

REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–12, were presented by Stephen R. Permut, MD, JD, Chair:

1. PRINCIPLES FOR HOSPITAL SPONSORED ELECTRONIC HEALTH RECORDS (RESOLUTION 825-I-14)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 825-I-14
REMAINDER OF REPORT FILED
ADDITIONAL RECOMMENDATION REFERRED**
See Policy D-478.973

INTRODUCTION

At the 2014 Interim Meeting, the House of Delegates (HOD) referred Resolution 825-I-14, “Principles for Hospital Sponsored Electronic Health Records,” for report back at the 2015 Interim Meeting. This resolution was introduced by the California Delegation and asked that our American Medical Association (AMA):

Continue to urge Congress and the Centers for Medicare & Medicaid Services (CMS) to mandate that all electronic health record (EHR) systems be interoperable; and

Urge Congress and CMS to require hospitals to adhere to the following principles when a hospital or other sponsoring entity provides a subsidized EHR platform to a physician or medical group, and that our AMA advocate and communicate these principles to the hospital community:

1. A hospital or other sponsoring entity providing a subsidized EHR platform to a physician or medical group must provide an interoperable system for the physicians and medical groups treating patients in that hospital.
2. Physicians or medical groups entering into a subsidized EHR agreement with a hospital must maintain ownership and control of its patient data, including but not limited to demographic information, quality, cost and utilization data.
3. Hospitals are prohibited from requiring physicians or medical groups to surrender their rights to own, control and access their patient data when entering into a donated or subsidized EHR agreement with the hospital.
4. Hospital sharing of aggregated data may only occur with the written approval of the physician or medical group and may be fully revoked at the termination of the EHR agreement between the hospital and the physician or medical group.
5. In the event a subsidized EHR agreement between a physician/medical group and a hospital is subsequently withdrawn or terminated, the hospital shall protect the physician/medical group’s clinical data and promptly transfer the data to the contracted physician or medical group if such data was recorded in the treatment of the physician’s/medical groups’ patient.
6. Hospitals or other entities providing sponsored EHR must participate in regional health information exchanges when they become available to achieve meaningful use.

This report provides background regarding the current obstacles and costs associated with EHR implementation, considerations that should be made when a hospital or other sponsoring entity provides a subsidized EHR platform to a physician or medical group, and outlines AMA advocacy efforts to improve interoperability through the Office of the National Coordinator for Health Information Technology (ONC) certification process and other avenues.

BACKGROUND: EHRS AND FEDERAL REQUIREMENTS

Meaningful Use

The Health Information Technology for Economic and Clinical Health Act (HITECH), which established both the Meaningful Use (MU) program and the EHR certification process, has radically increased the adoption of EHRs. The most recent data (2013) from the National Center for Health Statistics find that between 2012 and 2013 EHR adoption increased by approximately 21 percent. In fact, over 80 percent of physicians use an EHR today.¹ HITECH incentives are seen as the primary driver to EHR uptake across the nation. To date over \$29 billion has been paid to physicians and hospitals through the MU program.²

However, the hope and promise of EHRs to provide greater efficiency in health care, improve care coordination, and facilitate data exchange have not materialized.³ Many of the MU objectives were intended to enhance patient choice and quality of care. Unfortunately, many of these requirements, especially those in the latter phases of the MU program, are having the opposite effect.

Participation in the MU program continues to dwindle and less than 10 percent of physicians participated in Stage 2 of MU.⁴ Often the requirements decrease the efficiency of patient visits. Further, the MU program drives the design priorities for many EHR vendors—resulting in electronic systems that promote MU objectives and compliance over clinical need, patient wellbeing, and innovation in general.⁵ The lack of interoperability among EHRs is a direct result of this misalignment.

Federal Anti-kickback Statute

The federal anti-kickback statute (AKS) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. Thus, the offer, provision, solicitation, or receipt of health IT products or services may constitute illegal remuneration under the AKS.^{6,7} However, the federal government allows hospitals to subsidize EHR platforms to physicians in their service areas by creating a safe harbor under the AKS for donation arrangements that meet certain requirements, one of which is interoperability, meaning the subsidized EHR must be able to work within and across the same and different EHR platforms utilized by unrelated physicians.

Specifically under the AKS, the EHR donor should not take any action to limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or electronic health records systems (including, but not limited to, health information technology applications, products, or services).⁸ Any such engagement in information blocking can cause the donor to fall outside the safe harbor exemption which would in turn violate the AKS. Yet, as noted in the ONC's report to Congress, defining information blocking—and even to the extent of measuring interoperability—is a complex endeavor such that, “information blocking means different things to different people and entities. No authoritative or commonly accepted definition exists.”⁹

This has led ONC to build a framework for information blocking based on three criteria: 1) a party must actively interfere with data exchange; 2) information blocking must be made knowingly; and 3) such conduct is objectively unreasonable in light of public policy.¹⁰ Through this lens, an entity could be seen as participating in information blocking if they had the knowledge of unreasonably interfering with the exchange or use of electronic health information.

GENERAL BARRIERS TO INTEROPERABILITY, DATA ACCESS, AND DATA TRANSPORT

As outlined in Resolution 825, physicians are facing significant barriers to exchanging, accessing and transporting data. While Resolution 825-I-14 highlights the specific situation related to donated or subsidized EHRs, this problem is pervasive and is impacting all EHR systems, regardless if subsidized. Therefore, hospitals and other donors of EHRs may not be able to comply with requirements related to interoperability, data access, ownership and transport unless these barriers are more broadly addressed. The following highlights general barriers that are impeding these processes.

Certification Implications

The basis of interoperability in current EHRs is constructed from the requirements in ONC's health information technology (health IT) certification program. This process specifies what EHR vendors must include in their products to become certified. Both hospitals and physicians must then use certified EHR technology (CEHRT) to participate in MU.

The existing certification process attempts to ensure EHRs are interoperable. However, the act of two computers sending and receiving data, which is what is predominantly tested during the certification process, does not constitute functional interoperability—the ability for information to be exchanged, incorporated, and presented to a physician in a contextual and meaningful manner. In addition, these certification criteria are only part of a more complex federal process EHR vendors participate in to sell their products. Other entities including testing and certifying organizations play a role in an EHR's path to the marketplace, but their policies and procedures are still governed by federal requirements.

While it is widely known that ONC's certification program is primarily designed to validate an EHR's ability to meet MU requirements, it is also clear that the program has become the high watermark for EHR design. Vendors narrowly follow the certification requirements, spending the majority of their time meeting CMS and ONC mandates, while allowing for little time and resources to address physician and patient needs.¹¹ Technology and data exchange standards widely exist across other industries where information seamlessly interoperates.¹² However, health IT continues to lack focus on interoperability and usability as a result of federal priorities and vendor capitulation.

Technology Costs

The costs to purchase, train users, deploy software, and continually support an EHR are a significant hurdle to interoperability and data access for physicians and medical clinics.¹³ There is growing concern that for many physicians the cost of compliance with the MU program far exceeds not only the maximum incentives offered under MU but also the cost estimated by CMS to purchase and maintain an EHR. Furthermore, physicians are incurring significant expenses to update their EHRs or purchase additional software to perform other basic functions not included in the initial price of the system.

Besides the cost of adopting and maintaining an EHR, there are additional costs associated with data exchange. Today, due to interoperability challenges only 10 percent of physicians are moving data through a health information exchange (HIE).¹⁴ Little is known about the cost for physicians to move data on HIEs because access to these contracts is not readily available. There is also a lack of data available on the cost of using a Health Information Service Provider (HISP), an entity involved in the movement of health data, which can be part of a vendor, HIE, or stand-alone service.

What data are available can be found from the US Government Accountability Office's (GAO) March 2014 report on EHRs:

Providers we interviewed reported challenges covering costs associated with health information exchange, including upfront costs associated with purchasing and implementing EHR systems, fees for participation in state or local HIE organizations, and per-transaction fees for exchanging health information charged by some vendors or HIE organizations. Several providers said that they must invest in additional capabilities such as establishing interfaces for exchange with laboratories or other entities such as HIE organizations. For example, many providers told us that the cost of developing, implementing, and maintaining interfaces with others to exchange health information is a significant barrier. One provider and several officials estimated various amounts between \$50,000 and \$80,000 that providers spend to establish data exchange interfaces. Other stakeholders we interviewed or who responded to HHS's March 2013 RFI also identified costs associated with participation in HIE organizations and maintaining EHR systems as a challenge for providers.¹⁵

Not only are these costs substantial, but many providers are unaware of vendor fees. Contracts with some EHR vendors have failed to itemize these additional expenses, leading to a lack of transparency and confusion over what is or is not included in purchasing an EHR system.¹⁶ In addition, fees to migrate data vary greatly due to a number

of factors, including staff, number of office locations, as well as the unique circumstances of a provider's technical infrastructure.

ONC has attempted to address this lack of transparency in its 2014 EHR Certification Final Rule by requiring vendors to outline additional types of expenses (i.e., one-time, ongoing, or both) that affect a product's total cost of ownership.¹⁷ However, the regulation only requires clarity in the type of costs that need to be disclosed, not the actual dollar amounts, leaving broad discretion to vendors.¹⁸ Since EHRs are currently the main method for physicians to access and share information, it is necessary that connection points and interfaces are cost effective, reliable, and flexible enough to support a wide array of business needs.

In addition to the specific features and functions required to connect an EHR to an HIE, many vendors limit access to their systems by requiring:

- 1) special training and certification by the developer before users can extract data from the system or integrate an application; 2) users to sign a "non-disclosure agreement"; 3) users to pay an additional license fee to access data or integrate an application; 4) customized programming that only the developer can do; or 5) access to documentation that requires special permission or additional fees.¹⁹

This lack of transparency and the methods vendors utilize to complicate data extraction is particularly concerning given that many physicians are considering switching EHRs—a process that requires the extraction and transfer of EHR data. In one survey one in six medical practices considered switching their EHR vendor in 2013.²⁰ Vendors utilizing high costs as a method for limiting data extraction—and thus limiting physicians from going to new EHRs—was also cited as a considerable issue in Board of Trustees (BOT) report 18-A-14.²¹ While many providers are changing vendors due to dissatisfaction with existing products, others have little choice but to switch EHRs as vendors sunset certain products or decide not to seek Stage 2 certification.²² Essentially this leaves physicians with a choice of incurring the cost to switch EHRs or incurring penalties under the MU Program.

Technological Barriers

Part of the problem with achieving data portability is the technical barriers that impair this process. Data stored within one EHR system may not be compatible with another vendor's products, especially if systems are highly customized or a mismatch exists between the source EHR and the receiving system. For example, many first generation EHRs did not code all of the patient information stored in their systems, leaving data as free text. In this format, the data are not easily transferred from one EHR to another.²³

Another technical challenge is the sheer scale of the data sets stored in EHRs. Even for small practices, moving patient records and all of the supporting documentation amounts to numerous files that require a significant amount of time and resources to transfer. As a result, physician practices are likely to experience disruptions in workflow or delays when trying to migrate data or switch EHR systems.²⁴

Last, the lack of interoperability is a significant obstacle to data migration. As previously mentioned the technology to achieve interoperability is still in its very early stages of development and currently lacks clear standards and guidelines. Without a clear path forward, EHR vendors are hesitant to come to a consensus on how to transport the data since any agreement on data migration will also impact how interoperability is achieved. This same concept was identified in BOT Report 18-A-14.²⁵ The report further highlighted one study that found that approximately 70 percent of surveyed clinicians cited a lack of interoperability and information exchange infrastructure as major barriers to electronic information sharing.²⁶ Effective data exchange therefore may be delayed until the market is also capable of achieving interoperability. However, much of this relies on the federal government's ability to realign MU goals and EHR certification.

