2012.
4. Centers for Disease Control and Prevention (CDC). Physical activity facts. 2011. <http://www.cdc.gov/healthyyouth/physicalactivity/facts.htm> Accessed February 20, 2012.
5. US Department of Health & Human Services. Healthy people 2020. <http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=33> Accessed February 20, 2012.
6. Demetriou Y, Höner O. Physical activity interventions in the school setting: A systematic review. Psychology of Sport and Medicine. 2012;13(2):186–196. <http://dx.doi.org.proxy.cc.uic.edu/10.1016/j.psychsport.2011.11.006> Accessed February 20, 2012.
7. US Department of Health & Human Services. Promoting health through physical activity. 2006. <http://www.hhs.gov/news/factsheet/physactive.html> Accessed February 20, 2012.
8. Lee, SM, Burgeson CR, Fulton JE, and Spain CG. Physical education and physical activity: results from the school health policies and programs study 2006. J School Health. 2007; 77(8): 436-463.
9. Institute of Medicine. Schools can play a role in preventing childhood obesity. Preventing Childhood Obesity, Health in the Balance. 2005.
10. American Heart Association. Policy position statement on physical education in schools. http://www.heart.org/adc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_301654.pdf Accessed March 12, 2012.
11. Division of Adolescent and School Health. US Department of Health & Human Services. School-based obesity prevention strategies for state policymakers. National Center for Chronic Disease Prevention and Health Promotion, US Dept of Health and Human Services; 2008. http://www.cdc.gov/healthyyouth/policy/pdf/obesity_prevention_strategies.pdf Accessed February 27, 2012.
12. National Association for Sport and Physical Education (2003). Opposing substitution and waiver/exemptions for required physical education [Position statement]. Reston, VA: Author. <http://www.aahperd.org/naspe/standards/upload/Opposing-Substitution-Waiver-Exemptions-for-Required-PE-2006.pdf> Accessed March 12, 2012.
13. Bernstein AB, Hing E, Moss AJ, Allen KF, Siller AB, Tiggie RB. Health care in America: trends in utilization. Hyattsville, Maryland: National Center for Health Statistics; 2003. <http://www.cdc.gov/nchs/data/misc/healthcare.pdf> Accessed February 27, 2012.
14. The Henry J. Kaiser Family Foundation. Medicaid benefits. http://medicaidbenefits.kff.org/about_mb.jsp Accessed February 27, 2012.
15. Newman F, Fitzgibbon K, Lloyd S, and Thomas S. A large-scale investigation into the relationship between attendance and attainment: a study using an innovative, electronic attendance monitoring system. Studies in Higher Education. 2008; 33(6): 699-717. Accessed March 9, 2012.
16. Forrest CB, Bevans KB, Riley AW, Crespo R, and Louis TA. School outcomes of children with special health care needs. Pediatrics. August 2011; 128(2): 303-312.
17. Breneman R. The detrimental effects of missing school: evidence from urban siblings. Education week. May 25, 2011; 30(32):5-5.
18. Johnston LD, O'Malley PM, Terry-McElrath Y, Freedman-Doan P and Brenner JS. US middle and high schools making progress to provide healthier lunches, falling short on physical activity. Princeton, NJ: Bridging the Gap; 2011. <http://www.rwjf.org/pr/product.jsp?id=72280> Accessed February 27, 2012.

22. UPDATE ON CORPORATE RELATIONSHIPS

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 – December 31, 2011 as mandated in PolicyG-630.040 (AMA Policy Database).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships. These "Guidelines for American Medical Association Corporate Relationships" were incorporated into the corporate review process and are reviewed regularly. AMA managers are responsible for reviewing all projects to ensure they fit within these guidelines. Corporate activities that associate the AMA name or logo with a company, non-Federation association, or foundation, or include commercial support, must undergo review and recommendations by the Corporate Review Team (CRT) (See Appendix A – Corporate Review Process Overview).

YEAR 2011 RESULTS

In 2011, 26 activities were approved through the Corporate Review Process and implemented. Of the 26 approved projects, 4 were conferences/media briefings or events, 15 were education/information or content materials, 5 were member service provider programs, and 2 were business arrangements. In addition, two projects were not approved by CRT in 2011 due to potential negative impacts to the AMA (See Appendix B – Summary of Corporate Review Recommendations Projects Annual Report 2011).

CONCLUSION

The BOT continues to evaluate the review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

APPENDIX A - Corporate Review Process Overview

Chaired by the Vice President, Governance and Program Support, the Corporate Review Team (CRT) includes senior managers from the following areas: Finance, Business, Advocacy, Federation Relations, Office of the General Counsel, Science, Ethics, Marketing/Communications and Membership.

The CRT evaluates each project with the following criteria:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Fit or conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database licensing.)
- Member service provider programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.
- Vendor requests for usage of AMA name beyond a client listing.

For the above specified activities, if the CRT recommends approval, the project proceeds. In addition, the Executive Committee of the Board reviews and must approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees. The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

APPENDIX B - Summary of Corporate Review Recommendations of Annual Report 2011

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
	CONFERENCES / EVENTS		
1104-0459	National Health Information Exchange Summit - Strategic partner for a summit to discuss issues relevant to the implementation of the HITECH Act	Accenture Axolotl Healthcare Connected Optum Cerner Covisint GE Healthcare Harris ICA MediCity MediConnect Global Oracle Orion Health Siemens American College of Emergency Physicians American College of Physicians AHIMA BluePrint Healthcare IT CAQH	5/3/2011
1104-0473	PCPI and The Joint Commission Overuse Summit - Summit on overuse as a quality and patient safety concern	The Joint Commission	9/27/2011

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
4401-0138	IMG Desserts From Around the World Reception - International Medical Graduates Section reception during the 2011 Annual Meeting	American Association of Physicians of Indian Origin Association of Pakistani Physicians of North American Association of Philippine Physicians in American Medical Association Association of Haitian Physicians Abroad Association of Kerala Medical Graduates Korean-American Medical Association of the US Islamic Medical Association National Arab American Medical Association National Hispanic Medical Association	2/15/2011
6602-0402	AMAF Corporate Roundtable - Roundtable and unrestricted funds to support the AMA Foundation	AstraZeneca BlueCross Blue Shield Eli Lilly Pfizer Purdue Pharma Abbott Laboratories Boehringer Ingelheim Merck Walgreens Allegren GlaxoSmithKline	6/13/2011
EDUCATION / INFORMATION OR CONTENT DEVELOPMENT			
1100-0401	NCHPEG Colorectal Cancer Toolbox - Partnership between AMA and National Coalition for Health Professional Education in Genetics to develop colorectal cancer risk assessment tools	National Coalition for Health Education in Genetics	2/14/2011
1103-0046	Pertussis Immunization Outreach -Letter on the importance of Pertussis immunization	American Nurses Association	3/1/2011
1103-0048	Adolescent Immunization Awareness - Co-branding project with the Vaccine Education Center of the Children's Hospital of Philadelphia for adolescent immunization booklets	Vaccine Education Center	7/6/2011

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
1103-0049	Patient/Clinician Communication: Principles and Expectations - Joint working group developed set of guiding principles for patient-clinician communication	Institute of Medicine Roundtable on Value and Science-Driven Healthcare American College of Clinical Pharmacy American College of Cardiology American Nurses Association National Business Group on Health American Osteopathic Association Healthwise Consumers Union Foundation for Informed Medical Decision Making	7/22/2011
1103-0051	WorldScopes/Henry Schein Cares Foundation Matching Program - Pilot program for Henry Schein matching donations to WorldScopes for stethoscope purchases	Henry Schein Cares Foundation	8/30/2011
1104-0469	Physician Quality Reporting System Academic Testing - An academic medical center collaborative to test PCPI-developed performance metrics	University Health System Consortium Association of American Medical Colleges	6/13/2011
1104-0470	PCPI Measurement from EHRs Webinar with CHIREC - Co-produced webinar with the Chicago Regional Extension Center	CHIREC	6/13/2011
1104-0471	AMA Grand Rounds Program –Program to highlight effective approaches for diagnosing and treating LGBT patients	Pfizer The Fenway Institute	8/10/2011
1104-0475	Partnership with NIA for Go4Life Campaign - Exercise and activity campaign for older adults	National Institute of Aging	10/7/2011
1104-0477	Learning Management System with CE City - Deliver CME, non-CME, and PI-CME AMA educational activities to physicians	CE City	9/30/2011
1104-0478	Patient Preventative Services Brochure with AARP - Patient brochure on preventative services and cost sharing co-branded with AARP and in collaboration with the CDC	AARP CDC	10/21/2011
1104-0482	National Strategic Partnership with USDA - Partnership with the Center for Nutrition Policy and Promotion at USDA to promote the 2011 Dietary Guidelines with other organizations	USDA	7/13/2011
5502-0432	The JAMA Network Author Interviews- JAMA multilingual author interviews translated by Excerpta Medica and posted on the JAMA and Univadis websites	Univadis Excerpta Medica	12/14/2011
5503-0077	HIPAA 5010 Testing Awareness Campaign - AMA Sponsorship of a campaign to prepare physicians for the January 2012 compliance deadline	HIMSS	1/18/2011

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
6602-0406	Nutrition Education Grants Program - Educational grants from Walmart Foundation to the Healthy Communities/Healthy America and Healthy Living grant programs	The Walmart Foundation	8/1/2011
MEMBER SERVICE PROVIDER			
5505-0034	Transfer of AMA Hospital Income Insurance Plan - A new underwriter	New York Life	10/10/2011
5505-0316	AMA Insurance Agency Dental Insurance Program - Addition of a dental plan program	Metropolitan Life Insurance	3/23/2011
5505-0346	AMA-Sponsored Credit Card Program – Transfer of an existing program from Chase Bank to Pentagon Federal	Pentagon Federal	12/6/2011
5505-0456	AMA-Sponsored Credit and Debit Card Processing Service - Transfer of a program from First National Merchant Solutions to TSYS	TSYS	3/15/2011
5505-0471	AMA-Sponsored Kaplan Discount- Member discount on Kaplan USMLE and COMLEX question banks	Kaplan	5/9/2011
BUSINESS ARRANGEMENTS			
5505-0035	AMAIA MPA Service Project - Contest for medical students through MedPlus Advantage to win a medical brigade trip	Timmy Global Health	12/14/2011
5505-4060	AHIMA ICD-10 Training - Co-branded and developed education offerings on the ICD-10 transition	AHIMA	4/26/2011
Projects NOT Approved			
2201-0401	Ladies Home Journal Personal Health History Form - A co-branded personal health history form to run in Ladies Home Journal	Ladies Home Journal	5/23/2011
5505-4062	AMA Co-Branded Syndicated Research Pilot - Development of a syndicated market research offering by the AMA and a market research firm	Reimbursement Intelligence	7/6/2011

23. HEALTH INSURANCE DIFFERENCES CONTRIBUTE TO HEALTH CARE DISPARITIES AND POORER OUTCOMES

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

Policy H-185.943 (AMA Policy Database), adopted at the 2011 Annual Meeting, asks that our American Medical Association affirm its support for elimination of health care disparities that cause differential treatment based on insurance status of Americans. Directive D-350.989 (A-11) asks that the AMA provide a report back on the progress of its efforts at the 2012 Annual Meeting of the AMA House of Delegates.

The directive also seeks to establish an understanding of the effects of insurance status both on access to health care as well as health outcomes, in order to better define the health care delivery disparities within the US health care

system. To that end, this informational report reviews current literature examining the role that insurance status has in a variety of health measures, including access to care, disease screening, morbidity and mortality outcomes, self-reported health, and quality of life. This report provides an overview of the insured (public and private) and the uninsured and addresses the limitations of current knowledge. It also summarizes the current policies and efforts of the AMA to ensure elimination of healthcare disparities and thereby ensure healthcare equity for all.

INTRODUCTION

Health insurance coverage is a complex and rapidly evolving aspect of the US health care system. Where private employment-based health insurance was at one time the pillar of health insurance for most Americans, the cost to employers of providing health benefits to workers has inflated over the past few decades to the point that many employers are now limiting this option. For those who are offered employer-based private insurance, the premiums have increased at such a rate (73% increase since 2000 for family coverage) that it is often unaffordable.¹ Public insurance in the US generally can be broken down into Medicaid and Medicare benefits, with some overlap between the two. While Medicare is fairly standard in its eligibility requirements for those over age 65 or with disabilities, Medicaid eligibility is state-determined and thus varies. The last few years have seen an increase in the demand for Medicaid at the same time that spending has been cut. As of 2008, Medicaid covered 27 million children, 14 million adults, 8 million disabled people, and 6 million seniors. An additional 6 million children are covered by the State Children's Health Insurance Program (SCHIP), which amounts to more than 25% of the nation's children being covered by some type of public insurance.²

Location or region is also tied to insurance status, with rural inhabitants reporting higher numbers of uninsured or of public insurance coverage than those living in non-rural areas.³ Adults with chronic health conditions and disabilities affecting their ability to perform activities of daily living also disproportionately rely on public health insurance (more than 50% compared to less than 5% of adults without any disability). Given the racial/ethnic and socioeconomic differences in the populations who have public versus private insurance, as well as those who have no insurance at all, it is crucial to consider the role that health insurance plays in health outcomes. This report takes a closer look at this issue as it relates to prevention of disease, screening, diagnosis, disease management, and advanced interventions.

THE INSURED: PUBLIC VS. PRIVATE

Access to preventive care is a basic necessity of health maintenance for patients and, as such, provides a sensitive marker for the quality of an insurance plan. For many common diseases, like asthma and diabetes, a strong preventive care relationship can allow most patients to manage their disease effectively in the outpatient setting and avoid related hospitalizations as well as progression of the disease. For example, public insurance coverage is a key predictive variable in the rates of asthma hospitalization. In urban and non-rural areas, the strongest factor determining risk of hospitalization for asthma was insurance type.³ Insured people access care at a rate four times those who lack insurance (35% versus 9%).⁴ In reviewing diabetes care, while those with public insurance (Medicaid or Medicare) had enough contact with the health care system to be recognized as diabetic, prevention of diabetes is weaker than in a population with private insurance.²⁰

Screening and diagnosis are also important aspects of preventive medicine that can serve as a measure of how patients are being served by their health care system. For example, women with a diagnosis of breast cancer who are covered by public health insurance (Medicaid or Medicare) more often present with higher grade cancers, larger lesions, positive lymph nodes, and metastasis compared to women with private insurance.⁵ Similarly, public insurance is correlated with a poor prognosis after a prostate cancer diagnosis as well as decreased likelihood of colorectal cancer screening.^{6,7} These factors suggest that deficits exist in current screening practices for patients with public insurance. Projecting these treatment disparities onto health outcomes can be difficult; however, transplant studies have shown that patients with private insurance report significantly higher quality of life following liver transplant than those patients with public insurance. In fact, insurance status is more predictive of higher post-transplant quality of life scores than a patient's household income.⁸

THE UNINSURED

The largest barrier for those without insurance in the current health system is access to affordable care. Many studies have examined barriers to access for those without insurance and the overwhelming consensus is that a lack of

insurance is detrimental to access to preventive and primary care.^{4,9,10,18} Additionally, studies reveal that the uninsured proportion of the US population is higher among racial and ethnic minority groups.⁴ Overall, the uninsured are more likely than the insured to forego needed health care and to skip filling prescriptions due to costs.⁴ Changing status from uninsured to insurance coverage leads to a 15% increase in use of prescription drugs and a more than 55% increase in the number of outpatient visits.⁹ Studies suggest that the uninsured are less likely to have a usual source of care (or a “medical home,”) that provides them with a consistent source of health care, screening for disease prevention, and treatment for disease management.¹⁸ Health outcomes for the uninsured are therefore negatively impacted.¹⁸ Likewise, problems with access to care often lead the uninsured to postpone needed treatment for injuries, which can cause more serious (and expensive) health problems later due to such delay.¹⁰ Interestingly, those with even a short period of time without insurance in a given year (defined as 1-5 months) reported significantly fewer ambulatory visits and prescription fills during the uninsured period than those with continuous insurance.¹¹

Given that insurance status is in constant flux for many working adults (as many as 12% reported only part-year coverage), it is important to consider the implications for access to health care for those who are frequently moving in and out of the insurance system.¹¹ The literature shows that there are real barriers to receiving adequate screening for disease when one lacks insurance. Uninsured women were 3.66 times more likely to have metastatic breast cancer, 2.37 times more likely to have breast tumors larger than five centimeters, and 1.48 times more likely to have positive lymph nodes than women with private insurance.⁵ These statistics are similar to such screening procedures as pap smears, mammograms, and colonoscopy.⁷ In women with abnormal mammographic or clinical breast examinations, those with insurance are twice as likely to have follow-up with a breast biopsy than those without insurance.¹² These findings illustrate the difficulty faced by patients in obtaining cancer screening and, when a problem is detected, having it addressed in an appropriate manner.

According to recent studies, there is significant improvement in self-reported mental and physical health by patients who obtain health insurance after a period of no insurance. Those with insurance coverage, compared to those without coverage, have an increase of about 10% in the probability of screening negative for depression and a 25% increase in the probability of reporting their health as either good or excellent.⁹ While this effect holds true for all races, it is most apparent for Spanish-speaking Hispanic/Latino populations.¹³ In terms of health outcomes and self-reported quality of life, patients without insurance are therefore being negatively impacted.

Mortality is significantly greater for the uninsured individual relative to insured adults (hazard ratio 1.43), leading to more than 13,000 excess deaths annually.¹⁴ This places lack of insurance third on the list of leading causes of death just behind heart disease and cancer. Also, increased mortality within the uninsured population is disproportionately concentrated in adults with low incomes and chronic illness (specifically diabetes or cardiovascular disease). This may demonstrate the interaction between insurance status and other variables that are known to contribute to poor health outcomes, such as minority status and socioeconomic status.¹⁴

DISCUSSION

Although it is evident in reviewing the literature that public insurance recipients have inferior health outcomes relative to private insurance recipients, independent of racial and socioeconomic factors, the exact reasons for these disparities remain unclear. One possibility is that systemic barriers exist for patients with public insurance in knowing how and what their health insurance covers combined with a lack of understanding of programs offered either through their insurance or the government directly.¹⁵ Patient navigation programs have been developed to help connect patients to available community resources through the help of social workers and community health workers. However, these programs do not seem to address difficulties with handling insurance specifically and work more to remedy socioeconomic inequalities, which is a distinct but intertwined issue.¹⁶ Research is needed to better identify the barriers to patient education, navigation, and communication that lead to inefficiencies in the utilization of public insurance. The challenge in this research will be the state-dependent variance of public health insurance plans (e.g., Medicaid).

Other factors in poorer health outcomes for patients with public insurance may include negative racial bias on the part of providers, patients' lack of trust of the provider and/or the health care system, as well as a lack of access to providers. As an example, for many physicians, Medicaid patients are associated with a perceived lack of reliability and as having poor compliance. These perceptions can foster stereotypes that impact the provider's treatment approach and medical decision making.

Studies reveal that minority patients with Medicaid receive opiates at lower doses for a complaint of back pain when compared to Caucasian patients with private health insurance presenting with the same chief complaint.¹⁷ Further complicating the problem is the limited number of primary care physicians and specialists who are willing to serve patients with public insurance, given the lower reimbursement rate for Medicaid services. This likely explains a large part of the disparity that is evident in preventive care as patients with public insurance struggle to find physicians who will provide basic screening and disease management even though these services are covered by the public insurance plan.

Many of those who are currently uninsured are likely to gain access to health insurance under provisions of the Affordable Care Act (ACA). Insurance coverage has already increased as a result of ACA, resulting in an additional 1.3 million minority adults being covered.¹⁹ It is important to understand the barriers to access to care that remain following full implementation of the ACA and to work towards eliminating these barriers. However, even with the ACA, a significant percentage of people in the US will remain uninsured and many will remain dependent on public insurance; it will also be important to understand the problems that continue to exist for those with public insurance and also work to address these problems. While the idea of expanding coverage to the uninsured is appealing given the evidence showing the poor health outcomes associated with lack of insurance, the overall fiscal impact of these increased expenditures is difficult to estimate. The savings reaped from better preventive care are often delayed by decades and are therefore hard to calculate. Study of the financial impacts of expanding public insurance coverage will likely grow as the landscape of our health care system continues to change. It is important that the AMA continue to monitor such change and its impact on health care disparities.

AMA POLICY AND EFFORTS

The AMA has over 30 policies that address and support the elimination of health care disparities in varying capacities. Additionally, the AMA promoted a focused national campaign, “Voice of the Uninsured”, from 2007-2010 that was intended to impact health system reform and equity in health care. The AMA is represented on national groups working to eliminate disparities and achieve healthcare equity such as the Equity of Care Committee (a subsidiary of the American Hospital Association) and the National Business Group on Health’s Disparities Committee. Since its inception in 2004, the Commission to End Health Care Disparities (CEHCD), sponsored by the AMA, National Medical Association, and National Hispanic Medical Association, has had an AMA president or president-elect as a co-chair. As a result of Resolution 119-A-11, the AMA sent letters in July 2011 to the CEHCD, the NMA, and the NHMA asking that these organizations address the contribution of differences in insurance status to health care disparities. Also, a letter was sent to the Agency for Healthcare Research and Quality (AHRQ) from the AMA requesting that the AHRQ investigate the impact of insurance based health outcome differences and to make appropriate evidence-based recommendations.

In summary, as our AMA collaborates with external partners and applies a disparities lens to internal AMA work through the Office of Healthcare Disparities, our AMA will continue to track, as well as positively impact the progress of healthcare delivery, access to coverage and quality outcomes for all.

REFERENCES

1. Shields AE. “Trends in Private Insurance, Medicaid/State Children’s Health Insurance Program, and the Healthcare Safety Net: Implications for Asthma Disparities.” *Chest*. 2007; 132:818S-830S.
2. Shields AE, McGinn-Shapiro M, Fronstin P. “Trends in Private Insurance, Medicaid/State Children’s Health Insurance Program, and the Healthcare Safety Net.” *Ann. N.Y. Acad. Sci.* 2008; 1136: 137-148.
3. McGrath RJ, Stransky ML, Seavey JW. “The Impact of Socioeconomic Factors on Asthma Hospitalization Rates by Rural Classification.” *J Community Health*. 2011; 36:495-503.
4. Richardson LD, Norris M. “Access to health and Health Care: How Race and Ethnicity Matter.” *Mount Sinai journal of Medicine*. 2010; 77:166-177.
5. DeSantis C, Jemal A, Ward E. “Disparities in breast cancer prognostic factors by race, insurance status, and education.” *Cancer Causes Control*. 2010; 21:1445-1450.
6. Marlow NM, Halpern MT, Pavluck AL, Ward EM, Chen AY. “Disparities Associated with Advanced Prostate Cancer Stage at Diagnosis.” *Journal of Health Care for the Poor and Underserved*. 2010; 21:112-131.
7. Shi L, Lebrun LA, Zhu J, Tsai J. “Cancer Screening among Racial/Ethnic and Insurance Groups in the United States: A Comparison of Disparities in 2000 and 2008.” *Journal of Health Care for the Poor and Underserved*. 2011; 22: 945-961.
8. Saab S, Bownik H, Ayoub N, Younossi Z, Durazo F, Han S, Hong JC, Farmer D, Busuttill RW. “Differences in Health-Related Quality of Life Scores After Orthotopic Liver Transplantation With Respect to Selected Socioeconomic Factors.” *Liver Transplantation*. 2011; 17:580-590.