Given the technological barriers, EHR products are still held to few or no standards with respect to data migration. ONC's certification policy focuses on EHRs achieving specific MU measures (e.g., electronic prescribing and computerized physician order entry), leaving other aspects, such as data transfer, outside of the certification process. Consequently, EHR vendors are focusing primarily on achieving certification—which can be a time-consuming and demanding process that limits resources to adopt and improve other technology, such as data migration.²⁷

SPECIFIC BARRIERS WITH RESPECT TO SUBSIDIZED OR DONATED EHRS

Significant costs associated with the implementation and use of health IT in ambulatory settings can limit a physician's ability to purchase or migrate between EHRs. Given the serious concerns mentioned above with respect to technology costs some of the financial load can be shouldered by a local hospital seeking to donate or subsidize an EHR to the physicians in its community. In these cases physicians generally receive a product that matches the hospital's native EHR. While many large vendors produce EHRs for both ambulatory and inpatient settings, both products must be ONC certified as a requirement for participation in the MU program. Furthermore, many hospitals have selected their EHR from a shrinking list of certified vendors on the market. As of March 2015 only eight EHR vendors accounted for the majority of hospital MU attestations.²⁸ Limited choice, the vendor's business cases for data exchange, and ONC's EHR certification process drastically constrain the ability for hospitals to choose interoperable systems for their own use—let alone for the use of affiliated physicians. However, beyond the broad issues identified above, there are also specific issues related to subsidized or donated EHRs that can further complicate achieving interoperability, data access, ownership and transport.

As noted by the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS), some hospitals and large health systems could potentially gain a competitive edge by preventing data portability since "...the limited accessibility of the data makes it harder for the physician recipient to access and use it for clinical purposes. As a result, a physician recipient is more likely to utilize only the donor's services to make sure that necessary data are easily accessible."²⁹

There is a growing body of research that has found limited electronic health information exchange with competing or unaffiliated providers. Recent evidence gathered by ONC has shown that some hospitals and large health systems are more likely to exchange electronic health information internally, but are less likely to exchange electronic health information externally with competing hospitals and unaffiliated providers.³⁰ Moreover, it was shown that larger health systems have the ability to influence health information exchange by other providers in their communities.³¹

Similarly, anecdotal evidence collected by the AMA supports that limited data exchange can occur between hospitals and unaffiliated physicians. These issues were discussed at a recent event held in Atlanta co-sponsored by the AMA and the Medical Association of Georgia.³² Physicians elaborated on specific instances where both technological and health system policies combined to create excessive hurdles to exchange the simplest of patient of information. Examples provided by physician participants suggested that business and competitive motivations may influence whether some hospitals and large health systems choose to exchange electronic health information with them.

In some instances entities cited Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements as reasons for denying the exchange of electronic protected health information. ONC's Congressional report also identified these issues; however, with respect to HIPAA privacy and security laws, many of these circumstances do not in fact impose real restrictions.³³ There is a general consensus that requirements and policies established by federal and state law, which protect patients' electronic health information, are confusing, unclear, and lack specific examples needed to guide physicians, hospitals and other stakeholders.

Normally, in a free market, consumer demand would mitigate such business practices since customers would simply chose to buy other products that allow for data migration. Yet, in the case of donated or subsidized systems, this choice may be restricted. While many provider stakeholders are committed to ensuring data can be freely exchanged, current economic and market conditions may create business incentives for some persons, hospitals, or large health systems to exercise control over electronic health information in ways that unreasonably limit its availability and use.³⁴ An ONC 2015 report to Congress identified complaints and other evidence that suggest some entities are interfering with the exchange or use of electronic health information in ways that preclude physicians from exchange data or extracting patient data from their donated or subsidized EHRs.³⁵ Yet, it remains unclear to what extent technological issues, cost, and lack of clarity are the main forces behind this limited data exchange or if potentially anti-competitive behavior is a driving force.

DISCUSSION

Limitations placed on physicians to extract data from their systems impede care coordination and the development of new delivery models, which diminishes any value associated with the use of an EHR. In addition, the inability to

access data can present significant legal challenges for physicians since federal laws mandate that providers access, furnish, and retain patient records for a number of years.³⁶ Further, loss of data or obstacles in accessing relevant information can lead to disruptions in billing for services or problems with quality measurement. All of these concerns suggest a need to remove the barriers to data access, ownership, and interoperability.

Similarly, the barriers found in working with donated or subsidized EHRs limit improvements in care quality; however, it is often difficult to identify if these limitations are due to more general problems relevant to all EHRs or are specific to the donor. In particular, problems with data access and ownership become more complex in this context. One way to ameliorate these concerns is to ensure that data collected and entered by the affiliated physician are retained in a completely separate database other than the one used by the hospital/donor to store patient information. This “firewall” helps segregate the ambulatory physician’s patient data from that of the hospital or sponsor. This separation of electronic data can provide physicians a basic guarantee of control and access of their patient data.

However, current EHR design does little to ensure seamless, timely, or cost effective methods for patient data extraction. ONC has proposed in its 2015 Edition Health IT Certification that EHRs must be able to export patient data in the Consolidated Clinical Document Architecture R2.0 (C-CDA).³⁷ The C-CDA is a document standard that specifies the structure and semantics of clinical records to facilitate data exchange. A version of this data packaging method is already part of current (2014 Edition) EHR certification; however, version 2015 proposes to reduce the cost and complexity of using C-CDA data extraction.

While the C-CDA does provide some level standardization for data extraction, it is woefully insufficient for a complete migration between two EHRs. For one, the C-CDA does not extend into the accounting or patient demographics section required for billing and practice management systems. Secondly, the C-CDA does not ensure the export, import, and incorporation of all medical data into the correct patient’s medical record. Current certification requirements neither test nor force EHR vendors to comply with a completely consumable method for data portability. ONC has proposed an increased level of rigor and scrutiny with its 2015 Edition, the earliest we expect to see 2015 compliant EHRs on the market is 2018.

While internal policy can reduce data exchange with respect to donated or subsidized EHRs, interoperability and data access are still limited across all EHR systems. Furthermore, it is exceedingly difficult to identify and separate out data blocking practices that are due to internal as opposed to external factors. Since resolving the internal barriers to data exchange will only ensure some relief, it is necessary to first address broader vendor and federal activities which promote data lock-in.

Recognizing this significant problem for physicians, the AMA has actively engaged in efforts to reduce the barriers that currently inhibit data portability. The AMA has engaged with ONC to refine the certification process, urging ONC to place greater emphasis on data migration. AMA members have testified in front of relevant policymakers that vendors should be required to provide contractual, pre-defined specifications on data migration fees. The AMA provided additional testimony on the issue of data lock-in to the Federal Trade Commission, highlighting factors which may be influencing the EHR market, including market consolidation and hurdles to data portability. The AMA has also called for an online list of vendors’ data migration fees so that physicians can compare products and prices. Finally, the AMA has further recommended that ONC urge vendors to include independent (vs. vendor-employed) physicians during the EHR development and testing process to ensure that physician workflow needs are being met.

Resolving these issues will not only encourage the reduction of costs and technical barriers for data exchange, but will also help to clear the air to better examine health system policies or competing business practices which limit interoperability. It is vital that technical limitations to data exchange are normalized for there to be greater transparency on actions taken by entities to block data. Once federal and vendor limitations are resolved, it will be much harder for entities to use technical issues as a cover for information blocking practices. As an accompanying issue, more work will be required to gain a better understanding how to measure interoperability. ONC’s definition of information blocking is a first step, yet further clarity is needed regarding how to account for third-party actors such as HIEs, public health agencies, mobile application developers, or discrepancies between state privacy laws.

The utility an HIE provides is also up for debate. Many physicians have noted that once they are connected to an HIE the availability of data is inconsistent. Due to vendor fees or technology barriers, some entities are electing not

to connect to HIEs until there is a proven business case. By using this “wait-and-see” approach, individuals who are participating in an HIE may find it difficult to access data if the health system where the patient records are located is not participating. If physicians query for patient records before there is enough data available, providers may search several times without finding what they are looking for, creating a perception of limited value of the HIE.³⁸

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 825-I-14 and the remainder of the report be filed:

1. That our American Medical Association promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. That our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. That our AMA work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. That our AMA advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

[The following proffered recommendation was referred for report back at the 2016 Annual Meeting.]

That our AMA advocate that medical practices are the ultimate custodians of individual and aggregate patient information and should have unfettered access to their data.

or alternatively proposed

That our AMA advocate that the physician or physician group is the ultimate custodian of individual and aggregate patient information and should have unfettered access to their data if a physician or physician group elects to terminate their use of a hospital sponsored EHR.

REFERENCES

1. Hsiao C., et al., “Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001–2013” U.S. Department Of Health And Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. January 2014. Available at cdc.gov/nchs/data/databriefs/db143.pdf. Accessed July 2015.
2. U.S. Department of Health and Human Services. “Medicare & Medicaid EHR Incentive Programs HIT Policy Committee March 10, 2015,” March 2015. Available at healthit.gov/FACAS/sites/faca/files/HITPC_CMS_Presentation_2015-03-10.pdf. Accessed July 2015.
3. Adler-Milstein J., et al., “A Survey Analysis Suggests That Electronic Health Records Will Yield Revenue gains for Some Practices and Losses for Many,” *Health Affairs*, March 2013.
4. Data released by the Centers for Medicare and Medicaid Services (CMS) in March 2015 report that 56,367 Eligible Professionals (EP) had attested for Stage 2 in 2014. CMS estimates there were 595,100 EPs in 2014. (56,367/595,100=9.4%)
5. Payne T.H., et al., “Report of the AMIA EHR 2020 Task Force on the Status and Future Direction of EHRs,” *Journal of the American Medical Informatics Association*, May 2015.
6. Id.
7. Section 1128B(b) of the Social Security Act, codified at 42 U.S.C. § 1320a-7b(b).
8. 42 C.F.R. § 1001.952(y)(3); see also, 42 C.F.R. § 411.357(w)(3).
9. ONC, “Report To Congress: Report on Health Information Blocking,” April 2015.
10. Id.
11. Krist A. H., et al., “Electronic health record functionality needed to better support primary care,” *Journal of the American Medical Informatics Association*, January 2014. Available at <http://jamia.oxfordjournals.org/content/jaminfo/21/5/764.full.pdf>. Accessed July 2015.
12. Mandl et al., “Driving Innovation in Health Systems through an Apps-Based Information Economy,” *Cell Systems* June 2015. Available at [sciedirect.com/science/article/pii/S2405471215000046](http://www.sciencedirect.com/science/article/pii/S2405471215000046). Accessed July 2015.