9. Finkelstein A, Taubman S, Wright B, Bernstein M, Gruber J, Newhouse JP, Allen H, Baicker K. "The Oregon Health Insurance Experiment: Evidence From the First Year." NBER Working Paper Series. 2011; Working Paper 17190. <http://www.nber.org/paper/w17190>. Accessed 1/16/2012.
10. Berdahl TA, Zodet M. "Medical Care Utilization for Work-Related Injuries in the United States 2002-2006. *Med Care*. 2010; 48: 645-651.
11. Gulley SP, Rasch EK, Chan L. "Ongoing Coverage for Ongoing Care: Access, Utilization, and Out-of-Pocket Spending Among Uninsured Working-Aged Adults with Chronic Health Care Needs." *American Journal of Public Health*. 2011; 101(2): 368-375.
12. Jacobson JS, Grann VR, Hershman D, Troxel AB, Li H, Neugut AI. "Breast biopsy and race/ethnicity among women without breast cancer." *Cancer Detection & Prevention*. 2006; 30:129-133.
13. Sudano JJ, Baker DW. "Explaining US racial/ethnic disparities in health declines and mortality in late middle age: The roles of socioeconomic status, health behaviors, and health insurance." *Social Science & Medicine*. 2006; 62: 909-922.
14. McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. "Health Insurance Coverage and Mortality Among the Near-Elderly." *Health Affairs*. 2004; 23(4): 223-233.
15. Ramos BM, Jurkowski J, Gonzalez BA, Lawrence C. "Latina Women: Health and Healthcare Disparities." *Social Work in Public Health*. 2010; 25:258-271.
16. Kim J. "Socioeconomic Inequalities in Self-Rated Health Among Middle-Aged and Older Adults." *Social Work in Health Care*. 2011; 50:124-142.
17. Nampiaparampil DE, Nampiaparampil JX, Harden RN. "Pain and Prejudice." *Pain Medicine*. 2009; 12(4): 716-721.
18. Hammond WP, Mohottige D, Chantala K, Hastings JF, Neighbors HW, Snowden L. "Determinants of Usual Source of Care Disparities among African American and Caribbean Black Men: Findings from the national Survey of American Life." *Journal of Health Care for the Poor and Underserved*. 2011; 22:157-175.
19. Sommers B, Kronick R. "The Affordable Care Act and Insurance Coverage for Young Adults." *JAMA*. 2012; 307(9): 913-914.
20. Hastings JF, Hawkins J. "Health Insurance and Diabetes Among Multiracial Men: The Mediation Effects of Usual Source of Care." *American Journal of Men's Health*. 2010; 4(3):207-217.

24. RESIDENT AND FELLOW REPRESENTATION IN THE AMA HOUSE OF DELEGATES

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2006 Annual Meeting, the House of Delegates (HOD) adopted policy that provided a proportional method for resident and fellow representation in the HOD. At that time, the HOD decided to add resident and fellow delegates on the basis of one seat for every 2,000 resident and fellow members.

AMA Policy D-600.965 (AMA Policy Database) provides that the proportional representation structure for adding resident and fellow delegates to the House of Delegates shall be reviewed at the end of the fifth year of implementation. This informational report is provided for that purpose.

BACKGROUND

Resident and fellow representation in the HOD was initiated by Resolution 612-A-05, "Resident and Fellow Representation in the AMA House of Delegates," and was referred at the 2005 Annual Meeting. This resolution directed the AMA to:

Investigate and recommend at the 2006 Annual Meeting how to provide equal voting representation of residents and fellows in House of Delegates.

Testimony on Resolution 612-A-05 emphasized the importance and value of resident and fellow representation in the HOD and highlighted the inequity of having 24,069 (year-end 2004 numbers) resident and fellow members represented by very few delegates.

Board of Trustees Report 20-A-06, "Resident and Fellow Representation in the AMA House of Delegates," was prepared in response to Resolution 612-A-05. The House of Delegates adopted BOT Report 20 in lieu of Resolution 612, which led to sectional delegates being seated in the HOD under AMA Policy D-600.965.

DISCUSSION

Proportional representation was implemented because residents and fellows were substantially underrepresented in the HOD in relation to their AMA membership. In the absence of proportional representation, this would continue to be true.

At year-end 2005, there were 23,430 resident and fellow AMA members. At year-end 2011, there were 36,344 resident and fellow members, which was 16.7% of the AMA's total membership. Without proportional representation, only seven residents and fellows would have participated in the HOD as part of a state or specialty delegation in 2011. Of the seven residents serving in the HOD, two were delegates and five were alternate delegates, which represented less than 1% of the HOD. Factoring in proportional representation in 2011, the total number of resident and fellow delegates and alternates participating in the HOD was 37, which is 4% of the HOD.

Residents and fellows were given proportional representation because they have unique challenges and perspectives that should be reflected in AMA policy. This also gives state and specialty leadership the opportunity to mentor future leaders, since residents are seated with and represent their endorsing society in the HOD.

CONCLUSION

Resident and fellow membership in the AMA has increased 55% from 23,430 in 2005 to 36,344 in 2011. Residents and fellows comprise an increasing percentage of the AMA's membership and offer unique perspectives that should be considered in the AMA policy process. Proportional representation of resident and fellow members provides this important segment with a meaningful, representative voice in the HOD.

25. AMA PERFORMANCE, ACTIVITIES AND STATUS IN 2011

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

Policy G-605.050 (AMA Policy Database) calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. The core strategy the AMA employs to accomplish this mission is—put simply—to help doctors help patients. To that end, the AMA brings together physicians and medical students from around the United States to address the most important professional and public health issues.

In 2011, the AMA focused its activities on a series of strategic goals and complementary services, many relating directly to specific aspects of its broad vision for comprehensive health care system reform. This report summarizes the AMA's 2011 activity toward its goals.

AMA'S PRINCIPAL COMMITMENTS TO FURTHER THE CORE STRATEGY IN 2011

Quality of Care

As of December 2011, there were 182 PCPI member organizations, a 6% increase over 2010. This increase was the result of an extensive communication campaign, with promotions on the PCPI website, targeted AMA membership promotions, Webinars, and various AMA publications, including *JAMA* and *AMNews*.

Performance measures developed by the AMA-convened Physician Consortium for Performance Improvement® (PCPI™) constitute 68% of *unique* measures in the 2011 Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS) program and 43% in Stage 1 Meaningful Use (MU) program.

PCPI measures were on the active measure development list evaluated for feasibility of EHR specification with 80% identified as eligible. Through December 2011, 35% of the eligible measures were specified for EHRs.

The PCPI's Quality Improvement Panel members convened in August 2011 for a full day to begin to develop a recommendation related to gaps in the current quality improvement support environment.

Phase I of the PCPI website upgrade was completed with content updated and a new interface to select PCPI measures implemented.

The AMA initiated the exploration and feasibility phase of the National Quality Registry Network (NQRN) concept, including two stakeholder meetings and support of a multi-stakeholder task force. Two documents were developed and distributed to PCPI members and others interested in registries entitled "Advancing Health Care Improvement Through Patient Registries: Moving Forward" and "The NQRN Coordinating Task Force Recommendation."

Medical board maintenance of certification (MOC) programs continue to remain in various stages of development so it is not possible to have measures fully embedded; however, the PCPI and American Board of Medical Specialties have agreed to involve medical boards in measure projects relevant to the respective boards. In 2011, 6 boards (ABR, ABAI, ABIM, ABEM, ABPN, ABA) were engaged in PCPI work that has been completed or is underway. Two additional boards (ABOS, ABS) will be included in upcoming measure projects.

The AMA submitted a letter along with 38 specialty societies to the Health IT Policy Committee on proposed MU Stage 2 requirements and facilitated specialty societies input at a hearing on MU Stage 2. The AMA also submitted testimony to the HIT Policy Committee's Certification/Adoption Workgroup on EHR usability and continues to meet with the Office of the National Coordinator (ONC) and CMS to communicate needs of physicians in adopting an EHR and the need to synchronize incentive programs, particularly those related to measurement and e-prescribing. The CMS final rule on Stage 2 MU represents an increased alignment of measures in PQRS, MU and e-prescribing requirements.

The development of performance improvement continuing medical education (PI-CME) activities in 2011 included modules on influenza vaccination and on obesity, both of which were certified for CME credit.

Prevention and Wellness

Two Webinars on competencies and practice implementation on gaps in clinical care were conducted in 2011. The Webinars were actively promoted by the medical societies of Arizona, Ohio, and Mississippi and by the American College of Preventive Medicine, the Illinois Alliance for CME, the American Association of Physician Assistants, the Public Health Education and Health Promotion Section and the Alcohol, Tobacco & Other Drug Section of the APHA also promoted the Webinars.

Collaborations have been established to promote AMA prevention and wellness activities with the Partnership to Fight Chronic Disease (PFCD), the National Physical Activity Plan, the United States Department of Agriculture (USDA), the American Association for Retired People (AARP), CDC, CMS, the One Million Hearts Campaign, Substance Abuse and Mental Health Services Administration (SAMHSA), Food and Drug Administration (FDA), American College of Preventive Medicine (ACPM), American College of Lifestyle Medicine (ACLM), and the Partnership for Prevention. A CME session on the National Physical Activity Plan was held at the 2011 Interim Meeting of the House of Delegates.

The AMA's obesity prevention campaign, Weigh What Matters (WWM), was launched in September 2011, with a Webinar for participating physicians. Twenty-two physician practices in three states (New Jersey, Tennessee, and New Mexico) participated in the pilot. The program consists of an extensive series of resources available to physicians to help address obesity issues with patients. Collateral products developed include a physician manual, a series of trackers in English and Spanish, posters for the office, a scale hanger, branded BMI wheel as well as a number of other resources to support physicians as they address this issue with patients. The WeighWhatMatters.org website was also launched in early September, and the development of a smartphone application to support patient behavior change and tracking is under development. The revised family obesity monograph has been completed and is posted on the AMA's website. The monograph is featured on the newly designed Doctors' Channel website along

with two CME videos for total of 3 CME credits on Promoting Healthy Families (www.thedoctorschannel.com/go/Obesity_CME/).

A number of Cook County physicians completed the AMA's Healthier Life Steps (HLS) pilot test. Initial results indicate strong physician approval of the materials and acceptance by patients. The practices agreed that the program materials made it easier for them to approach patients about lifestyle issues, and both patients and physicians indicated that patients had a "positive" response to the program and "somewhat agree" that the program helped their patients make positive lifestyle changes.

A three-part CME program has been developed in collaboration with Medscape, CMS, and CDC on the annual wellness visit utilizing information from the *CPT Pocket Guide* and *Medicare Brochure*. The three parts include: 1) A PowerPoint presentation with audio to address Medicare preventive services; 2) A simulated patient vignette to identify methods to engage and code for services; and 3) FAQs that will be provided by CMS, AMA, and CDC.

Medical Education

The LCME database for 2012–2013 full surveys were completed for preliminary and provisional accreditation and were posted on the LCME website. The LCME's *Guide to the Institutional Self-Study*, to accompany the 2013 databases, was completed and posted. Two new LCME survey team orientation sessions were implemented in 2011. Data from the LCME 2010-2011 Annual Medical School Questionnaire, which contained questions on mistreatment/professionalism, contributed to the student mistreatment conference and the Council on Medical Education's report on this subject at the 2011 Interim Meeting.

The AMA's graduate medical education (GME) program was active in 2011. GME program requirements for nine additional disciplines were developed and the Accreditation Council for Graduate Medical Education (ACGME) was alerted to new AMA House of Delegates policies affecting GME. Visits and page views of FREIDA Online increased 23% and 6%, respectively, in 2011 compared to 2010. AMA GME workforce policies and GME strategies were presented at eleven national meetings and over 80 requests from the press, governmental agencies, and AMA officials were answered. The AMA supported, and the US House approved, H.R. 1852 to reauthorize federal funding for GME positions for freestanding children's hospitals and S.1627, Resident Physician Shortage Reduction Act of 2011. The AMA joined 39 other organizations calling on the special joint senate house committee on deficit reduction (the "Supercommittee") to protect existing Medicare GME funding; and advocated against Public Citizen's petition that OSHA regulate resident duty hours.

Nineteen new medical schools joined the AMA's Innovative Strategies for Transforming the Education of Physicians (ISTEP) program in 2011, bringing the total to 31 schools and 6,000 students now participating in the learning environment study. An article was published in *Academic Medicine* in November on ISTEP Sound Prescribing. Three national invitational meetings were held highlighting innovations resulting from 2010 New Horizons Conference, focusing on the medical education learning environment and connecting with the ISTEP study.

The AMA partnered with the Federation of State Medical Boards (FSMB) to identify needs for physician Maintenance of Licensure (MOL) and/or reentry programs and produced a report outlining next steps. The report was disseminated nationally for comments. A survey on physician reentry policies was disseminated to 65 medical boards and obtained an 88% response rate. The results will be analyzed and published in the 2012 "State Medical Licensure Requirements and Statistics" book.

Ethics

Collaboration was initiated between the Council on Ethical and Judicial Affairs (CEJA) and the Council on Constitution and Bylaws (CCB) to review updated content of the *Code of Medical Ethics*. CCB has completed its review of the chapter on inter-professional relationships. Drafts have been completed of updated content for chapters on privacy and confidentiality, genetics and reproductive medicine, organ procurement and transplantation, and public health. Work plans have been developed for significant revision of chapters on research and innovation, health care financing and delivery, and opinions E-8.061 and E-9.011 as a follow-up to adoption of CEJA Report 1 on Financial Relationships with Industry in Continuing Medical Education at the 2011 Annual Meeting.

The AMA convened a multi-stakeholder expert panel on ambulatory safety and care transitions. The panel obtained consensus on several core issues, including a model for care transitions and identification of five care transitions domains, with key roles for ambulatory practitioners. The panel is developing a monograph entitled, *Safer Transitions in Care: The Roles of Ambulatory Practices*. Initial assessments of the monograph's impact are pending, but the expert panel members expressed their appreciation for the AMA taking leadership by promoting the roles of ambulatory practitioners in safer care transitions.

A comprehensive overview of the state-of-the-field in ambulatory safety and a chronological time-line of ten years of ambulatory patient safety research were developed. Increasing attention is being given to ambulatory safety research in peer reviewed journals, and experts recognize the difficulties in translating inpatient safety methods and practices to ambulatory care. Once again, the experts have indicated their appreciation of AMA leadership in these domains.

Nine hospitals have used the Communication Climate Assessment Toolkit (C-CAT) in 2011. A user feedback meeting was conducted in December and received positive comments and very strong support from existing users. Interviews of C-CAT users show that hospitals are using survey results to enhance quality improvement efforts and culturally competent care. Specifically, the tools are often helpful in obtaining leadership support for initiatives to improve patient-clinician communication. C-CAT is being adapted for use in Canada in collaboration with the Canadian Medical Association.

An iPhone app to facilitate safer patient care transitions from the hospital to the outpatient/home care setting was developed in 2011, and marketing of the tool has begun. The AMA has received requests to use the "Physicians Role in Medication Reconciliation" monograph and "My Med Card" from Bon Secours Health System Inc. in Richmond, VA, the Cleveland Clinic, and others.

Virtual Mentor (VM) will move to the Silverchair platform with *JAMA* and the *Archives* in 2012, boosting awareness and readership of the journal and adding ethics to the AMA's recognized publication offerings. Visits to *VM* increased by 14% over 2010 and pages viewed increased 17%.

The AMA convened a meeting in July 2011 on patient safety organizations (PSOs), with representatives of AHRQ, the Iowa Foundation for Medical Care and PSOs. An AMA-branded PSO systems readiness checklist was developed for the AMA website, and a survey of physician experience in patient safety, the Patient Safety Quality Improvement Act (PSQIA), and PSOs is being developed. An agreement with AHRQ was reached to collaborate to develop Train the Trainer materials for educating physicians and others on the PSQIA and reporting to a PSO.

Science, Medicine and Public Health

Mental/emotional health modules for the AMA's Healthier Life Steps program and for the Healthier Life Steps™ Toolkit: *A Physician's Guide to Emotional (Mental) Health* were developed for both patient and physician health. CME programs on *MyPlate* and intimate partner violence were completed in 2011.

The AMA produced and disseminated an influenza immunization pocket guide to more than 240,000 physicians through *AMNews*. The AMA continues to lead the National Influenza Vaccine Summit with the CDC and other stakeholders. The AMA Board Chair participated in the 2011 National Influenza Press Conference, which received significant media attention. The AMA holds weekly Summit calls and also sends out regular Summit eUpdates. Summit efforts have resulted in an increase in influenza immunizations in the 2010-2011 season, and current mid-season results show continued improvement. More than 160 million doses of vaccine were available in the 2011-2012 flu season.

The physician health survey of 90,000 physicians was completed, and a commentary based on the findings was submitted to the *New England Journal of Medicine*. The next phase of the physician health survey will involve sending the survey to 15,000 randomly selected residents in training (across specialties) and to 15,000 randomly selected students.

A CME application to convert the live presentations from the Commission to End Health Care Disparities conferences into enduring CME credit for posting on the AMA-Commission website was submitted. An educational session on disparities was presented at the 2011 Annual Meeting, and an interactive CME session on Cultural

Competency, “Building Blocks for Patient-Centered Care in 21st Century Medicine,” was developed with the New Hampshire Medical Society and presented in September.

Clinic staff in Chicago received in-person training on clinical smoking prevention interventions, and a Webinar was produced and is being marketed to faculty at Chicago area medical schools to promote to their students. Nearly 200 Chicago-area medical students have been trained. A Chicago Transit Authority (CTA) ad campaign promoting the quit line and smoking cessation began in November ran through early 2012. An abstract on the medical student training project was submitted and accepted to the Break Free Alliance Conference that addresses tobacco use in low income and special populations.

AMA activities in genetics, personalized medicine, and pharmacogenomics made significant contributions in 2011, including meetings and collaborations on evidence-based strategies for educating physicians in genetics, addressing regulatory proposals for genetic tests, and pharmacogenomics education with the pharmacy community. The “Genetics of Colorectal Cancer” program was launched, and the AMA’s Personalized Medicine Physician Workgroup developed consensus guiding principles that were approved by Board of Trustees. The AMA’s comment on the FDA’s Draft Guidance on Companion Diagnostics and AMA’s testimony at the FDA’s Molecular and Clinical Genetics Panel/Medical Devices Advisory Committee hearing addressing the scientific basis of DTC genetic testing both garnered significant media attention.

Four issues of the AMA’s *Disaster Medicine and Public Health Preparedness (DMPHP)* journal were published in 2011. The number of subscriptions to the journal increased by 19.5% over 2010 to 318. *DMPHP* articles were cited 38 times in broadcast and print/online. The March quarterly issue of the journal and a special issue on nuclear preparedness were published in the first quarter of 2011 and received significant media attention.

A two-hour Webinar was hosted in April on the health implications of the nuclear reactor crises in Japan. The program was viewed by 968 participants and received 13 earned media mentions. A speaker’s kit on radiation for physicians and other health professionals was developed as well as modules on “disaster preparation and planning” and a “terrorist bombing” scenario. A 90-minute education session on radiation was also convened at the 2011 Annual Meeting.

The AMA has updated its Advanced Disaster Life Support program, for pilot testing at two training sites, and has published a new edition of the Basic Disaster Life Support program. Nearly 6,000 physicians, first responders, and others attended NDLS programs in 2011.

The National Disaster Life Support Education Consortium, co-sponsored by the AMA and the National Disaster Life Support Foundation, Inc., increased its membership by 23% since 2010 and currently has 125 members.

The geriatric competencies for surgery residencies have been widely disseminated through publication in the Journal of the American College of Surgeons and have been presented to the Boards of Urology and Emergency Medicine. A review of the United States Medical Licensing Exam (USMLE) for geriatric content was completed and submitted to the National Board of Medical Examiners (NBME) for its review and approval.

The AMA’s e-book, *Geriatric Care by Design: a Clinician’s Handbook* and Web course, “Medical Fitness to Drive: is your patient at risk?” were promoted at three national conferences and in multiple announcements. 5,000 printed copies and 1,000 CDs of *Geriatric Care by Design* were produced, and over 3,500 print copies and 150 CDs were distributed to residency directors and practice managers for use in educational programs.

The 4th edition of the *Medical Management of the Home Care Patient: Guidelines for Physicians* was launched on the AMA website in December, and 5,000 print copies were made available in January 2012.

FEDERAL AND STATE ADVOCACY

Medicare Physician Payment

A 27 percent Medicare payment cut for physician services scheduled for January 1, 2012, was prevented and future cuts postponed until 2013. Bipartisan momentum for permanent repeal of the sustainable growth rate (SGR) formula grew substantially.

Legislation to repeal the scheduled Internal Revenue Service withholding of 3 percent of federal contractor payments, including Medicare payments to physicians, passed the US House following advocacy efforts by the AMA and the Government Withholding Relief Coalition.

Based on policy adopted by the AMA House of Delegates, the AMA secured introduction of H.R. 1700, introduced by Rep. Tom Price (R-GA), and S. 1042, introduced by Senator Lisa Murkowski (R-AK), to allow physicians and Medicare patients to privately negotiate payment rates that differ from Medicare with no penalties for either party.

In response to persistent AMA advocacy, the Centers for Medicare & Medicaid Services (CMS) reimbursed physicians for retroactive increases made by the Patient Protection and Affordable Care Act (ACA) related to geographic adjustments for work and practice expense values.

At the urging of AMA and other national medical associations, provisions that would have produced more than \$400 million in new Medicare cuts for imaging procedures were eliminated as a budget offset in the Trade Adjustment Authority legislation.

The final rule on Medicare physician payments for 2011 reflected a number of AMA policy recommendations including a proposal to create a Medicare Economic Index technical panel to consider revisions in the tool used to reflect practice cost inflation and improved availability of primary care bonus payments. An AMA economist was selected as a member of that panel.

Regulatory Relief

AMA secured substantial wins on Medicare enrollment including extending the revalidation period through 2015 so that physicians will have much more time to re-enroll in Medicare. Additional improvements were secured in Medicare's internet-based provider enrollment system (PECOS), including automation to simplify the process for physicians updating their information and an indefinite postponement of a requirement for all referring and ordering physicians to be enrolled in the system.

At the AMA's urging, language was inserted in the FY 2012 House Labor-HHS-Education appropriations bill to prevent a contemplated expansion of the Emergency Medical Treatment and Labor Act (EMTALA) mandate. CMS subsequently withdrew its EMTALA expansion proposal.

Due to aggressive AMA advocacy, CMS took the rare step of opening up the regulatory process to greatly expand the number and breadth of hardship exemptions in the e-prescribing program. CMS sent letters to and called each physician they anticipated would be subject to a penalty. When at the 11th hour physicians had technical difficulties filing their hardship exemptions, AMA immediately secured a one-week delay.

President Obama signed into law the "Red Flag Program Clarification Act of 2010," which limits the type of "creditor" that must comply with the Red Flags Rule that is intended to help prevent consumer identify theft. The AMA advocated for this legislation after the Federal Trade Commission (FTC) determined that physicians would be classified as creditors for purposes of this rule and inappropriately subjected to new administrative burdens.

Legislation was signed into law that repealed a provision in the ACA that would have required businesses, including physician practices, to file a 1099 form with the Internal Revenue Service (IRS) for every vendor or contractor paid more than \$600 for goods or services in a year.

Aggressive AMA advocacy secured retraction of CMS's physician signature requirement for all lab test requisitions.

AMA advocacy resulted in CMS revising the home health face-to-face encounter requirement to significantly extend the period of time in which the encounter can occur. The AMA also secured a three month delay in implementation of this requirement.

Fraud and Abuse

Directly pursuant to AMA advocacy, CMS announced a new streamlined process for investigating and restoring the financial integrity of physicians who are victims of identity theft in the Medicare program. Among other things, each program integrity contractor will have an ombudsman to assist physicians.