13. Friedburg M. W., et. al, "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy," *RAND*, October 2013.
14. Julia Adler-Milstein, et., "Operational Health Information Exchanges Show Substantial Growth, But Long-Term Funding Remains a Concern," *Health Affairs*, August 2013.
15. GAO (GAO-14-242), "Electronic Health Records HHS Strategy to Address Information Exchange Challenges Lacks Specific Prioritized Actions and Milestones" March 2014.
16. Conn, J., "Fee Frustrations: Connecting EHR Systems Too Pricey, Providers Say," *Modern Healthcare*. July, 2013. Available at modernhealthcare.com/article/20130727/MAGAZINE/307279974. Accessed July 2015.
17. Office of the National Coordinator for Health Information Technology. 2014 Edition Standards & Certification Criteria Final Rule. September 2012. Available at gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-20982.pdf. Accessed July 2015.
18. Id.
19. Sittig D. F. et al., "What makes an EHR 'open' or interoperable?," *Journal of the American Medical Informatics Association*, May 2015. Available at <http://jamia.oxfordjournals.org/content/early/2015/06/13/jamia.ocv060>. Accessed July 2015.
20. Black Book Rankings. "Electronic Health Record Sellers Face Make-or-Break Year of Client Ultimatums and Revolts, Reveals 2013 Black Book Survey," February 2013. Available at prweb.com/releases/2013/2/prweb10416655.htm. Accessed July 2015.
21. AMA Board of Trustees Report 18-A-14. Data Transition Costs When Switching Electronic Medical Records (Resolution 728-A-13). March 2014.
22. Zwerling. H. The Health Care Blog. "Open Letter From a Small EMR Vendor to Our Customers and Our Friends in Washington," December 2013. Available at <http://thehealthcareblog.com/blog/2013/12/05/open-letter-from-a-small-emr-vendor-to-our-customers-and-our-friends-in-washington/>. Accessed July 2014.
23. Murphy, K., "EHR Replacement: Challenges for Providers Making the Switch," *EHR Intelligence*. April 2013. Available at <http://ehrintelligence.com/2013/04/02/replacement-ehr-challenges-for-providers-making-the-switch/>. Accessed July, 2015.
24. Id.
25. AMA Board of Trustees Report 18-A-14. Data Transition Costs When Switching Electronic Medical Records (Resolution 728-A-13). March 2014.
26. Bipartisan Policy Center. Clinician Perspectives on Electronic Health Information Sharing for Transitions of Care. October 2012.
27. AMA Board of Trustees Report 18-A-14. Data Transition Costs When Switching Electronic Medical Records (Resolution 728-A-13). March 2014.
28. ONC. "EHR Vendors Reported by Hospitals Participating in the CMS EHR Incentive Programs," March 2015. Available at <http://dashboard.healthit.gov/quickstats/pages/FIG-Vendors-of-EHRS-to-Participating-Hospitals.php>. Accessed July 2015.
29. OIG. "Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships: Exception for Certain Electronic Health Records Arrangements," 78 Fed. Reg. 78,751, 78762. December 2013. Available at gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30923.pdf. Accessed July 2015.
30. Id.
31. Id.
32. http://youtu.be/0KLxW_9yYXQ
33. ONC, "Report To Congress: Report on Health Information Blocking," April 2015. Available at healthit.gov/sites/default/files/reports/info_blocking_040915.pdf. Accessed July 2015.
34. Id.
35. Id.
36. See e.g., 45 C.F.R. § 164.524(a).
37. ONC. "2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications," March 2015. Available at gpo.gov/fdsys/pkg/FR-2015-03-30/pdf/2015-06612.pdf. Accessed July 2015.
38. Id.

APPENDIX — AMA POLICY

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 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 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.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and

financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

D-478.996 Information Technology Standards and Costs

Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

D-478.991 Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs

Our AMA will: (1) develop contracting guidelines for physicians considering accepting or donating Electronic Medical Records and Electronic Health Records systems (EMRs/EHRs) from or to hospitals and health care systems; (2) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (3) encourage interoperability of information systems used by hospitals and health care facilities.

D-478.994 Health Information Technology

Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; (3) support initiatives to ensure interoperability among all HIT systems; and (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

H-315.974 Guiding Principles, Collection and Warehousing of Electronic Medical Record Information

Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

H-478.994 Health Information Technology

Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.

H-478.988 Data Ownership and Access to Clinical Data in Health Information Exchanges

1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues. 2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures. 3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice. 4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices.

H-225.973 Financial Arrangements Between Hospitals and Physicians

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

**2. DONATING REIMBURSEMENTS TO THE AMERICAN MEDICAL ASSOCIATION FOUNDATION
(RESOLUTION 602-A-15)**

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

**HOUSE ACTION: RECOMMENDATION ADOPTED
IN LIEU OF RESOLUTION 602-A-15
REMAINDER OF REPORT FILED**
See Policy D-630.968

Resolution 602-A-15, “Donating Reimbursements to the American Medical Association Foundation,” introduced by our AMA Minority Affairs Section and referred by the House of Delegates asked:

That our American Medical Association explore a mechanism to make a donation from its non-employee travel reimbursement worksheet to allow members of the Board of Trustees, councils, and sections the option of donating a tax-deductible portion or the total amount of their travel reimbursement to the AMA Foundation Minority Scholars Fund or, when specified, another AMA Foundation program benefitting medical students.

DISCUSSION

Our AMA is a strong supporter of the AMA Foundation. The mission of the Foundation is aligned with the mission of our AMA and its activities complement our priorities. AMA’s support over the years has included the original establishment of the Foundation, staffing, financial and in-kind services, and appointment of several sitting Board of Trustees members serving on the Foundation’s Board of Directors. Our AMA itself has relied on Foundation support for selected programs where the collaboration has benefitted both organizations.

Our AMA also is a champion for the encouragement of recruitment and financial support to minority medical students. The cost of medical school to students has become a tremendous burden that frequently is a special barrier to minority students. The funds made available through the Foundation to these scholars are a valuable way of showing both our organizations’ commitment to advancing the diversity of medical students. But the Foundation and its contributors also support many other worthy and important programs.

Therefore, the Board of Trustees believes that our AMA must be perceived as being supportive of the AMA Foundation as a whole. Specifying a particular fund may create the perception that one initiative is more important. Our AMA’s internal processes for managing deposits to even one Foundation fund from individual donors would be difficult. Expense reimbursements are processed electronically. Partial payment processing would be done manually, thereby incurring additional costs, time, and staffing for both our AMA and the Foundation.

In recent years, the AMA Foundation has created a number of easily accessible ways to make donations by telephone, mail, online, or in person. By these means, the donor has more flexibility to direct their contributions to specific funds in a cost-efficient manner. AMA could add verbiage to its expense forms directing individuals to the Foundation’s website should they wish to make a contribution, either in the amount of their reimbursement from AMA for travel or in any other amount.

Individuals wishing to make a charitable contribution, deductible for tax purposes, based on redirecting their entitlement to an expense reimbursement from our AMA to the AMA Foundation would need to seek advice from their individual tax advisors regarding documentation and deductibility. Our AMA is not in a position to provide tax advice to potential donors as to what would or would not be deductible on their tax return or what support would be required to take a deduction.

RECOMMENDATION

Because of the concerns expressed above, the impact on reimbursement processing and the readily available alternate forms of donation, the Board of Trustees recommends that the following be adopted in lieu of Resolution 602-A-15 and the remainder of the report be filed:

That our American Medical Association add verbiage to its non-staff expense form directing individuals to the AMA Foundation's website should they wish to make a contribution.

3. 2015 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2014 American Medical Association (AMA) Annual Meeting, the House of Delegates (HOD) adopted Policy G-640.005 "AMA Advocacy Analysis." This policy calls on the Board of Trustees to provide a report to the HOD at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. Your Board of Trustees has prepared the following report to provide an update on 2015 AMA advocacy activities.

2015 FEDERAL LEGISLATIVE ACTIVITIES

Elimination of the SGR/Enactment of MACRA

The repeal of the Sustainable Growth Rate (SGR) formula and the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) comprise a watershed moment for our nation's patients and physicians. The shortcomings of the SGR are well known. It threatened patients' access to health care; disrupted physician practice finances; inhibited innovation in health care delivery; and finally, repeatedly forced our AMA and the Federation to prioritize potential SGR cuts over other vital policy issues that needed to be addressed.

Our AMA led the multi-year effort to repeal the SGR, working collaboratively with the Federation. It was a remarkable achievement during a time of political gridlock, when many other interest groups are struggling to reach legislative closure on their top issues. Over 700 physician organizations signed a letter urging Congress to support MACRA, and Congress responded with overwhelming bipartisan votes. On March 26, 2015, the US House of Representatives voted 392-37 in support of H.R. 2 (MACRA), and on April 14, 2015, the Senate passed MACRA by a vote of 92-8. In a letter to AMA Immediate Past President Robert M. Wah, MD, 46 state medical associations wrote, "Never before has the slogan 'Together We Are Stronger' been more true. It was the unity within organized medicine that brought us to this important victory."

Besides preventing the 21 percent SGR cut and stabilizing Medicare payment rates, MACRA accomplished several other important AMA policy objectives too.

- It provides a pathway to new payment models, including bonuses to mitigate risk and technical assistance funding for small practices.
- It extends the Children's Health Insurance Program (CHIP) for two years.
- It includes improvements to quality reporting programs.
- It includes protections against the misuse of federal quality standards in medical liability cases.
- Finally, it reversed a Centers for Medicare & Medicaid Services (CMS) policy that would have eliminated global surgical payments.

Our AMA addressed several other federal legislative priorities in 2015.

Diabetes Prevention Programs

Our AMA successfully sought introduction of the Medicare Diabetes Prevention Act (S. 1131/ H.R. 2102) which would require coverage of the National Diabetes Prevention Program (DPP). Preventing diabetes is a major focus for our Improving Health Outcomes strategic pillar and ensuring coverage of DPPs is a critical element of this work.

Independent Payment Advisory Board

Our AMA remains committed to seeking repeal of the Independent Payment Advisory Board (IPAB). The IPAB has yet to be established, and the spending thresholds required to trigger IPAB's authority have not been met to date. However, a recent Medicare Trustees report indicates that IPAB could be triggered in 2017. The US House of Representatives passed an IPAB repeal bill (H.R. 1190), which is a positive development; however, the spending offset would remove money earmarked for preventive services. A bill has also been introduced in the Senate (S. 141). Our AMA will continue to press for IPAB repeal and encourage Congress to find a different financial offset as the bill moves forward.

Opioid Misuse

Our AMA is also addressing the opioid misuse crisis in Congress by seeking to ensure that federal legislation tackling this issue takes a comprehensive public health approach. AMA Board of Trustees Chair-Elect Patrice A. Harris, MD, MA, testified to Congress and recommended this approach as we seek to shape the policies proposed by Congress on this topic. More information on AMA efforts on opioid misuse is contained in the "2015 State Legislative Efforts" section of this report.

Health Insurer Mergers

In September, the AMA released the 2015 edition of its Competition in Health Insurance study, as well as two special analyses of the impact of the proposed Anthem-Cigna and Aetna-Humana health insurer mergers. The 2015 edition, which analyzed competition in health insurance markets in 388 metropolitan areas, as well as all 50 states and the District of Columbia, found that seven out of 10 metropolitan areas were "highly concentrated" based on the Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines. Forty-six states had two health insurers with at least a 50 percent share of the commercial health insurance market, while 14 states had a single insurer that had at least a 50 percent market share. Using data from the 2015 edition, the special analyses showed that the combined impact of the proposed mergers among four of the nation's largest health insurers would exceed the DOJ/FTC guidelines designed to preserve competition by enhancing market power in as many as 97 metropolitan areas with 17 states. On September 10, AMA Trustee Barbara McAneny, MD, presented this study within testimony before the House Judiciary subcommittee which held hearings on competition in the health care marketplace. Dr. McAneny's testimony expressed concern that the consolidating health insurer markets would give insurers the ability to raise premiums, disregard physician advocacy on behalf of patients, impair innovation, and control physician payment in a manner that could harm the quality of health care.

Private Contracting

Rep. Tom Price, MD (R-GA) and Senator Lisa Murkowski (R-AK) reintroduced the Medicare Patient Empowerment Act this year as H.R. 1650 and S. 1849, respectively. The bills would eliminate the current onerous restrictions on the ability of Medicare patients and their physicians to enter into private agreements regarding payment for services. The AMA has engaged physician grassroots and is encouraging legislators to cosponsor the legislation. The House bill currently has 28 Republican cosponsors and the Senate legislation has three Republicans cosponsors.

The MACRA legislation signed into law last April includes two provisions relevant to the current private contracting rules. Effective June 15, 2015, physicians who have opted out of Medicare will no longer need to renew their opt-out status every two years. In addition, beginning on February 1, 2016, the Centers for Medicare and Medicaid Services will be required to issue an annual list of physicians who have opted out of the program, including information on their specialty and region.