Significant improvements were made in the processes governing Medicare Recovery Audit Contractors (RACs), including limits on the number and frequency of medical records that can be requested from physicians, expedited coverage and coding reviews, and greater accessibility to RAC medical directors.

Improvements were made in the Medicaid RAC program and its implementation was delayed. Adopted improvements recommended specifically by the AMA include a limited claims look-back period, limits on the number and frequency of medical record requests, and employment of a full-time physician medical director and certified coders.

Medical Liability Reform

The AMA collaborated with medical societies in Tennessee (\$750,000 cap on non-economic damages), Florida (expert witness requirement reforms), West Virginia (state's highest court affirmed cap on non-economic damages) and North Carolina (\$500,000 cap on non-economic damages) to successfully enact legislation and/or defend AMA-consistent policies in the courts.

The House Judiciary Committee and the Energy and Commerce Committee both took positive action on H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Health Care (HEALTH) Act. The HEALTH Act includes comprehensive medical liability reforms, including a cap on noneconomic damages. AMA advocacy efforts included an ad campaign highlighting the impact that medical liability has on health care costs.

After successful lobbying by the Oklahoma State Medical Association with advocacy support from the AMA, Gov. Mary Fallin signed House Bill 2128, which establishes a \$350,000 cap on noneconomic damages for claims for bodily injury filed on or after Nov. 1, 2011.

Quality Improvement and Delivery System Innovation

Final regulations setting forth the structure and rules governing Medicare Accountable Care Organizations (ACOs) were vastly improved, reflecting AMA recommendations. Improvements include reduced financial risk to physicians and greater opportunity to share in savings, and fewer required quality measures.

AMA advocacy secured a new \$170 million program to provide physicians with the upfront capital needed to invest in the infrastructure required to form an ACO. The program is targeted specifically at physician-led ACOs that do not include a hospital.

AMA advocacy led to the Federal Trade Commission and Department of Justice issuing a joint statement on ACOs that incorporates many AMA recommendations to ease antitrust and anti-kickback impediments to small physician practices leading the formation of the new health care delivery models.

AMA secured additional improvements in the Physician Quality Reporting System, including the lowering of thresholds to ease reporting and interim feedback to physicians that are planned for 2012 to promote successful reporting.

Implementation of Stage 2 of the Health IT Meaningful Use requirements was postponed.

Health Insurance Market Reform

The National Association of Insurance Commissioners (NAIC) passed a controversial but patient-friendly medical loss ratio regulation that will require health insurers to provide consumers with rebates if they spend less than 80 percent (small and individual insurers) or 85 percent (large insurers) of premium dollars on medical care. The AMA

advocated for these rigorous standards to ensure that the maximum amount of premium dollars are spent on medical care rather than administrative expenses and will continue to press to keep these provisions in the final regulation.

The AMA led rigorous advocacy efforts that defeated the National Conference of Insurance Legislators proposed prohibition of balance billing. The AMA successfully advocated for the adoption of the “Healthcare Balance Billing Disclosure Model Act,” which requires health insurers, health care facilities and facility-based physicians to disclose to patients that they may receive a bill for medical services they were provided that their health insurance does not pay.

FDA And Drug Policy

Legislation banning the sale of products containing methylenedioxypropylvalerone, also known as “bath salts,” advanced through the committee process in the US House and US Senate, with the AMA’s support and consistent with policy adopted at the 2011 Annual Meeting.

Private Insurance Advocacy

The AMA released its fourth annual National Health Insurer Report Card, which provides a reliable source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by health insurance companies. The results reflect tremendous improvements since the NHIRC’s inception in 2008, including a 50% improvement in payment accuracy by UnitedHealthcare, large reductions in denial rates by Aetna, Anthem Blue Cross Blue Shield, CIGNA, Health Care Service Corporation and UnitedHealthcare, which cut its denial rate by half since 2010 to 1.05 percent, and large reductions in median claims response times, with both CIGNA and Humana having cut those times in half.

The AMA collaborated extensively with the Medical Association of Georgia (MAG) to ensure enactment of key legislation that extends the state’s prompt pay standards to third-party administrators. This enactment establishes a precedent for the AMA to advance its “full enforcement” agenda in other states.

Consistent with AMA policy and advocacy efforts, the URAC Health Standards Advisory Committee revised its standards for “Health Plan, Health Network and Utilization Management” to use pluralistic approaches to the verification and validation of physicians’ credentials, standardize the timely review of physician privileges applications, encourage health networks to issue accurate provider directories and strengthen credentialing application standards.

Following AMA and Federation advocacy, UnitedHealthcare changed its coordination of benefits policy so that it will now process and release for reimbursement claims that are less than \$10,000, regardless of pending coordination of benefits inquiries.

FAIR Health was created to establish and maintain a new database for “usual, customary and reasonable” charges that will enable consumers to look up the average costs for medical services according to the region in which they live. The AMA worked closely with national medical specialty societies to appoint physicians representing 14 specialties to the Health Provider Advisory Group, which will assist FAIR Health in ensuring that the information it publishes accurately reflects physician charges and provides consumers with correct, clinically appropriate information.

Antitrust

Through multiple meetings with the Department of Justice (DOJ) Chief of Litigation in the health care area, the AMA obtained a commitment for review of AMA referrals of health insurer anticompetitive conduct. The AMA also coordinated and moderated a national antitrust leadership conference for orthopedic surgeons and the DOJ, the FTC and Congressional leaders. This conference resulted in a US House Judiciary Committee hearing on health insurance market concentration.

Administrative Simplifications

The AMA successfully advocated to X12, a key organization for the development of electronic standards, that electronic standard transactions must identify all of the organizations that play one or more of the health plan roles. The next version of the electronic health care standard transactions will require identification of all health insurer intermediaries. This will make it possible for physicians to handle eligibility and claims issues without having to pick up the phone.

Protecting the Practice of Medicine

In response to advocacy by AMA, the American Society of Anesthesiologists, and other specialty societies, Reps. John Sullivan (R-OK) and David Scott (D-GA) introduced H.R. 451, the Healthcare Truth and Transparency Act, to help patients make more informed decisions by prohibiting health care professionals from engaging in misleading and deceptive advertising about their training and qualifications.

In the first full year of the “Truth in Advertising” campaign, more than 10 states introduced legislation based wholly, or in part, on the AMA model Truth in Advertising bill. Utah enacted Senate Bill 134, which requires all health care providers to disclose their type and title of their license in any advertisement for their services, and several other state efforts are ongoing. In addition, the AMA—with its state and specialty medical society partners—is developing additional materials to further assist states in enacting legislation for both the current and future legislative sessions.

Grassroots

Physician activists were very engaged in 2011, generating more than 26,000 contacts to Capitol Hill, including nearly 8,000 phone calls. The Patients’ Action Network generated more than 820,000 contacts to Congress, recruiting nearly 200,000 new activists and growing its social media reach by 107%. A number of campaign plans were presented and executed effectively throughout the year. Most notably, an integrated effort involving mail, TV, and digital outreach was conducted in the fall to engage grassroots activity on behalf of the AMA’s Medicare SGR repeal message. The campaign reached millions of voters in targeted Congressional districts and gained even more traction online as the popular TV spot received nearly 400,000 views via YouTube.

Litigation Center

Challenges to the settlement in *American Medical Association v. United Health Care* were successfully resolved, and a final distribution order, which authorized approximately \$200 million in payment to physicians (out of a total settlement fund of \$350 million), was prepared for the court. Approval for distribution of the settlement and payments began in early 2012.

The United States Court of Appeals for the Second Circuit found that, as a result of the Red Flags Program Clarification Act, physicians and other professionals would not be required to comply with the Federal Trade Commission Red Flags Rule regulation.

The Litigation Center helped to fund a challenge in *Iowa Medical Society v. Iowa Department of Public Health*, to regulations of the Iowa Department of Public Health and the Iowa Board of Nursing that allow advanced registered nurse practitioners to supervise fluoroscopy procedures.

MacDonald v. City Hospital upheld the West Virginia statutory cap on noneconomic damages in medical liability suits, and *Stinnett v. Tam* upheld a similar cap in California. Also, in *Loudin v. Radiology Imaging Services, Inc.*, the Ohio Supreme Court refused to allow emotional distress damages in medical liability suits unless those damages accompanied a physical injury. The Litigation Center had filed *amicus* briefs in all of those cases.

In *Brown v. Gaalla* the Litigation Center filed an *amicus* brief to support a claim by a group of Indian cardiologists that a hospital had denied them medical staff privileges on account of their national background. In *Palomar Medical Center v. Sebelius*, the Litigation Center filed an *amicus* brief to oppose a RAC audit of payments received under Medicare.

A SUSTAINABLE AMA

Detailed information about the AMA's financial results, including the audited financial statements, is available in the 2011 *AMA Annual Report*.

Business Products and Services

The Business Products and Services (BPS) team supports AMA's strategic direction by delivering impactful and profitable physician solutions and services which fund AMA's mission-focused activities, operations, and administration

In 2011, BPS offered member value by providing revenue generating products and services that enabled physicians to solve problems in their day to day practice. BPS improved the usefulness of existing CPT coding and practice related products such as Code Manager Online, enhanced physician credentialing services by introducing Continuous Monitoring Profiles, offered new insurance benefits (eg, physician dental plan), and launched the AMA member APP Challenge program which engaged members in the development of two new smartphone applications (CPT E/M Quick Ref and My Medication).

GOVERNANCE AND MANAGEMENT

House of Delegates Meeting Operations

In 2011, the use of virtual reference committees (VRCs) expanded dramatically. For the 2011 Annual Meeting, a single reference committee collected online comments and prepared a preliminary report, but for the 2011 Interim Meeting, all reference committees did likewise. On the whole, these VRCs expedited the onsite hearings. Although some have expressed concern about the role of the VRCs relative to the onsite hearings, feedback overwhelming supports continued testing of the concept. The tools upon which the VRCs are built have been extended to collect feedback on other issues for the House of Delegates (HOD), including a forum on the Interim Meeting.

For the HOD meetings themselves, an investment was made in hardware to ensure more reliable and consistent access to the AMA's onsite wireless network. This has improved attendees' access to online materials while allowing a decrease in the number of printed copies of reports and other materials.

The *Proceedings* for each HOD meeting have incorporated a number of improvements that allow users to link an item of business to the corresponding reference committee report or the resulting policy statement as recorded in PolicyFinder (www.ama-assn.org/go/policyfinder).

Corporate Review Process

Corporate activities that associate the AMA name or logo with a company, non-Federation association, or foundation, or include commercial support, must undergo review and recommendations by the Corporate Review Team (G-630.040, AMA Policy Database). Chaired by the Vice President, Governance and Program Support, the Corporate Review Team (CRT) includes senior managers from Finance, Business, Advocacy, Federation Relations, Office of the General Counsel, Science, Ethics, Marketing/Communications, and Membership to provide a cross functional review of new initiatives in accordance with *Guidelines for American Medical Association Corporate Relationships*. For each project, the CRT evaluates fit with AMA mission and values, use of AMA logo, funding source, risk of implied endorsement or undue influence, and background on external partners. CRT recommendations are summarized annually for the Board of Trustees and provided for information to the House of Delegates at the Annual Meeting. In 2011, 26 activities were approved through the CRT process and implemented. In addition, two projects were not approved due to potential negative impacts to the AMA.

International Relations

The strategic objectives of the AMA's role in international health are to influence policy and operations at the World Medical Association (WMA) and to demonstrate influence on the World Health Organization through WMA or directly.

The following 2011 accomplishments helped fulfill these objectives:

- The AMA contributed written testimony through its delegation, including comments solicited from appropriate Federation organizations, on WMA policies on disaster preparedness, the global burden of chronic disease, access to adequate pain treatment, health hazards of tobacco and tobacco-derived products, and end-of-life medical care. All these policies were adopted at the 2011 WMA General Assembly in Uruguay. The AMA introduced a new policy on electronic cigarettes with consultation from the American Academy of Pediatrics and other international experts.
- Dr. Cecil B. Wilson was appointed to the US Delegation to the World Health Assembly of the World Health Organization (WHO) in Geneva. Dr. Wilson was able to promote a wide range of AMA and WMA policies on public health and the socioeconomic aspects of medical practice during his interactions with the Secretary of HHS and other department officials.
- In preparation for the UN High Level Meeting on Non-Communicable Diseases in September 2011, the AMA submitted written testimony to the WHO on chronic disease, including the hazardous use of alcohol.

AMA Councils, Section, and Special Groups

The Council on Long Range Planning and Development (CLRPD) continues in its advisory role to the Board of Trustees. To that end, the CLRPD solicits and synthesizes input from constituent groups into an annual report, “Synthesis of Stakeholder Input,” which plays an important role in the AMA’s strategic planning process.

The CLRPD developed a Letter of Application for use by component groups seeking to change their status and become AMA sections.

In 2011, the CLRPD submitted two informational reports to the HOD: (1) “International Medical Graduate Leadership Report,” and (2) “Demographic Characteristics of the House of Delegates and AMA Leadership.” Additionally, the HOD adopted the report, “Proposal for an Integrated Physician Practice Section,” which will transition the Advisory Committee on Group Practice Physicians to the Integrated Physician Practice Section as a delineated section.

Last year, a marketing plan was developed for the CLRPD’s Health Care Trends Report, which has greatly increased the visibility of this product. Health Care Trends Fact Sheets on “Science and Technology” and “Health Care Resources” were developed and present information from these *Health Care Trends* chapters in a condensed format. Four chapters of the Trends Report are posted on the Introduction to the Practice of Medicine (IPM) website.

The Council on Constitution and Bylaws (CCB) updated the House of Delegates Reference Manual: Procedures, Policies and Practices and the AMA Constitution and Bylaws (with changes for both A-11 and I-11) and achieved widespread electronic distribution of both.

CCB amended the Bylaws to: (1) establish the Minority Affairs Section; (2) modify the allocation and apportionment formula to expand representation in the HOD for Medical Student regional delegates; (3) specify which AMA sections are fixed and which are delineated; and (4) establish the role of the Council on Long Range Planning and Development and the Board of Trustees vis-à-vis the special groups, sections and ad hoc committees.

CCB also authored reports to: (1) codify into policy the criteria for fixed and delineated AMA sections; (2) update the HOD on the CCB/CLRPD collaboration to develop a methodology to consolidate AMA policies and devise new mechanisms to guide the development of future policies, and (3) review and provide recommendations for sunset and/or retention of AMA policies and directives from 2001.

CCB worked through the Board of Trustees to update the Internal Operating Procedures (IOP) of the Medical Student Section and the Resident and Fellow Section, as well as the inaugural IOP of the newly formed Minority Affairs Section (MAS). The MAS-IOP included the rules and procedures governing the newly formed section, including election of officers, membership, and MAS meetings. CCB also developed a template for future IOPs and created an interactive database of IOP provisions and bylaws governing all the AMA sections.

The Medical Student Section (MSS) offered numerous involvement opportunities to its members including the summer Discovery Channel program, Chapter Involvement Grants, the Medical Specialty Showcase, and its National Service Project on healthy lifestyles. At Medical Student Lobby Day, attendees visited the offices of more than 300 members of Congress and discussed the issues of funding graduate medical education, fixing the sustainable growth rate, and improving the Affordable Care Act. The MSS also conducted virtual reference committees at the Annual and Interim meetings with 49 and 52 items of business respectively and continued to grow its Medical Student Online Community, reaching over 1000 members.

The Resident and Fellow Section (RFS) has continued to focus on building value for its members. The RFS and Medical Student Section organized the ninth annual Research Symposium and received approximately 520 abstract submissions and 287 new members. This has become the largest event of its kind in the nation. The RFS has also sponsored business of medicine educational events, created resources on handoffs, and fully updated its resource *Succeeding from Medical School to Practice*, which was ranked as a top resource among AMA members in a 2011 survey and is being used to build additional resources.

The Young Physicians Section (YPS) focused its efforts on policies related to maintenance of certification/maintenance of licensure, scope of practice, prescription drugs, and patient safety. In addition, the YPS completed its new five-year strategic plan with an emphasis on promoting young physician leadership, mentorship, and membership within the AMA and throughout the Federation. The Section also provided educational sessions on strategic planning and AMA advocacy priorities and initiated a review of its Internal Operating Procedures. Overall, the YPS remains committed to creating member value and enhancing resources for young physicians.

The International Medical Graduates Section (IMGS) held its Third Annual Symposium in December in Chicago. The IMGS continues to be the largest advocacy and policymaking group for its constituents who represent over 25% of the US physician workforce while providing tangible resources for international medical graduates who are awaiting residency program acceptance.

The Minority Affairs Section (MAS) is the newest AMA section and continues to create impactful partnerships with minority physician and patient issue organizations, such as the National Medical Association and the Commission to End Health Care Disparities. A large number of physicians and medical students have participated in the Doctors Back to School™, Physician Interview Project, and the Minority Scholars programs.

The Organized Medical Staff Section (OMSS) centered its advocacy and education efforts in three areas: physician leadership, evolving systems of health care delivery, and physician employment.

With physician leadership being a focus for the Section, at the 2011 Annual Meeting the OMSS co-hosted a highly attended educational program along with the sections, special groups and House of Delegates (HOD) entitled, “Physician Leadership in Healthcare: If Not Physicians, then Who?” In continuation, at the 2011 Interim Meeting the Section hosted a program entitled, “Implementing the Physician Leadership Imperative for Quality and Value.”

With the increase in the number of physicians becoming employees, the AMA Annotated Model Physician-Hospital Employment Agreement developed by the Office of the General Counsel and the OMSS has proved to be a valuable resource for physicians who are preparing to negotiate an employment contract with a hospital or related entity.

Finally, the OMSS now has multiple CME recognized webcasts available to physicians on the initiatives referenced here, as well as other matters at OMSS Webcasts.

The AMA Special Groups continued to produce opportunities for member involvement and to educate physicians on issues affecting special populations. The Advisory Committee on Gay, Lesbian, Bisexual, and Transgender (GLBT) Issues has continued to help the AMA emerge as a leading organization on GLBT health. This has been accomplished by: (1) elevating our visibility in the national media on issues important to this community; (2) working with GLBT experts to develop resources for physicians and the public; and (3) presenting at GLBT related events and conferences to gain members. The Women Physicians Congress (WPC) is focused on providing a dedicated forum within the AMA for advocacy on women’s health and women in medicine professional issues. The WPC provided scholarships, in conjunction with AMA Foundation, to advance the progress of women in the medical profession and to strengthen the AMA’s ability to identify and address the needs and interests of women physicians and medical students. In addition, the WPC honored mentors who have made a difference in the

advancement of women physicians and their professional issues. The WPC also hosted educational sessions on the disparity in pay between male and female physicians and work/life balance. The Advisory Committee on Group Practice Physicians' (GPP) proposal for an Integrated Physician Practice Section was approved by the House of Delegates at the 2011 Interim Meeting. The new section will attract physicians from physician-led integrated systems such as large multispecialty groups and independent practice associations that have achieved or are moving toward clinical integration. During the Interim Meeting, the GPP co-sponsored a successful educational program with the Forum on Medical Affairs on accountable care organizations and featured members of the Advisory Committee as the program speakers. The Senior Physicians Group (SPG) hosted an educational program focused on retirement patterns and transitional issues affecting senior physicians, "Senior Physicians Returning to Practice." It conducted an SPG survey to help better understand the needs and wants of senior physicians, and continued to develop its Senior Physician Ambassador program to engage those members who volunteer in their local communities.

Board of Trustees and Senior Management

A primary activity of the Board was the search for a new EVP/CEO. This activity was carried out successfully, and the Board was pleased to bring James L. Madara, MD, aboard as EVP/CEO in July. The Board worked in concert with senior management to achieve a successful EVP transition. In addition, the Board had unprecedented turnover in membership, with seven new trustees joining after the Annual Meeting--a transition that was also successful. These two transitions have resulted in a great degree of teamwork, with management providing its skills in administering the Association's work, and the Board providing its proper oversight.

A second primary activity was centered on the development of a new five-year strategic direction for the AMA. The Board's planning session in July resulted in a clear directive to management to identify areas of focus and impact for the AMA. Through the fall, senior management worked to develop criteria that could be used to assess the areas in which the AMA could achieve such focus and impact. These criteria were presented to the Board and approved in November. Following that meeting, senior management continued its work to develop the strategic plan. More details regarding the strategic plan will be discussed with the House during the Annual Meeting. The myriad activities noted in this report attest to the robust nature of the AMA and its work. While the AMA continues a multitude of activities that benefit physicians and patients, the Board and senior management are committed to continuing to focus the Association's efforts in the future.

EVP Compensation

During 2011, pursuant to his employment agreement, total cash compensation paid to Michael D. Maves, MD, MBA, as AMA Executive Vice President was \$694,103 in base salary, \$242,180 in bonus, \$30,918 in accrued vacation payment and \$4,200 in automobile allowance. Additional taxable amounts per the contract were paid as follows: \$7,392 for life insurance, \$318 for club membership, and \$330 for parking.

During 2011, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD as AMA Executive Vice President was \$433,333 in base salary. Additional taxable amounts per the contract were paid as follows: \$5,709 for life insurance and \$385 for parking. A \$50,000 contribution to a deferred compensation account was made by the AMA, that will not be taxable until earned.

Membership

AMA Membership grew by 0.8% and ended 2011 with 217,490 members. The total 2010 membership count was 215,854. For additional information, please refer to BOT Report 6-A-12, Demographic Report of the House of Delegates and AMA Membership.

**26. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES:
FIVE-YEAR REVIEW**

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
AND REMAINDER OF REPORT FILED**

See Policies [D-600.959](#) and [D-600.984](#)

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2012 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020 (AMA Policy Database) and AMA Bylaw 8.50.

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of national medical specialty organizations and professional interest medical associations is also required as set out in AMA Bylaw 8.20.

The following organizations were reviewed for the 2012 Annual Meeting:

- American Society of General Surgeons
- American Society for Reproductive Medicine
- American Thoracic Society
- College of American Pathologists
- Congress of Neurological Surgeons
- Contact Lens Association of Ophthalmologists
- International College of Surgeons – US Section
- Society for Investigative Dermatology, Inc.
- Society for Medical Consultants to the Armed Forces
- United States and Canadian Academy of Pathology

In addition, the following organizations were to be reviewed for having completed a one-year probationary period for having failed to meet the membership requirements when they were reviewed for the 2011 Annual Meeting:

- Academy of Physicians in Clinical Research
- American Medical Directors Association
- American Pediatric Surgical Association
- American Society of Bariatric Physicians
- American Society of Neuroradiology
- Korean American Medical Association
- Renal Physicians Association
- Society of Interventional Radiology

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society and professional interest medical association representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that the: Academy of Physicians in Clinical Research, American Society of General Surgeons, American Society of Neuroradiology, American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Contact Lens Association of Ophthalmologists, Congress of Neurological Surgeons, International College of Surgeons – US Section, Society for Investigative Dermatology, Inc., Society for Medical Consultants to the Armed Forces, Society of Interventional Radiology and the United

States and Canadian Academy of Pathology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the: American Medical Directors Association, American Society of Bariatric Physicians and the Renal Physicians Association did not meet the membership requirements for specialty organizations represented in the HOD and therefore are not in compliance with the five-year review requirements.

The American Pediatric Surgical Association and the Korean American Medical Association failed to submit any materials and are therefore found to be non-compliant. The American Pediatric Surgical Association notified the AMA that they would no longer be participating in the AMA.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That the: Academy of Physicians in Clinical Research, American Society of General Surgeons, American Society of Neuroradiology, American Society for Reproductive Medicine, American Thoracic Society, College of American Pathologists, Congress of Neurological Surgeons, Contact Lens Association of Ophthalmologists, International College of Surgeons – US Section, Society for Investigative Dermatology, Inc., Society for Medical Consultants to the Armed Forces, Society of Interventional Radiology and the United States and Canadian Academy of Pathology retain representation in the American Medical Association House of Delegates.
2. That the American Pediatric Surgical Association and Korean American Medical Association representation in the House of Delegates be terminated at the conclusion of the 2012 Annual Meeting.
3. That the American Medical Directors Association, American Society of Bariatric Physicians and the Renal Physicians Association retain representation in the American Medical Association House of Delegates.
4. That the Board of Trustees undertake a study of membership requirements with respect to the five-year review process given a declining membership in the organization.