Other Legislative Issues

In addition to the issues discussed above, AMA staff routinely engage with Congress on a wide variety of topics to promote AMA policies and advise lawmakers in the development of policies affecting physicians, patients, and the health care system as a whole. During the previous year, issues have included: public health; mental health and substance abuse; research funding; disability policy; fraud and abuse; Recovery Audit Contractor (RAC) reforms; Laboratory Developed Tests (LDT) regulation; telemedicine coverage and licensure; Graduate Medical Education (GME) and student loan support; coding issues; immigration policy; Veterans' health; tort reform; scope of practice; Indian Health Service policy; toxic substances regulation; pharmaceutical policy; and Medicare coverage policy.

Defensive Efforts

While our AMA spends a great deal of time and resources seeking passage of bills that we support, a key part of our advocacy efforts includes working to defeat legislation that would be harmful to patients or the profession. Earlier this year, our AMA was integral to the removal of a provision in the Trade Adjustment Assistance bill that would have extended the Medicare Sequester. The provision was included as a "payfor" in the legislation, but our AMA argued successfully that extending the Sequester would harm our health care system moving forward and ultimately a different "payfor" was found.

We will be very vigilant as we approach the end of 2015 for further budgetary risks that may arise. There is the possibility of cuts to health programs and provider payments as part of ongoing budgetary maneuvering. Our AMA will oppose measures in this process that weaken our health care system and hinder efforts to advance payment and delivery reform.

Further, we successfully called for the removal of language within the 21st Century Cures legislation that would have overly mandated clinical data registries and stifled meaningful quality improvement.

2015 FEDERAL REGULATORY ACTIVITIES

Our AMA has been very active and secured positive results on the regulatory front at the federal level as well.

MACRA Implementation

Our AMA is firmly committed to ensuring that MACRA is implemented properly. We are in frequent contact with the federal agencies charged with implementing MACRA and have engaged the Federation through several workgroups as we seek to ensure that regulations stemming from MACRA establish a framework for a health care delivery system that provides high quality care to patients and promotes thriving physician practices.

ICD-10

Another top regulatory priority for our AMA has been the transition to ICD-10. Our AMA has opposed ICD-10 repeatedly through legislative and regulatory channels. We have commissioned research depicting the financial toll that ICD-10 will have on physician practices. We have also been vocal in the media about the shortcomings of ICD-10. However, we have reached a point where implementation of ICD-10 is inevitable. Public and private stakeholders, including hospitals and some large physician practices, have lined up to support a firm implementation deadline of October 1, and the Administration and key Congressional committee chairs have affirmed that this deadline will not be delayed again.

In order to minimize the disruption that ICD-10 may cause for physician practices, our AMA has been working with the Administration to develop a mitigation plan that is in line with recent ICD-10 policy adopted by the HOD. Toward this end, our AMA and CMS jointly announced on July 6, that we have reached an agreement on important elements of a "grace period" for implementation of ICD-10. Under the agreement, Medicare claims will not be denied solely on the specificity of the ICD-10 diagnosis codes provided, as long as the physician submitted an ICD-10 code from an appropriate family of codes. In addition, Medicare claims will not be audited based on the specificity of the diagnosis codes as long as they are from the appropriate family of codes. This policy will be followed by Medicare Administrative Contractors and Recovery Audit Contractors. CMS will make accommodations in its quality programs in 2015 if physicians use the correct family of diagnosis codes. CMS will

also establish an ICD-10 ombudsman to assist with the transition, and CMS will authorize advanced payments if Medicare contractors are unable to process claims within established time limits due to problems with ICD-10 implementation. Our AMA continues to work with CMS on further clarification and guidance related to this agreement.

Meaningful Use

Our AMA is also pressing the Administration to fix the Meaningful Use (MU) program. MU is transitioning from an incentive program to one where many physicians will incur financial penalties. In 2015, 256,000 physicians will receive a financial penalty for not meeting the MU requirements. While CMS re-opened the previous MU regulation for the second time and agreed to make improvements to the program that include short-term positive relief for physicians, MU Stage 3 will be a major problem for physician practices and will have a negative impact on patients if it is not modified significantly.

We know from our AMA's research with the RAND Corporation that physicians support increased use of technology in their practices, but because technology was not designed with physicians and their patients in mind, it has become a major hindrance to providing high quality care and a barrier to the patient-physician relationship. Our AMA is trying to raise awareness of the problems with the MU program and Health Information Technology (HIT) in general, so that policymakers will see this issue as a priority and seek solutions to solve it. On July 20, 2015, our AMA collaborated with the Medical Association of Georgia and held a town hall meeting in Atlanta. AMA President Steven J. Stack, MD, moderated the event, and Congressman Tom Price, MD (R-GA), spoke about his concerns with the MU program and what solutions are needed. Over 50 physicians attended the meeting, and over 200 participated online. At the time of this writing, similar forums and other activities are also being planned. Our AMA will continue to find ways to express physician concerns on this issue to policymakers, and our work to improve MU Stage 3 will continue as well.

Our AMA also worked with Rep. Renee Ellmers (R-NC) in developing her Flex-IT Act (H.R. 3309), introduced in late July. This bill would address many key concerns with the MU program by: (1) delaying MU Stage 3; (2) harmonizing various Medicare reporting programs; (3) establishing a 90-day reporting period; (4) encouraging interoperability; and (5) creating more hardship exemptions.

Drug Shortages

Our AMA met with representatives of the US Federal Trade Commission, Office of Policy and Planning to discuss the impact of pharmaceutical mergers, acquisitions, and consolidations on brand and generic drug pricing and drug shortages. The FTC was provided an overview of existing AMA policy, and they provided an overview of their interest in collaborating with our AMA to identify significant price increases after mergers, consolidations, and acquisitions as well as the factors that could contribute to shortages such as consolidations shrinking the market to a single manufacturer.

Proposed Medicare Fee Schedule

There were also several positive developments in the 2015 Medicare Fee Schedule Notice of Proposed Rulemaking prompted by AMA advocacy. Under the proposed rule:

- Advance Care Planning - CMS recommends paying physicians for advance care planning (CPT codes 99497 and 99498). CMS proposed to pay for these services based on recommended resource costs identified by the AMA/Specialty Society RVS Update Committee (RUC). The recognition of these services is a significant step forward in supporting discussions between physicians, patients, and families regarding medical treatment options.
- CPT/RUC timeline - The CPT Editorial Panel and RUC successfully implemented new processes to improve transparency within the Medicare Physician Payment Schedule. In July, CMS released the first Proposed Rule to new CPT codes and RUC recommendations for implementation on January 1, 2016. Our AMA also published detailed data and RUC recommendation material at ama-assn.org/go/rucrecommendations. This earlier release provides physicians and other stakeholders with increased opportunity for public comment prior to implementation.

- Physician Quality Reporting System - After three years of tremendous changes with the Physician Quality Reporting System (PQRS), CMS responded to our AMA's concerns and will refrain from proposing significant changes to the 2016 PQRS program.
- Qualified Clinical Data Registries - Group practices will be able to participate in PQRS through a qualified clinical data registry (QCDR). Previously only individuals were allowed to report via QCDRs.
- Value Based Modifier - CMS will also refrain from increasing the current maximum Value Based Modifier (VBM) penalty of four percent for groups of 10 or more and two percent for those fewer than 10. CMS is also proposing to exempt the Pioneer and other Center for Medicare & Medicaid Innovation (CMMI) demonstration participants from the VBM.
- Risk Adjustment - CMS also seeks to improve risk-adjustment and sample size issues in the VBM in the proposed rule. Our AMA is seeking an additional hardship exemption for groups fewer than 10. These changes would translate into fewer physicians being at risk for negative adjustments.

Two Midnight Rule

The Hospital Outpatient Prospective Payment System (OPPS) proposed rule addressed the “Two-Midnight Rule” which has been a serious concern for many physicians. CMS proposes to improve the rule by increasing respect for physician’s clinical judgment as well as shifting review of the necessity of hospital admissions to Quality Information Organizations which are required to use appropriate specialists as part of the review.

Our AMA will support the positive provisions in these rules and seek to improve areas that are concerns. We will continue to provide updates through regular AMA communications vehicles including Advocacy Update.

Our AMA is also working on several other regulatory issues and had further victories in 2015.

- E-prescribing - The US Drug Enforcement Administration (DEA) is developing new rules for electronic prescribing of controlled substances to make it more feasible for physicians to adopt these systems.
- Sunshine Act - CMS issued guidance on the Open Payments (Sunshine Act) program that clarified that certified/accredited Continuing Medical Education (CME) is exempted.
- Provider networks - CMS strengthened Medicare Advantage provider network rules requiring plans to be monitored more closely and be subject to audits, compliance, and enforcement actions if they do not regularly update their accurate provider directories.
- Veterans Choice Program - The Veterans Administration expanded eligibility for the Veterans Choice Program – effectively doubling the number of veterans served – by changing the distance requirement so that a facility is measured in terms of actual travel distance rather than “as the crow flies.”
- Medicare ACOs - CMS also improved the Medicare ACO program by retaining the shared savings only model, removing specialists from the patient assignment process, and modifying various benchmarks.
- Blood donation - The US Food and Drug Administration (FDA) also took a positive step when it ended the ban and proposed new guidance on blood donations by men who have sex with men.
- Colonoscopy screenings - In a major win for patients, CMS clarified that insurers cannot charge patients for anesthesia administered during a free colonoscopy screening.

2015 STATE LEGISLATIVE ACTIVITIES

While our AMA has a robust federal advocacy presence, we are also very active and effective in the states. We collaborate with the state medical associations and the national medical specialty societies to advance AMA policy in state legislative and regulatory bodies. Our AMA advocates extensively to national groups focused on state policy such as the National Governors Association, the National Association of Insurance Commissioners (NAIC), and the National Conference of Insurance Legislatures.

Opioid Misuse Crisis

A good example of this partnership is our recent collaborative efforts on opioid misuse. This has become a national epidemic with tens of thousands of Americans dying each year due to opioid overdoses. A tragic offshoot of this problem is that as policymakers have sought to limit access to the prescription drugs most widely misused, while not increasing access to substance disorder treatment or other pain management resources, there has been a spike in heroin deaths as people have drifted to the illegal drug market to replace prescription drugs. To further augment

ongoing advocacy, our AMA formed the AMA Task Force to Reduce Opioid Abuse, which includes the American Osteopathic Association, 17 national medical specialty societies, seven state medical associations, and the American Dental Association. The initial focus for the Task Force is to encourage physicians to register for and use state Prescription Drug Monitoring Programs (PDMP) and to stress to physicians prescribing opioids the need for them to be educated on appropriate prescribing practices. The Task Force will also seek to reduce the stigma of pain and promote comprehensive assessment and treatment; reduce the stigma of substance use disorder and enhance access to treatment; and expand access to naloxone in the community and through co-prescribing.

As mentioned above, Dr. Harris testified before Congress urging a comprehensive public health approach to this issue. Our AMA and Federation partners are doing the same at the state level. The challenge in many states is that policymakers are focused on stronger law enforcement measures as the solution. However, we have made major progress encouraging them to take a public health approach instead. We partnered with the Harm Reduction Coalition, National Safety Council and more than 150 Federation members to urge our nation's governors to increase the emphasis on overdose prevention and treatment. We also supported 20 new state laws over the past two years that will increase access to naloxone and provide Good Samaritan protections for those who help a person experiencing an overdose. Our work on this issue will continue as we try to end the crisis.