APPENDIX

Exhibit A - Summary Membership Information

<u>Organization</u>	<u>AMA Membership of Organization's Total Eligible Membership</u>	
Academy of Physicians in Clinical Research	164/677	25%
American Medical Directors Association	881/4,185	21%
American Pediatric Surgical Association	data was not submitted	
American Society of Bariatric Physicians	176/1,118	16%
American Society of General Surgeons	543/1,522	36%
American Society of Neuroradiology	709/2,442	29%
American Society for Reproductive Medicine	954/2,937	33%
American Thoracic Society	1,186/7,290	17%
College of American Pathologists	1,985/15,354	13%
Congress of Neurological Surgeons	833/3,261	26%
Contact Lens Association of Ophthalmologists	24/81	30%
International College of Surgeons – US Section	406/1,055	39%
Korean American Medical Association	data was not submitted	
Renal Physicians Association	541/2,511	22%
Society for Investigative Dermatology, Inc.	258/1,026	25%
Society of Interventional Radiology	743/2,891	26%
Society for Medical Consultants to the Armed Forces	33/53	63%
United States and Canadian Academy of Pathology	1,475/7,190	21%

Exhibit B - Summary of Guidelines for Admission to the House (Policy G-600.020) - Specialty Societies

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty-five percent (25%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Summary of Guidelines for Admission to the House (Policy G-600.022) - Professional Interest Medical Associations

1. The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
2. The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - 1,000 or more AMA members;
 - At least 100 AMA members and that thirty-five percent (35%) of its physician members who are eligible for AMA membership are AMA members; or
 - Have been represented in the House of Delegates at the 1990 Annual Meeting and that thirty-five percent (35%) of its physician members who are eligible for AMA membership be AMA members.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C - Responsibilities of National Medical Specialty Organizations (Bylaw 8.20)

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organization so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.50 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.20. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.20.

8.51 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.52 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.53 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.531 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.20, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.532 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.20, the House may take one of the following actions:

8.5321 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.531.

8.5322 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

27. EQUAL ACCESS TO ORGAN TRANSPLANTATION FOR MEDICAID BENEFICIARIES (RESOLUTION 1-I-11)

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: REFERRED

At the 2011 Interim Meeting, the House of Delegates (HOD) referred Resolution 1, which was introduced by the Florida Delegation. Resolution 1, "Equal Access to Organ Transplantation for Medicaid Beneficiaries," asked that our American Medical Association (AMA) urge the Centers for Medicare and Medicaid Services (CMS) to designate organ transplantation care and services which are covered by Medicare to be designated as mandatory benefits under Medicaid, and deemed life-saving and essential, such that Medicaid coverage throughout the United States be uniform, predictable, and enabling regarding access to life-saving care. While some testimony in opposition was presented before the Reference Committee on Amendments to Constitution and Bylaws (reference committee), the majority of both virtual and onsite testimony was in favor of adoption. The reference committee,

therefore, recommended adoption of Resolution 1. The HOD, however, voted to refer Resolution 1 for the development of a Board report to the HOD at the 2012 Annual Meeting.

BACKGROUND

Arizona Medicaid Cuts

Resolution 1 was precipitated by the controversy created when the state of Arizona cut funding for certain organ transplantation services for Medicaid beneficiaries in 2010. Struggling with a budget crisis and revenue shortfalls, the Arizona legislature voted to cut a number of optional Medicaid services, such as most dental care, orthotics, insulin pumps, well exams, and specific organ transplants as follows: pancreas-only; pancreas-after kidney; heart for non-ischemic cardiomyopathy; liver for patients with Hepatitis C virus; and lung. These cuts were effective October 2010. The action to cut specific transplants affected nearly 100 Arizona Medicaid patients on the transplant waiting list. This led to significant local and national media attention to the ethical, political, and policy issues surrounding access to and public funding for organ transplantation. Critics, including the American Society of Transplantation, the American Society of Transplant Surgeons, and the United Network for Organ Sharing, argued that Arizona, in its attempt to balance the budget, had relied on flawed and outdated data, which had led to coverage decisions with no medical justification. In April 2011, after a concerted lobbying campaign and public pressure, the state legislature reversed its decision and restored funding for the defunded organ transplant services.

Medicaid Coverage of Organ Transplantation

Unlike the Medicare program, which is federally financed and administered, Medicaid is a jointly financed partnership between the federal government and states. The federal government provides matching dollars for allowable state spending on Medicaid, while states administer the program on a day-to-day basis. State programs must operate under and comply with broad federal rules to receive federal financing. However, states have a great deal of flexibility to design and administer their own programs. Thus, state variation is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are delivered and reimbursed. To participate in Medicaid, states are required to meet federal core requirements, which include covering a specified set of core eligibility groups (e.g., children, pregnant women, parents, elderly individuals, and individuals with disabilities up to specified minimum income levels) and benefits (e.g., inpatient hospital services, outpatient hospital services, physician services, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services).¹ In light of the diverse health needs of enrollees, there is a broad range of optional benefits states may choose to cover for which they may receive federal matching funds, including but not limited to prescription drugs, clinic services, dental services, and long-term care services and supports.

Organ transplants are not included in the list of mandatory services nor are they included in the definitions of any of the mandatory categories, such as inpatient hospital services. They are not specifically listed under optional services either, although states and CMS treat coverage for organ transplantation as an optional service under Medicaid.² States may be required to cover organ transplant services for children, however, under EPSDT even if they are not otherwise covered by the state's Medicaid plan, since EPSDT requires coverage of any medically necessary services, treatment, and care.³ CMS does not have clear authority on its own to designate organ transplants as mandatory and essential benefits under Medicaid; congressional action would be needed to amend federal Medicaid law (Title XIX of the Social Security Act).

If a state chooses to cover organ transplants in its Medicaid plan, the plan must meet the following requirements in order to receive federal financial assistance for these types of procedures: 1) written standards for coverage of organ transplants must be provided; 2) the standards must treat similarly situated individuals alike; and 3) restrictions on the facilities or practitioners who may perform transplants must not deny recipients access to high quality care.⁴ The meaning of this provision—e.g., whether it is an express grant of discretion to the states in their decisions to fund organ transplants under Medicaid, or simply sets out the conditions for federal matching funds in transplant procedures, should the states choose to cover them—has been the subject of litigation in federal courts, with the appellate courts reaching different conclusions, and remains unsettled.⁵ Some transplants may be excluded from Medicaid coverage as experimental and states may also impose standards relating to medical necessity.⁶ Therefore, coverage can differ depending on where a Medicaid beneficiary lives. However, few, if any, states systematically deny coverage for organ transplantation, which was one of the reasons why Arizona's action in 2010 was so controversial.⁷

Impact of State Fiscal Challenges on Medicaid

When Arizona defunded certain organ transplantation services in 2010, it was confronting significant budget challenges. State revenue collections were down 34 percent and enrollment in the Arizona Medicaid program was up by over 44 percent since the start of the “Great Recession” in 2007. In December of 2010, over 20 percent of Arizona’s population was covered by Medicaid, and Medicaid spending had increased 63 percent since the start of the recession. Arizona’s base Medicaid obligations had increased from 18 percent of the state General Fund in fiscal year 2007 to 30 percent in FY 2011.⁸

Other states faced similar budget challenges in recent years. Since 2008, states have been facing declines in state revenues and have needed to make multiple budget cuts over the past several years. As one of the top-line items in most state budgets, Medicaid programs have been subject to cuts for several years. While the overall fiscal situation in the states has improved, Medicaid continues to be a growing portion of state budgets. According to the National Association of State Budget Officers, Medicaid accounted for 23.6 percent of total state spending in FY 2011, which was the single largest portion of state spending. State Medicaid officials continue to feel pressure to control rising costs in their programs, and, as a result, in FY 2011, every state implemented at least one new policy to address Medicaid costs. According to the Kaiser Family Foundation, as states prepared their budgets for FY 2012, almost all continued to experience the ongoing effects of the recession, including high unemployment and depressed state revenue collections. States also had to increase FY 2012 state spending for Medicaid by an average of 28.7 percent largely to replace temporary Medicaid federal stimulus funds that expired in June 2011.⁹

The Patient Protection and Affordable Care Act (ACA) included significant coverage expansions under Medicaid, as well as new requirements on states, including new eligibility and enrollment systems that coordinate with the state-based or federal Health Insurance Exchanges. As a result, there will be many fiscal and operational challenges in administering these new systems, as individuals are expected to move between Medicaid and the exchanges as their incomes fluctuate. The ACA’s maintenance of effort provisions prevent states from cutting eligibility requirements. As a result, states confronting budget challenges are limited somewhat to considering cuts in optional benefits and provider reimbursement in their Medicaid programs. In addition, as part of efforts to cut the federal debt and annual federal budget deficits, Congress continues to examine reforms in entitlement spending, especially Medicaid. It is anticipated that further changes to the Medicaid program will be part of any serious discussion by Congress on entitlement reforms and deficit spending, which could result in cuts in Medicaid funding and further increase pressure on states, as well as negatively affect beneficiaries’ access to care.

AMA POLICY

Our AMA has long-standing policy regarding physicians’ ethical obligation to support access to medical care for all people. Opinion E-9.0651 (Financial Barriers to Health Care Access) states that “Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means” (emphasis added). This opinion calls on individual physicians to take steps to promote access to care for individual patients and to help patients obtain needed care through public or charitable programs when patients cannot do so themselves. It calls on the medical profession to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services. Physicians are also called on individually and collectively through their professional organizations to participate in the political process as advocates for their patients so as to diminish financial obstacles to health care (E-9.0651, AMA Policy Database).

With respect to organ transplantation guidelines, AMA ethical policy states, in relevant part, that “Recipients of organs for transplantation should be determined in accordance with the Council’s [i.e., Council on Ethics and Judicial Affairs] guidelines on the allocation of limited medical resources” (E-2.16 Organ Transplantation Guidelines). Opinion E-2.03, in focusing on the physician’s duty to do all he or she can for the benefit of the individual patient, provides that access to limited resources, such as organs, should be decided by medical criteria only:

Physicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health

resources. Decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible (emphasis added). See also Policy H-370.982, Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients.

Opinion E-2.03 further notes that decision-making mechanisms for the allocation of limited resources should be “objective, flexible, and consistent to ensure that all patients are treated equally.”

With respect to Medicaid, AMA policy has two general views about the scope of the Medicaid program. One perspective supports sustaining and expanding Medicaid as a safety net program. Policies H-290.974 and H-290.986 advocate eligibility expansions of Medicaid with the goal of improving access to health care coverage to otherwise uninsured groups. The other perspective supports alternatives to public sector expansion and encourages the medical care portion of the Medicaid program to be financed with federally issued tax credits to allow acute care patients to purchase individual coverage of their choice (Policy H-165.855[1]).¹⁰ Regarding benefits in the Medicaid program, AMA policy supports greater equity, through adoption of basic national standards of uniform minimum adequate benefits and the establishment of national standards that result in uniform eligibility, benefits, and adequate payment mechanisms for services across jurisdictions (Policy H-290.997). Our AMA has no specific policy regarding the prioritization of benefits or services in state Medicaid programs or in support of delineating specific services or benefits as mandatory in the Medicaid program. Our policy on prioritization of health care services is more general, and calls on physicians to work to assist society, including legislatures, whenever discussions regarding prioritization of resources take place; and provides that our AMA will assist medical societies in developing processes and criteria for prioritization of resources that best serve the needs of patients (Policy H-165.997). In addition, AMA policy supports minimizing benefit mandates and does not support expanding benefit mandates (Policy H-165.856[10]).