Network Adequacy

Our AMA has also been advocating to the NAIC on network adequacy extensively in 2015. NAIC has been a key policymaking body on Affordable Care Act (ACA) implementation issues, and it is developing network adequacy model legislation that will include input from a litany of stakeholders. Our AMA is the leading physician voice in these discussions and is ensuring that patient and physician issues are addressed. In 2015 our AMA has been involved in important victories in California that include the release of regulations to significantly protect patients from inaccurate directories and inadequate networks. Oregon has enacted network adequacy legislation, and Rhode Island and others have considered progressive bills this year on directories based on our model legislation. But most states are looking toward the work of the NAIC for its model bill to address network adequacy.

Our AMA is also advocating on a host of other issues at the state level, including but not limited to:

- Electronic payment protections - Oregon passed a law in 2015 based on AMA model state legislation that protects physicians' rights related to electronic payment. Specifically, the Oregon law requires health plans to disclose in advance any fees related to electronic payments, including virtual credit cards and standard electronic funds transfer, and obtain physician consent regarding the payment method. Similar bills were also introduced in Alabama and Texas.
- Telemedicine - Following the release of AMA model telemedicine legislation in late 2014, states saw a flurry of activity in the area, with dozens of laws and regulations proposed to address telemedicine licensure, reimbursement, and practice standards. To date, eight states have enacted laws that align with components of our model legislation. We have also been advocating for the Federation of State Medical Boards (FSMB) interstate compact legislation, which helps facilitate the adoption of telemedicine and creates an alternative for proponents of federal licensure for telemedicine. So far, 11 states have enacted the FSMB legislation.
- Immunization exemptions - Immunizations were a priority issue again in 2015 as measles outbreaks gained significant media attention. Our AMA and our Federation colleagues worked in many states to tighten or remove personal and philosophical exemptions to immunizations. The enactment of S.B. 277 in California, sponsored by HOD member Richard Pan, MD, was a major achievement in this regard and a big step forward on the issue.
- Prior authorization - Arkansas and Virginia enacted prior authorization bills, and several other states introduced bills this year. Our AMA is aware of how frustrating this process can be for patients and physicians and is working to ensure that the process is streamlined and relies on physician input.
- "Truth in Advertising" - Georgia and Nebraska enacted truth in advertising legislation in 2015, becoming the 19th and 20th states to establish laws based on AMA model legislation that promotes truth and transparency in advertising for medical services.
- Medicaid payment for primary care - After federal funding expired for Medicare-level reimbursement rates for primary care physicians in Medicaid, our AMA and our Federation colleagues have worked to continue the enhanced rates at the state level. At the end of 2014, 17 states had elected to pay primary care physicians at or near Medicare payment levels. Efforts in 2015 added the District of Columbia, Georgia, and Vermont, bringing the total number of states with enhanced primary care payment rates to 20.

- Team-based care - Our AMA helped secure 20 victories in 15 states, defeating bills that would undermine physician-led, team-based care or otherwise inappropriately expand scope of practice.

2015 GRASSROOTS/GRASSTOPS ACTIVITIES

In 2015, our AMA continued to have a vibrant grassroots program. The Patients' Action Network (1 million members), the Very Influential Physician (VIP) Key Contact Program (1,000 members) and the Physicians' Grassroots Network (35,000 members) had a tremendous impact on our key issues, particularly SGR repeal. In the final weeks of our push to repeal SGR, the Fix Medicare Now campaign generated to Congress:

- 243,907 emails
- 60,229 phone calls
- More than 26,700 social media actions

These communications showed the breadth and depth of physician and patient discontent with the SGR, and they were critical in pushing repeal across the finish line.

With technology evolving rapidly and new grassroots tools available, our grassroots team utilized several innovative techniques in promoting our message. To highlight one of the trends, mobile advertising is fast becoming a critical part of running a successful advocacy campaign, with mobile ads comprising over 55 percent of all political online spending in 2015. Mobile viewers represent 52 percent of online video viewers. Video viewing on personal computers remained flat from 2014 to 2015. On smartphones it grew 44 percent, and on tablets it grew by 54 percent. By 2016, mobile ad dollars will exceed spending on desktop, and by 2018 mobile will account for 70 percent of total digital ad spending. A successful, multi-tiered approach means incorporating mobile into digital ad strategy, and our grassroots team accomplished this as part of our SGR repeal campaign.

We employed traditional media tactics too. Our aggressive print campaign consisted of 29 full page, color ads, strategically placed in premium, highly visible areas (back page, inside front cover, and on the first fold) of influential publications. We also used 16 "special cover stickers" that drove readers to the campaign messaging and promoted the campaign's Twitter hashtag: #FIXMEDICARENOW.

With the repeal of the SGR complete, our AMA will transition our grassroots efforts to other top physician and patient priorities. The first step in this transition is the creation of the "Break the Red Tape" campaign (breaktheredtape.org) which focuses initially on promoting changes to the MU Stage 3 program. In the near future, it will embrace other administrative burden and regulatory relief topics too. We will also maintain our efforts to protect federal funding for GME with our SaveGME.org campaign.

2015 AMPAC ACTIVITIES

In 2015, our AMA trained 65 physicians, students, and physician spouses at our Campaign School and Candidate Workshop. These trainings offer tips and strategies for those interested in running for office or who wish to run political campaigns. Thirty-six alumni of these trainings have been elected to public office, and they have been champions for patients and physicians during their time in office.

AMPAC is also aggressively raising funds for our political efforts in the 2016 elections. We will be supporting candidates who are supportive of patient and physician issues. And depending on the electoral climate, we may engage in independent expenditures. As with our grassroots work, we are pursuing innovative fundraising efforts. A complete AMPAC report will be provided in a separate report for the HOD at the Interim Meeting. Finally, we urge all members of the HOD to become AMPAC members if they have not done so already, and wish to thank our current members.

FEATURED ADVOCACY RESOURCES

Our AMA has also produced several new resources to assist physicians:

- MACRA resources - This resource helps physicians to understand MACRA and provides resources on key dates and key provisions in the law. It also covers questions frequently asked about MACRA. ama-assn.org/go/medicarepayment
- Digital health - While technological changes in health care can reduce inefficiencies and costs, increase quality and promote patient-centered care, usability is crucial. This resource helps physicians to learn about what our AMA is doing to address challenges physicians face with current EHRs, and help their practices make the most of MU, health information exchanges, telemedicine, mobile health and more. ama-assn.org/go/digitalhealth
- Pharmacy electronic prior authorization - A new resource released in September 2015 will provide physicians with an overview of the current prior authorization landscape and offer tips to minimize associated practice burdens, including implementation guidance on the new pharmacy prior authorization electronic transactions. ama-assn.org/go/priorauthorization
- Managing patient payments - Our AMA has created tips and resources to assist physician practices with reviewing their patient payment management process and to ensure that their payment process is convenient and transparent for both the practice and patients. ama-assn.org/go/patientpayments
- Health Workforce Mapper - The AMA Health Workforce Mapper empowers physician advocates with the evidence to make fact-based decisions on health workforce policy. This interactive mapper illustrates the geographic locations of physicians and other health care providers—down to medical specialty and practice type. ama-assn.org/go/healthworkforcemapper
- Policy briefs - Our AMA produced policy briefs on health care costs, network adequacy, physician-led team-based care, physician payment, and inpatient vs. observation care. “Maximizing value in the health care system” summarizes several policies addressing the need to properly align health care costs with quality of care. “Network adequacy” discusses AMA strategies to ensure patient and physician protections against excessively narrow networks, inaccurate provider directories and unclear criteria for physician participation in a network. A series of three policy briefs on physician-led team-based care defines the parameters of, explores various models for, and describes payment options in team-based care. “Payment and coverage for hospital admissions: Inpatient vs. observation care” clarifies the confusion about observation care and provides the AMA policy solution. Our AMA also produced a HIPAA privacy rights request form for use in physician offices when seeking to ensure the privacy of dependents on insurance company explanations of benefits. All of these policy briefs are based on reports of the AMA Council on Medical Service, and are available on the Council’s website. ama-assn.org/go/cms
- Claim payment issues - Our AMA created a resource to help physicians identify and appeal issues surrounding health insurer claims payments. “Identifying and Appealing Health Insurance Claim Payment Issues” details important steps for practices to take in order to implement an effective and efficient claims review/appeals process. This resource includes specific examples of some common claims payment issues facing physicians and outlines actions that physicians might consider if their claim appeal is denied. AMA members can also take advantage of template appeal letters that address a variety of claim payment issues. ama-assn.org/go/appeals
- Electronic transactions - Our AMA updated two resources to help physicians and their staff process electronic remittance advice (ERA) and make the most out of this standard electronic transaction. The newly revised ERA Toolkit offers a wealth of information for practices interested in implementing or maximizing the utility of ERA, including an overview of the transaction and the associated code sets, the information practices need from their trading partners prior to implementing ERA, and ERA processing tips and workflows. An archived webinar, also available as part of the toolkit, provides an introduction to these ERA topics. In addition, our AMA updated the Claims Workflow Assistant, an ERA code look-up tool, with the most current remittance advice codes and code combinations. This online tool allows practices to quickly research ERA code definitions, as well as identify recommended workflows for handling denied or partially paid claims. ama-assn.org/go/era
- STEPS Forward™ - Our AMA's STEPS Forward™ practice transformation series is a collection of interactive, educational modules developed by physicians to help physicians address common practice challenges and to achieve the quadruple aim of: better patient experience, better population health, lower overall costs, and improved professional satisfaction. Each module addresses a specific challenge by offering real-world solutions, steps to implementation, practical examples, case studies, and downloadable tools and resources. Topics covered include ICD-10, maximizing EHRs, and improving the operational effectiveness of your practice. Physicians and their practice staff can use these modules to help improve practice efficiency and ultimately enhance patient care. Modules also offer CME credit, so physicians can earn while they learn. stepsforward.org

NEW ADVOCACY RESEARCH

Our AMA has also produced the following studies to assist in our efforts:

- Actuarial study on IOASE - This independent actuarial analysis of 2008-2012 Medicare claims submitted for key services falling under the In-Office Ancillary Services Exception (IOASE) to the Stark self-referral law shows that current spending trends do not support arguments that physician self-referral encourages inappropriate utilization or increased Medicare spending. ama-assn.org/go/ioase
- Economic Impact Study - The Economic Impact Study focuses on the roughly 720,000 physicians who primarily engage in patient care activities. Nationally, these physicians support \$1.6 trillion in total economic output—that is \$2.2 million per physician—and 10 million jobs. ama-assn.org/go/eis
- Competition in Health Insurance - A Comprehensive Study of US Markets - In this report, our AMA produces the largest, most complete picture of competition in the commercial health insurance markets across the United States. It is a valuable resource for physicians, regulators and patients. ama-assn.org/ama/pub/advocacy/health-policy/policy-research.page
- ICD-10 Survey - A survey conducted in July 2015 revealed that physician practices still were not adequately prepared for the implementation of the ICD-10 coding set on October 1. This survey was conducted to strengthen our AMA's advocacy efforts for creating an ICD-10 transition process.

Our AMA is in the midst of conducting research on several other advocacy topics as well. We are continuing to review the implementation of the ACA and its impact on patients and physician practices. We are also engaged in research to determine the impact of administrative and regulatory burdens on physician practices. Finally, we have engaged on a project that will examine quality in health insurer networks. These studies will help to advance our policy recommendations as we seek to protect patients and strengthen physician practices.

DISCUSSION

In 2015, our AMA and the Federation of Medicine showed just how powerful we can be when we are unified in message and effort. Repeal of the SGR is a historic event, and one that will benefit patients and physicians for years to come. Repealing SGR was only half the battle though as we will now have to ensure that MACRA is implemented properly and achieves the potential that we see in it.