AMA policy and recent advocacy efforts on the development of benefit packages, particularly of the essential health benefits package under the ACA, have focused on maximizing patient choice, minimizing benefit mandates, and supporting flexibility in the design of benefit plans. Newly eligible Medicaid enrollees will be entitled to the essential health benefits package, as determined by future CMS guidance or rulemaking. Council on Medical Service Report 2-A-11 was written in response to a resolution referred by the HOD that asked that our AMA “update its efforts to create and disseminate a list of essential health care benefits that would need to be included in all plans offered by both the private sector and the government, as well as a list of additional benefits that could be added on to a basic benefits package.” In light of our AMA’s support for using existing coverage models to determine adequacy of benefits, and movement away from its support of minimum and standard benefits packages, the Council recommended that our AMA should not define a new, specific benefits package to be used in advocacy discussions concerning the development of the essential health benefits package. Rather, the report as adopted by the HOD reaffirmed existing AMA policy supporting the use of existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program regulations) as a reference when considering if a given plan would provide meaningful coverage. The same report recommended that our AMA support the use of the EPSDT program as the model for any essential health benefits package for children (Policy H-165.846). In our advocacy efforts, the AMA has supported the Administration’s proposed approach that would allow states to have flexibility (within certain parameters) in designing their own benchmark essential health benefit plans.

DISCUSSION

Resolution 1-I-11 involves complex and challenging ethical, legal, and policy issues pertaining to access to organ transplantation. On the one hand, it can be argued that adoption of this resolution would be consistent with existing ethical and HOD policy on allocation of limited resources that support equal care despite insurance status and social

standing, and that transplant decisions should be based on medical criteria rather than non-medical criteria. Moreover, supporting coverage of organ transplants as a mandatory benefit under Medicaid would be consistent with AMA policy to reduce health disparities, particularly among minorities. The reference committee, in recommending adoption of Resolution 1-I-11, found compelling the argument that quality medical standards should not change across state borders and that health care more broadly is a national issue. It can also be argued that transplantation of certain organs, e.g., kidneys, could cost less and improve quality of life, which could save the Medicaid program money over the long term, compared to a lifetime of dialysis.

On the other hand, it can be argued that AMA Ethical Opinion 2.03, regarding the allocation of limited medical resources and discussed earlier, has limited application because it is primarily focused on allocation decisions among individuals rather than across populations or groups. Our AMA has no specific policy on prioritizing which benefits should be covered by Medicaid, and, in practice, generally has refrained from prioritizing benefits or advocating that certain services should or should not be covered, especially under public programs. Moreover, AMA policy generally opposes benefit mandates, and support for organ transplantation as a mandatory benefit under Medicaid would be inconsistent with AMA policy and advocacy efforts relating to the development of essential health benefits packages, where our AMA has supported providing states with the flexibility to choose or design benefit programs that best serve the needs of their residents.

As states continue to confront fiscal challenges and the need to balance state budgets, they may have to make some very difficult decisions to meet short-term budget goals. Mandating that state Medicaid programs cover organ transplants could result in possible negative consequences, such as cutbacks in other critical services or to provider reimbursement, which could further exacerbate beneficiary access to basic Medicaid services and benefits.

The Board notes that Resolution 1-I-11 calls on our AMA to urge CMS to designate organ transplantation as a mandatory and essential benefit under Medicaid. However, as stated earlier, CMS does not have clear authority to make such a determination without congressional action to amend federal Medicaid law (Title XIX). Also, given the focus in Congress on reducing spending for entitlement programs such as Medicaid, it is unlikely that such an amendment would pass.

Finally, the Board notes that the action taken by Arizona, which was ultimately reversed, appears to be an isolated, albeit severe, response to one state's fiscal crisis. There have been no indications that other states that currently cover organ transplants are considering defunding such services.

CONCLUSION

In summary, to be consistent with AMA policy and recent advocacy efforts regarding the essential health benefits package under the ACA, especially with respect to supporting state flexibility and limiting benefit mandates, your Board concludes that, on balance, policy and strategic considerations weigh against adoption of this resolution.

RECOMMENDATION

The Board of Trustees recommends that Resolution 1-I-11 not be adopted and the remainder of the report be filed.

APPENDIX - Relevant AMA Policies

H-165.846 Adequacy of Health Insurance Coverage Options

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. 2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children. (CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11)

H-165.997 Prioritization of Health Care Services

(1) Our AMA urges the medical profession to develop and pursue an initiative for improvement in the systems design for medical and health care plans. (2) Our AMA opposes rationing of health and medical care services. (3) In developing its initiative to contribute responsibly to improvements in the systems design of health and medical care plans, our AMA urges the medical profession to support efforts to evaluate all mechanisms for financing, provision of care and reimbursement in light of their impact on access to care, quality of care and affordability. (4) Our AMA will develop additional clinically based criteria by which benefits desirable under both private and publicly funded health plans can be identified, and will use these criteria in further refining AMA policy in this area. (5) These criteria will be used to evaluate any benefit package developed by any source. (6) Our AMA continues to support the allocation of health services through a decentralized working of the market, coupled with incentives for effective individual choices, as the preferred alternative to centralized prioritization of services or decisions about coverage for such services. (7) Our AMA urges that physicians work to assist society, including legislatures, whenever discussion regarding prioritization of resources take place. (8) Our AMA will assist medical societies in those states considering or undertaking prioritization to develop processes and criteria for such prioritization that best serve the needs of patients. (9) Our AMA will study and take the lead in stimulating discussion among all concerned sectors of society about the implications of limited and limiting health care resources, current experimental programs for centralized allocation, and the processes and criteria to be used in any such allocation. (10) Our AMA will continue to assign a high priority to the problem of the medically uninsured and underinsured and continue working toward national consensus on providing access to adequate health care coverage for all Americans. (Res. 88, A-84; BOT Rep. EE, I-92; CLRPD Rep. 3 - I-94; Appended: Sub. Res. 109, I-98; Reaffirmed: Res. 808, I-02; Reaffirmed: CMS Rep. 5, A-04; Consolidated: CMS Rep. 7, I-05)

H-290.997 Medicaid - Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. (BOT Rep. UU, A-88; Reaffirmed: CMS Rep. G, A-93; Reaffirmation I-96; Reaffirmation A-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-05; Reaffirmed: Res. 804, I-09)

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation:.... (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:... (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options;... (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11)

H-370.967 Ethical Procurement of Organs for Transplantation

Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. (BOT Rep. 13, A-08)

H-370.982 Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. (2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. (3) Decisionmaking mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions. (4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision. (5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (6) Physicians should continue to look for innovative ways to increase the availability

of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them. (7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. (CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02)

H-370.990 Transplantable Organs as a National Resource

Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy. (Res. 94, I-87; Reaffirmed: Sunset Report, I-97; Appended and Reaffirmed CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 4, I-02)

H-370.995 Organ Donor Recruitment

Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following: (1) the need for organ donors; (2) the success rate for organ transplantation; (3) the medico-legal aspects of organ transplantation; (4) the integration of organ recruitment, preservation and transplantation; (5) cost/reimbursement mechanisms for organ transplantation; and (6) the ethical considerations of organ donor recruitment. (Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

E-2.16 Organ Transplantation Guidelines

The following statement is offered for guidance of physicians as they seek to maintain the highest level of ethical conduct in the transplanting of human organs. (1) In all professional relationships between a physician and a patient, the physician's primary concern must be the health of the patient. The physician owes the patient primary allegiance. This concern and allegiance must be preserved in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients. Care must, therefore, be taken to protect the rights of both the donor and the recipient, and no physician may assume a responsibility in organ transplantation unless the rights of both donor and recipient are equally protected. A prospective organ transplant offers no justification for a relaxation of the usual standard of medical care for the potential donor. (2) When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician, who should rely on currently accepted and available scientific tests. (3) Full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives is mandatory. The physician should ensure that consent to the procedure is fully informed and voluntary, in accordance with the Council's guidelines on informed consent. The physician's interest in advancing scientific knowledge must always be secondary to his or her concern for the patient. (4) Transplant procedures of body organs should be undertaken (a) only by physicians who possess special medical knowledge and technical competence developed through special training, study, and laboratory experience and practice, and (b) in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure. (5) Recipients of organs for transplantation should be determined in accordance with the Council's guidelines on the allocation of limited medical resources. (6) Organs should be considered a national, rather than a local or regional, resource. Geographical priorities in the allocation of organs should be prohibited except when transportation of organs would threaten their suitability for transplantation. (7) Patients should not be placed on the waiting lists of multiple local transplant centers, but rather on a single waiting list for each type of organ. (I, III, V) Issued prior to April 1977; Updated June 1994 based on the report "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," adopted June 1993.

E-2.03 Allocation of Limited Medical Resources

A physician has a duty to do all that he or she can for the benefit of the individual patient. Policies for allocating limited resources have the potential to limit the ability of physicians to fulfill this obligation to patients. Physicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources. Decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. When very substantial differences do not exist among potential recipients of treatment on the basis of the appropriate criteria defined above, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The treating physician must remain a patient advocate and therefore should not make allocation decisions.

Patients denied access to resources have the right to be informed of the reasoning behind the decision. The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (I,VII) Issued March 1981; Updated June 1994 based on the report "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," adopted June 1993 (Archive of Internal Medicine 1995; 155: 29-40).

E-9.0651 Financial Barriers to Health Care Access

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation: (1) Individual physicians should take steps to promote access to care for individual patients. (2) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves. (3) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care. (4) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services. (5) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people. (VI, IX) Issued November 2009 based on the report "Financial Barriers to Health Care Access," adopted June 2009.

REFERENCES

1. Under the Patient Protection and Affordable Care Act (ACA), Medicaid eligibility will expand to a national minimum of 133 percent of the federal poverty level across all groups.
2. CCH Online 2012 Wolters Kluwer, WK_Medicare and Medicaid AnswersNow Medicaid - Coverage 21040 When are organ transplants covered under Medicaid.pdf. Also, correspondence from Peter W. Thomas dated March 2, 2012, outside counsel for American Society of Transplant Surgeons, Principal with Powers Pyles Sutter & Verville PC
3. 42 U.S.C. § 1396d(r)(5)
4. 42 U.S.C. 1396b(i); 42 C.F.R §441.35; CCH Online 2012 Wolters Kluwer, WK_Medicare and Medicaid AnswersNow Medicaid - Coverage 21040 When are organ transplants covered under Medicaid.pdf. In addition, as a condition of participation in the Medicare and Medicaid programs, hospitals must establish protocols for encouraging organ and tissue donation; payment under Medicare and Medicaid is prohibited with respect to costs for procuring organs, for an organ procurement organization that does not meet the national organ transplant network standards. 42 C.F.R. §486.301 *et seq.*
5. Wong, Melissa. Coverage for Kidneys: The Intersection of Insurance and Organ Transplantation, 16 Conn. Ins. L.J. 535 (Spring, 2010)
6. CCH Online 2012 Wolters Kluwer, WK_Medicare and Medicaid AnswersNow Medicaid - Coverage 21040 When are organ transplants covered under Medicaid.pdf.
7. Email from Peter Thomas, *Ibid.* Numerous attempts were made to find a comprehensive listing of state Medicaid coverage of organ transplantation, by contacting the Kaiser Family Foundation, the American Society of Transplant Surgeons, CMS, and the National Conference of State Legislatures; such attempts proved unsuccessful.
8. Letter from Governor Janice Brewer to Speaker-elect John Boehner, December 17, 2010.
9. Issue Paper, "A Mid-Year State Medicaid Budget Update for FY 2012 and A Look Forward to FY 2013," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. February 2012.
10. The Council on Medical Service will be presenting a follow-up report to the House of Delegates at the 2012 Annual Meeting that will provide recommendations to reform Medicaid financing which include further support for and refinements of AMA policy supporting tax credits for the medical care portion of Medicaid.