With the SGR behind us, our AMA has the opportunity to advance our efforts to enhance the delivery of care and enable physicians and health teams to partner with patients to achieve better health for all. Improving the health of the nation is at the core of our AMA's work. Our policies, initiatives and advocacy are grounded in research and evidence-based best practices that support physicians and patients in three vital areas:

- Working with physicians to advance initiatives that enhance practice efficiency, professional satisfaction and the delivery of care;
- Collaborating to improve health care that helps people live longer, healthier lives; and
- Accelerating change in medical education with visionary partners and bold innovations.

Our AMA's advocacy efforts will advance these three pillars of our AMA's strategic vision for our nation's health care system. As detailed previously in this report, we will continue to focus on MACRA implementation, mitigate disruption from the ICD-10 transition; seek to improve the MU program; call for coverage of DPP efforts; protect Graduate Medical Education (GME) funding; and other issues that arise that advance the goals of the HOD and promote our strategic vision.

Our AMA is in a very good position to influence the future of our nation's health care system, and we will continue to do so.

CONCLUSION

Once again, our AMA had a very strong year on our advocacy agenda. Repealing the SGR and enacting MACRA are major achievements that will allow our AMA to transition our advocacy focus to further issues critical to patients and physicians. We will keep the HOD updated as we continue to make progress on these issues.

4. REDEFINING THE AMA'S POSITION ON THE ACA AND HEALTH CARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, which called on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13 accomplished the original intent of the policy. This report serves as an update on the issues discussed in that and subsequent reports.

REPEAL OF SGR

As reported at A-15, repeal of the Sustainable Growth Rate (SGR) formula was accomplished with the enactment of the “Medicare Access and CHIP Reauthorization Act of 2015” (H.R. 2), sponsored by Representative Michael Burgess, MD (R-TX). AMA has engaged a wide variety of members of the Federation in preparation for the implementation of new payment policies included in the legislation.

PAY FOR PERFORMANCE

It is anticipated that over the coming months the Centers for Medicare & Medicaid Services (CMS) will begin information collection activities in preparation for implementation of the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model options enacted by MACRA. In preparation for this activity, our AMA has convened groups of state and national medical specialty organizations to proactively engage with regulators to assist and guide them in the implementation of these programs.

REPEAL OF IPAB

On June 23, 2015, the House of Representatives passed the “Protecting Seniors Access to Medicare Act” (H.R. 1190) by a vote of 244-154. This legislation, sponsored by Representative Phil Roe, MD (R-TN) and Representative Linda Sanchez (D-CA) would repeal the Independent Payment Advisory Board (IPAB). Our AMA expressed support for adoption of the legislation at the time of consideration. However, in passing the legislation, House leadership chose to offset the cost of the bill by sharply reducing funding for the Public Health and Prevention Fund that was also enacted as part of the ACA. AMA has specific policy adopted by the HOD calling for opposition to further reductions to this fund. AMA expressed opposition to the inclusion of this provision and urged Congress to consider alternative funding sources as the bill moves to the Senate.

The need to repeal IPAB has become increasingly urgent as projections of health care spending growth rates are trending higher from recent lows. The most recent Medicare Trustees Report projected that IPAB will be triggered in 2017, necessitating Medicare cuts in 2019. AMA staff has also examined the underlying data and believes that IPAB could be triggered as early as 2016.

SUPPORT FOR MSA, FSA AND MEDICARE PATIENT EMPOWERMENT ACT

On March 26, 2015, Representative Tom Price, MD (R-GA) reintroduced the “Medicare Patient Empowerment Act” (H.R. 1650). Senator Lisa Murkowski (R-AK) introduced companion legislation (S. 1849) in the Senate on July 23. Our AMA has sent letters of support for both bills though no action has been scheduled to date.

Additionally, our AMA continues to support the “Restoring Access to Medication Act,” (H.R. 1270, S. 709) introduced in the House by Representative Lynn Jenkins (R-KS) and Representative Ron Kind (D-WI) and in the Senate by Senators Pat Roberts (R-KS) and Heidi Heitkamp (D-ND). The bill would turn back ACA imposed limitations on the use of FSA funds for the purchase of over the counter medications.

REPEAL THE PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

At this time, legislation repealing the provider non-discrimination provisions of the ACA has not been reintroduced. AMA will continue to seek opportunities to repeal this provision and monitor implementation activities by the Department of Health and Human Services.

CONCLUSION

AMA Policy D-165.938 calls for updates at each meeting of the HOD on a number of specific policies related to the ACA. Our AMA continues to pursue these issues. Other key advocacy issues will be addressed in the annual Advocacy report at each Interim Meeting of the HOD.

5. PAIN MEDICINE (RESOLUTION 214-I-14)

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

IN LIEU OF RESOLUTION 214-I-14

REMAINDER OF REPORT FILED

See Policies H-95.939, H-945.945, H-945.946, H-945.947, H-95.990, H-185.931, D-95.981, D-450.958 and D-450.962

INTRODUCTION

Resolution 214-I-14, “Pain Medicine,” introduced by the South Carolina Delegation and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) work to remove the pain survey questions from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and work to prevent the Centers for Medicare & Medicaid Services (CMS) from using pain scores as part of CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys;

That our AMA request that CMS educate the public about the real risk of narcotic use and patient responsibility;

That a patient and physician education program for non-narcotic pain control directed at the risk of addiction, diversion and abuse from prescription narcotics be promoted by our AMA.

That our AMA advocate that commercial insurance and CMS payment for non-pharmaceutical treatments should be increased and also advocate for payment for team-based care of the pain patient; and

That our AMA should encourage CMS to work with the states to develop nonpunitive drug monitoring programs for physicians and patients to help reduce the use of prescription pain drugs.

During reference committee, mixed testimony was presented on Resolution 214-I-14. Testimony differed on how to best balance legitimate medical access to pain medicine while protecting public safety. Testimony also highlighted the existing AMA multi-prong strategy that leverages engagement with a range of stakeholders among physicians, other prescribers, public health officials, and other interested parties to combat prescription drug abuse. In addition, testimony noted that our AMA has already engaged CMS to address the concerns raised regarding the HCAHPS pain survey. Other testimony described the range of existing AMA policies that already address all of the resolves contained in Resolution 214-I-14. Most significantly, the reference committee heard that our AMA Council on Medical Service was developing a report on these and other issues related to prescription drug abuse and concluded that referral of Resolution 214-I-14 would allow for the important issues raised in the resolution to be taken into consideration and addressed in that pending report.

This report reviews Board and Council reports and current AMA policy that comprehensively address the issues raised by Resolution 214-I-14, provides an update on recent AMA advocacy activities and other initiatives related to combatting prescription opioid misuse, abuse, unintentional overdose, and death tied to overdose, and recommends reaffirming existing AMA policy.

RECENT AMA REPORTS AND POLICY RELATED TO PAIN MEDICINE

Pain Survey Questions

The first Resolve in Resolution 214-I-14 involves the use of pain survey questions as part of the HCAHPS and their potential future use by CMS as part of CAHPS Clinician and Group Surveys (CG-CAHPS) scores.¹ The Board previously examined this issue at length in Board Report 9-A-13, Pain Management and the Hospital Value Based Purchasing Program, and recommended the following relevant policy statements, which were subsequently adopted by the HOD and incorporated into AMA Policy as D-450.962, Pain Management and the Hospital Value-Based Purchasing Program:

1. Our AMA urges CMS to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS survey related to pain management as reliable and accurate measures of the quality of care in this domain.
2. Our AMA urges CMS to suspend the use of HCAHPS measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.²

Our AMA has engaged with CMS and the National Quality Forum to address concerns with the role that HCAHPS has played in exacerbating the potential overuse of pain medications and the need to modify the survey questions related to pain. Most recently, as part of comments submitted to CMS in response to the 2016 Medicare Hospital Inpatient Prospective Payment System Proposed Rule, our AMA noted that we have been working with the White House Office of National Drug Control Policy and numerous others within the Federal government and the states on a multi-faceted strategy to address the epidemic of opioid misuse, diversion, overdose, and death tied largely to prescription opioids. The letter further stated:

It is simply not acceptable to have the government's own patient satisfaction survey contributing to this problem. Therefore, the AMA urges CMS to work with the Agency for Healthcare Research and Quality to reframe the questions used on the HCAHPS survey related to pain management; to assess whether the HCAHPS appropriately reflects patient satisfaction and whether it may encourage inappropriate treatment; and to suspend the use of HCAHPS measures addressing pain management until the revised questions are reexamined to determine whether they are contributing to over prescribing due to the pressures HCAHPS scores place on providers.

Coverage for Chronic Pain Management

The issues in the fourth resolve, related to increased insurance coverage for non-pharmaceutical treatments and payment for team-based care of the pain patient, were comprehensively addressed in Council on Medical Service-Council on Science and Public Health Joint Report 1, Coverage for Chronic Pain Management, adopted with amendments at our AMA's 2015 Annual Meeting. The report explores the issues of chronic pain, including the scope of the problem, factors influencing opioid prescribing, harms attributable to opioid analgesics, interdisciplinary approaches to chronic pain management, and barriers to access to comprehensive pain management treatments. The following recommendations in the report, as amended, were adopted by the HOD at A-15 and incorporated into AMA Policy as H-185.931, Coverage for Chronic Pain Management:

1. That our American Medical Association advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.

2. That our AMA support health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
3. That our AMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.

Prescription Drug Monitoring Programs (PDMPs)

The fifth resolve, which involves the issue of state-based PDMPs, was recently addressed by BOT Report 12-A-15, Development and Promotion of Single National Prescription Drug Monitoring Program. This report provides an update on the epidemic of overdose deaths involving prescription opioids and heroin, reviews the current status of state-based PDMPs, considers the experience of mandates, and discusses the effects on patients with substance use disorders and pain management needs. The HOD adopted the following recommendations, as amended, in the report (see Policy H-95.939):

1. That our AMA reaffirm Policy H-95.945, "Prescription Drug Diversion, Misuse and Addiction," Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality," Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances," and Policy H-95.990, "Drug Abuse Related to Prescribing Practices;"
2. That our AMA support the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate;
3. That our AMA encourage states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care;
4. That our AMA support the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law;
5. That our AMA encourage states to foster increased PDMP use through a seamless registration process;
6. That our AMA encourage all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management;
7. That our AMA encourage states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and
8. That our AMA encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

In addition to Board of Trustees Report 12-A-15, our AMA continues to be actively involved at the state and federal levels in advocating for increased funding for state PDMPs. Our AMA has led on this issue for almost a decade, starting with its support of the passage of the National All Schedules Prescription Electronic Reporting Act (NASPER), which established a grant program to set up PDMPs that had a public health focus. Our AMA continues to strongly advocate for the reauthorization of the NASPER program with full directed appropriations, and recently sent a letter of support to the House sponsors of the NASPER Reauthorization Act, H.R. 1725.

EDUCATING PHYSICIANS ON PRESCRIBING OPIOIDS AND OTHER INITIATIVES

In 2014, your Board formed the [AMA Task Force to Reduce Opioid Abuse](#) with the goal of establishing a clear strategy for organized medicine to demonstrate that physicians are leading the way to address the nation's prescription drug abuse, misuse, overdose and death epidemic. Chaired by Board Chair-Elect Patrice A. Harris, MD, MA, the Task Force is comprised of 27 physician organizations including our AMA, American Osteopathic Association, 17 specialty and seven state medical societies as well as the American Dental Association that are committed to identifying the best practices to combat this public health crisis and move swiftly to implement those practices across the country. The Task Force's initial focus is on urging physicians to register for and use state-based PDMPs as part of the decision-making process when considering treatment options, and making sure they are educated about pain management and prescribing. The new initiative will seek to significantly enhance physicians' education on safe, effective, and evidence-based prescribing of opioids. This includes a new [dedicated web page](#) that houses vital information on PDMPs and their effectiveness for physician practices, as well as, a robust national marketing, social and communications campaign to significantly raise awareness of the steps that physicians can take to combat this epidemic and ensure they are aware of all options available to them for appropriate prescribing.

As the web presence for the Task Force is phased in, it will incorporate Federation-based and other high-quality education and training resources on opioid prescribing, pain management, and treating patients with opioid use disorder, as well as prescribing guidelines, evidence-based reviews and journal articles, and patient resources. Additional initiatives will focus on reducing the stigma of pain and promoting comprehensive assessment and treatment, reducing the stigma of substance use disorder and enhancing access to treatment, and expanding access to naloxone in the community and through co-prescribing. These activities are planned to be well under way by our AMA's Interim Meeting, and thus, address the concerns raised in resolutes two and three of Resolution 214-I-14, which relate to education of patients and physicians about the risks of opioid use.

The Task Force activities complement and build upon ongoing AMA education initiatives to combat opioid abuse. For example, our AMA, along with several other medical organizations, is a partner in the Prescriber Clinical Support System for Opioid Therapies (PCSS-O) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the American Academy of Addiction Psychiatry. PCSS-O is a national training and mentoring project developed in response to the prescription opioid overdose epidemic. As part of this collaborative, our AMA is developing new training materials on responsible opioid prescribing and a focused educational module on opioid risk management for resident physicians, and is seeking to engage selected states and state medical associations on collaborative approaches to address opioid-related harms.

In addition, the Task Force activities complement other ongoing advocacy activities. For example, our AMA has worked with more than 20 states in the past two years to help enact legislation that increases access to naloxone and provides Good Samaritan protections to those who seek or provide aid to someone experiencing an overdose. Our AMA also is working with state and specialty societies to enact AMA model legislation that would increase access to medication assisted treatment (MAT), including removing administrative and other barriers to MAT services. On the national front, our AMA is actively engaged in robust advocacy with the Administration and Congress on a range of opioid-related bills and is working with a broad range of stakeholders.

CONCLUSION

In light of the comprehensive council and board reports summarized above and the advocacy activities and Task Force initiatives in which our AMA is engaged, your Board believes that the issues raised by Resolution 214-I-14 have been or are being addressed and that current AMA policy as recommended below should be reaffirmed.

RECOMMENDATIONS

The Board recommends that the following be adopted (see Appendix) in lieu of Resolution 214-I-14, and that the remainder of this report be filed.

1. That our American Medical Association reaffirm Policy D-450.962, "Pain Management and the Hospital Value-Based Purchasing Program," Policy H-185.931, Policy H-95.945, "Prescription Drug Diversion, Misuse and Addiction," Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality," Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances," Policy H-95.990, "Drug Abuse Related to Prescribing Practices," and Policy D-95.981, "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction," and H-95.939, "Development and Promotion of Single National Prescription Drug Monitoring Program."
2. That our AMA continue to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).
3. That our AMA continue to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys.
4. That our AMA encourage hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.

5. That Policy D-450.962 be amended by addition to read as follows:

D-450.962, Pain Management and the Hospital Value-Based Purchasing Program

1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain.
2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.

REFERENCES

1. CG-CAHPS, which is clinician-specific, does not currently include any measures related to pain, and AMA staff is unaware of any plans to add any pain-specific measures to CG-CAHPS.
2. The Report also recommended that Policy H-450.982, "Patient Satisfaction and Quality of Care," be reaffirmed.

APPENDIX – AMA POLICY

D-450.962 Pain Management and the Hospital Value-Based Purchasing Program Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS survey related to pain management as reliable and accurate measures of the quality of care in this domain. 2. Our AMA urges CMS to suspend the use of HCAHPS measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.

H-185.931 Coverage for Chronic Pain Management

1. Our American Medical Association will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 2. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. 3. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.

H-95.945 Prescription Drug Diversion, Misuse and Addiction

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

H-95.946 Prescription Drug Monitoring Program Confidentiality Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances Our AMA: (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states; (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities; (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances; (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions; and (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians.

H-95.990 Drug Abuse Related to Prescribing Practices

Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices: A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students. B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms. 2. Our AMA: A. promotes physician training and competence on the proper use of controlled substances; B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients; C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances. 3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities. 4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

D-95.981 Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction

Our AMA: 1. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth; 2. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics; 3. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends; 4. will consult with relevant agencies on potential strategies to actively involve physicians in being "a part of the solution" to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and 5. supports research on: (a) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (b) issues relevant to the long-term use of prescription controlled substances.

H-95.939 Development and Promotion of Single National Prescription Drug Monitoring Program

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

6. STARK LAW AND PHYSICIAN COMPENSATION (RESOLUTION 208-I-14)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 208-I-14**
See Policy H-385.914

At the 2014 Interim Meeting, the House of Delegates (HOD) referred Resolution 208-I-14, “Stark Law and Physician Compensation,” for report back at the 2015 Interim Meeting. This resolution was introduced by the Utah Delegation and asked that:

Our American Medical Association (AMA) support repeal of the Stark Law and regulations or their revision such that they cannot be used by employers to unfairly and arbitrarily cap or control physician compensation.

This report provides background on relevant Stark Law provisions, discusses fair market value compensation for physicians, and outlines current AMA policy focused on this issue.

STARK LAW

The federal physician self-referral statute—known as Stark Law in reference to its primary congressional champion—prohibits a physician from referring Medicare patients for certain designated health services (DHS) to entities with which the physician (or an immediate family member) has a financial relationship. It further prohibits billing for DHS associated with such referrals.¹ The Stark Law is comprised of a series of amendments, the most impactful of which were included as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Stark I) and the OBRA of 1993 (Stark II). Stark I applied to clinical laboratory services only; Stark II expanded the self-referral ban to a wide range of DHS.

The Stark Law authorizes the Secretary of the Department of Health and Human Services (HHS) to promulgate implementing regulations. Exercising delegated authority, the Centers for Medicare & Medicaid Services (CMS) has published a series of final rules, addressing Stark I in 1995 and Stark II in three phases from 2001-2007, along with other regulatory updates.²

Both the Stark Law and its accompanying CMS regulations establish numerous exceptions to the self-referral prohibitions.^{3,4} Some exceptions apply to both physician ownership and compensation arrangements, whereas others apply only to ownership interests or compensation arrangements. Central to many of the Stark Law exceptions, especially to those touching on physician compensation, is the concept of “fair market value.”

For example, the exception protecting *bona fide* employment relationships between employers and physicians specifies that the amount of remuneration must be “consistent with the fair market value of the services.”^{5,6} Similarly, the exception covering personal services arrangements—in which the physician serves as an independent contractor instead of an employee—states that the associated compensation must “not exceed fair market value.”^{7,8} A CMS-crafted exception for referrals within academic medical centers (AMCs) mandates that the aggregate compensation paid by all AMC components to the referring physician “does not exceed fair market value for the services provided.”⁹ Moreover, CMS created a stand-alone regulatory exception for “fair market value compensation” to or by a physician or group of physicians for the provision of items or services.¹⁰ This exception is in addition to the aforementioned statutory compensation arrangement exceptions that require fair market value remuneration as a condition for the exception to apply.

FAIR MARKET VALUE

The Stark Law defines “fair market value,” in relevant part, as “the value in arm’s-length transactions, consistent with the general market value.”¹¹ The Stark regulations further specify that “general market value” means, in relevant part, “the compensation that would be included in a service agreement as the result of *bona fide* bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party...at the time of the service agreement.” The regulatory definition provides that the fair market price

“usually” is based on “the compensation that has been included in *bona fide* service agreements with comparable terms at the time of the agreement, where the...compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”¹²

As such, fair market value for physician compensation under the Stark exceptions depends upon an evaluation of comparable employment or service agreements for the same specialty. Experts have deemed such valuations “a highly subjective exercise cloaked in scientific jargon.”¹³ In the second phase of its Stark II regulations, issued in 2004, CMS tried to provide clarity by creating a voluntary “safe harbor” for hourly payments to physicians for their personal services based upon one of two specified methodologies.¹⁴ However, the safe harbor provision proved problematic, with various parties challenging the selected methodologies as impractical, inaccurate, and/or overly prescriptive.

In response, CMS eliminated the safe harbor in the third phase of its Stark II regulations, published in 2007, while simultaneously emphasizing its intention to scrutinize fair market value as “an essential element” of many Stark exceptions. The agency adopted a more flexible, but arguably amorphous, approach to analyzing fair market value, with the following general guidance:

- Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value.
- Ultimately, the appropriate method for determining fair market value will depend on facts and circumstances, to include the nature of the transaction, its location, and other factors.
- Good faith reliance on an independent valuation, such as an appraisal, may be relevant to a party’s intent, but does not establish the accuracy of the valuation itself.
- Nothing precludes parties from calculating fair market value using an appropriate, commercially reasonable methodology.
- A fair market value hourly rate may be used to determine an annual salary, as long as the multiplier reflects hours actually worked.¹⁵

The highly contingent standard enunciated by CMS underscores the necessity of periodic reevaluation and renegotiation of physician compensation arrangements in light of prevailing conditions. Whereas declining Medicare and insurance reimbursement for physician services indicates that fair market value compensation may continue to decline, the growing physician shortage may augur in favor of steady or improved fair market valuations in the future.¹⁶ Assessments of fair market value cannot be addressed through CMS advisory opinions.¹⁷

AMA POLICY

Our AMA Principles for Physician Employment state that physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.¹⁸ AMA policy expresses opposition to financial arrangements between hospitals and physicians that require physicians to accept compensation at less than fair market value for the services that physicians provide to hospitals.¹⁹ Additionally, AMA policy states that the Stark II regulations issued by CMS should not impact the ability of health care institutions to offer, and physicians to receive, unlimited continuing medical education as a form of compensation.²⁰ Our AMA is committed to staying abreast of and monitoring the issue of restrictions on referrals in all health care delivery settings.²¹

DISCUSSION

Current and projected trends in physician practice arrangements indicate that physicians are increasingly likely to work as employees, particularly of hospitals and integrated delivery systems.²²⁻²⁵ The move toward hospital employment augments the importance of fair market value for purposes of the physician self-referral law, especially as it relates to physician compensation under employment and personal services arrangements.

Given the intense focus of both legislators and regulators on combatting fraud, waste, and abuse in federal health care programs, along with the stated intent of CMS to scrutinize closely fair market value, the current political environment makes repeal or major revision of the Stark Law or regulations a highly unlikely event in the foreseeable future. Nonetheless, the Stark Law provides CMS with considerable discretion to craft regulatory

exceptions for financial relationships that do not pose a risk of program or patient abuse. Moreover, CMS has evidenced a willingness in the past to consider safe harbors for fair market value payments, although the actual methodologies adopted were overly restrictive and inflexible. Thus, recent history suggests that the best approach for mitigating unfair and arbitrary caps or controls on physician compensation due to the Stark exceptions is for our AMA to use all available advocacy tools to oppose such misuse or misinterpretation of the fair market value benchmark. An advocacy campaign is more likely to be successful by working with Congress and the Administration to seek commonsense clarifications and explore more flexible and feasible safe harbors, rather than seeking outright repeal or drastic revision of the Stark regime in a politically difficult environment. Therefore, your Board recommends adopting a substitute resolution that is more strategically focused on protecting against misuse or misinterpretation of the fair market value benchmark.

Additionally, our AMA will continue to educate and provide resources for physicians who want to be prepared to negotiate an employment contract with a hospital or related entity in light of today's complex legal and regulatory environment. The Annotated Model Physician-Hospital Employment Agreement, released in 2012, is one such valuable AMA resource to guide physicians entering employment relationships with hospitals.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 208-I-14 and the remainder of the report be filed.

That our American Medical Association opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

REFERENCES

1. 42 U.S.C. § 1395nn.
2. 42 C.F.R. Part 411, Subpart J.
3. 42 U.S.C. §§ 1395nn(b)-(e).
4. 42 C.F.R. §§ 411.355-357.
5. 42 U.S.C. § 1395nn(e)(2)(B)(i).
6. 42 C.F.R. § 411.357(c)(2)(i).
7. 42 U.S.C. § 1395nn(e)(3)(A)(v).
8. 42 C.F.R. § 411.357(d)(1)(v).
9. 42 C.F.R. § 411.355(e)(1)(ii)(B).
10. 42 C.F.R. § 411.357(l).
11. 42 U.S.C. § 1395nn(h)(3).
12. 42 C.F.R. § 411.351.
13. American Medical Association (AMA), Annotated Model Physician-Hospital Employment Agreement (2012).
14. 69 Fed. Reg. 16,092 (March 26, 2004).
15. 72 Fed. Reg. 51,015-51,016 (September 5, 2007).
16. AMA, Annotated Model Physician-Hospital Employment Agreement.
17. 42 C.F.R. § 411.370(c)(1).
18. H-225.950, AMA Principles for Physician Employment.
19. H-225.973, Financial Arrangements Between Hospitals and Physicians.
20. D-300.988, Implications of the "Stark II" Regulations for Continuing Medical Education.
21. D-285.974, Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations.
22. Kane CK, Emmons DW. New data on physician practice arrangements: private practice remains strong despite shifts toward hospital employment. *Policy Research Perspectives*. September 2013. <http://www.ama-assn.org/resources/doc/health-policy/prp-physician-practice-arrangements.pdf>. Accessed August 3, 2015.
23. Gunderman R. Who does your physician work for? *The Atlantic*. November 22, 2013.<http://www.theatlantic.com/health/archive/2013/11/who-does-your-physician-work-for/281724/>. Accessed August 3, 2015.
24. Kocher R, Sahni NR. Hospitals' race to employ physicians—the logic behind a money-losing proposition. *N Engl J Med*. 2011;364(19):1790-1793.
25. Kane CK. Updated data on physician practice arrangements: inching toward hospital ownership. *Policy Research Perspectives*. July 2015. <http://www.ama-assn.org/resources/doc/health-policy/x-pub/prp-practice-arrangement-2015.pdf>. Accessed August 5, 2015.

APPENDIX – Current Policy

H-225.950 AMA Principles for Physician Employment

1. Addressing Conflicts of Interest (a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. (b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. (c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. (d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions. (e) Assuming a title or position that may remove a physician from direct patient-physician relationships – such as medical director, vice president for medical affairs, etc. – does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience. Refer to the AMA *Code of Medical Ethics* for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession (a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. (b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting (a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession. (b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts. (c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. (d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures. (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff. (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved. Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations (a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those

medical staffs. (b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes. (c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. (d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts. Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization. 5. Peer Review and Performance Evaluations (a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings. (b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status. (c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians – not lay administrators – should be ultimately responsible for all peer review of medical services provided by employed physicians. (d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment. (e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc. (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met: i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement. Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review. 6. Payment Agreements (a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement. (b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee. Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

H-225.973 Financial Arrangements Between Hospitals and Physicians

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

D-285.974 Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations

Our AMA will continue to receive information on and monitor the issue of restrictions on referrals in all health care delivery settings.

D-300.988 Implications of the "Stark II" Regulations for Continuing Medical Education

Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in

the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.

7. EMPLOYEE ASSOCIATIONS AND COLLECTIVE BARGAINING FOR PHYSICIANS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2014 Interim Meeting, the House of Delegates (HOD) adopted Policy D-383.981, Employee Associations and Collective Bargaining for Physicians. The underlying resolution recited that local medical societies typically have limited ability to assist physicians related to their employment; that employed physicians often are on their own as they deal with issues with their employer; that many other professionals in the US can be members of labor associations and have collective bargaining rights; and that “the lack of the ability of physicians to join together as a group to address employment issues runs counter to the principles of democracy and freedom in the US.” Policy D-383-981 asks that our American Medical Association (AMA) study and report back on physician unionization in the United States.

AMA POLICY AND EXPERIENCE WITH PHYSICIAN UNIONS

Our AMA supports the right of physicians to engage in collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians eligible for that right under federal law (Policy H-385.946; H-385.976). For example, our AMA supports efforts to narrow the definition of supervisors such that more employed physicians are protected under the National Labor Relations Act (NLRA) (Policy D-383.988).

AMA union related policies contain several caveats. First, physicians should not form workplace alliances with those who do not share physician ethical priorities (Policy E-9.025). Second, physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care.¹ Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws.²

In 1999, our AMA facilitated, by providing financial support, the establishment of a national labor organization – Physicians for Responsible Negotiation (PRN) – under the NLRA to support the development and operation of local negotiating units as an option for employed physicians and for resident and fellow physicians (Policy H-383.999). However, in mid-2004, after spending a substantial amount of money on the venture, which that signed up few physicians, our AMA discontinued financial support of the project.

DISCUSSION

Why Physicians may be Interested in Union Formation

Physicians interested in unions fall into four categories: (1) employees of hospitals or other entities; (2) resident physicians; (3) academic physicians; and (4) self-employed physicians.

Hospital Employed Physicians

According to AMA’s most recent Physician Practice Benchmark Survey,³ 43 percent of physicians are now employees. Among employed physicians, 14.7 percent are employed by hospitals. Among all physicians, 7.2 percent are direct hospital employees. Another 25.6 percent of all physicians are now working in practices that are at least partially owned by a hospital. Younger physicians are more than twice as likely as older physicians to be employed by hospitals. Twelve percent of the under 40 cohort were direct hospital employees compared to only 4.8 percent of physicians over the age of 54.

As many physicians have recognized, independently bargaining a second or third contract with a hospital can be a difficult experience. Recent research indicates that many hospital markets are highly concentrated, and becoming

more so.⁴ In a highly concentrated hospital market, a hospital-employed physician may have few hospital employment alternatives. Moreover, covenants-not-to-compete often exist in a physician's hospital employment contract, and these covenants may further contribute to a bargaining advantage that a hospital employer with market power may possess.

Dominant hospital employers may be under little, if any, competitive pressure to respond to an employed physician's request to renegotiate an equitable agreement that might offer competitive wages and benefits. Nor are hospitals with market power under competitive compulsion to respond to physician practice concerns in the areas of physical plant and equipment, support staff, and other resources it makes available to patients and physicians.

Physicians become upset when they feel that they have no influence or control over key decisions that affect them and their patients or that undermine their autonomy.⁵ Additionally, there is the concern that physicians working for dominant hospitals could experience divided loyalties and may feel that the interests of the hospital may not always be consistent with what they believe is in the best interests of the patient, as our AMA has recently recognized.⁶ Thus a combination of market conditions and the special organizational behavior needs of physicians may make the countervailing power that can be obtained through collective bargaining seem especially attractive to physicians who are employed by dominant hospitals. This creates a special opportunity for physician unions in the hospital setting.

Academic Physicians

According to the 2014 AMA Physician Practice Benchmark Survey, 5.8 percent of employed physicians are in faculty practice plans. Of the unionized academic physicians, most are in public institutions in states that authorize public employees to bargain collectively. That is because a US Supreme Court case, *National Labor Relation Board (NLRB) v. Yeshiva University*, 444 US 672 (1980), had concluded that faculty at Yeshiva were "managerial employees" and thus excluded from the coverage of the NLRA. This seemingly confined physician faculty collective bargaining to the public sector where state collective bargaining laws did not exclude faculty as supervisors. However, a very recent decision of the NLRB⁷ could clear the way for much more unionization of faculty members in private settings under the NLRA, including those who are physicians, because the opinion suggests that many private faculty members do not have enough power to be considered managerial.

Residents

Residents have organized out of a need to "create a better and more just healthcare system for patients and healthcare workers and to improve training and quality of life for resident physicians, fellows and their families."⁸

Residents continue to exercise and enjoy collective bargaining rights under the NLRA. Initially the NLRB treated residents as students unable to collectively bargain with the protections of the NLRA. That changed in 1999 when the NLRB held that house staff members are statutory employees with a right to organize under the NLRA. Scholars worried that an ensuing NLRB holding that graduate students had no right to bargain collectively would also apply to house staff. However, the NLRB recently reaffirmed house staff rights to bargain collectively.

Self-employed physicians

To level the playing field with monopoly health insurers, self-employed physicians have looked for legitimate ways to collectively bargain with health plans without running afoul of the antitrust ban on price fixing. Some have formed a financially or clinically integrated network – a physician joint venture – that is essentially treated like a single firm that is incapable of forming a price-fixing conspiracy and free to negotiate with health plans. Others have lobbied for state or federal legislation that would grant immunity to independent physicians jointly negotiating with insurers. In the 1990s, some physicians in independent practice hoped that by gaining recognition as a formal union, they could engage in collective bargaining with health plans under the labor exemption from the antitrust laws. However, before physicians can engage in collective bargaining under the labor exemption, the bargaining process must be part of a labor dispute. For there to be a labor dispute, the collective bargaining must concern the terms and conditions of employment. Therefore, the physicians must be employees. There is no labor dispute for purposes of the labor exemption if the physicians are independent contractors, entrepreneurs, or independent businesses.

While courts are willing to look at the substance of the relationship to determine whether a person is an employee for purposes of the antitrust and labor laws, the concept of an employee is largely restricted to a common-law agency test that differentiates employees from independent contractors. To date, physicians have been unsuccessful in establishing that their contractual relationships with health insurers meet the control test for the NLRA rights afforded employees. Thus, in *AmeriHealth Inc./Amerihealth HMO*, 329 NLRB 76, 4-RC-19260 (1999), the NLRB decided that a group of in-network physicians were independent contractors, reasoning that the HMO did not regulate the patient-physician relationship in a manner comparable to that of an employer. The NLRB determined that the physicians had a “meaningful opportunity” to negotiate the terms of compensation with a health plan. However, the NLRB expressly held that it was “not necessarily precluding a finding that physicians under contract to health maintenance organizations may, in other circumstances, be found to be statutory employees.”

More recently, the NLRB signaled a small shift in its definition of “independent contractor.” Specifically, in 2011, the NLRB held that a group of symphony orchestra musicians were statutory employees, not independent contractors.⁹ The decision largely hinged on the orchestra’s right to control the manner and means by which the performances of professional musicians were accomplished. This paradigm could reasonably be applied to physicians. In recent years the emergence of narrow networks, accountable care organizations, and other organizational forms of provider organizations have gained substantial control over the means by which physician services are performed. That development, together with the loss of a “meaningful opportunity” to negotiate compensation (the “employee” test in *AmeriHealth*), may be opening the door to the availability of NLRA coverage and of the labor exemption from the antitrust laws to an increasing number of physicians.

The Rights of Employed Physicians to Engage in Protected Collective Bargaining

Employed physicians who are not supervisors have the same right as other employees to the protections of section 7 of the NLRA. That law gives employees the right “to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection.”

No Traditional Formal Union Required for NLRA Protections

Physicians are not required to belong to a traditional formal union certified by the NLRB in order to receive the NLRA’s protection for employees engaged in concerted activities. Two or more employed physicians have the right to designate a representative and ask their employer to meet with the designated representative and to discuss and negotiate wages and other terms and conditions of their employment. Thus, in *In re New York Univ. Med. Ctr.*, 324 NLRB 887 (1997), the NLRB decided that the Association of Staff Psychiatrists (the Association), formed by staff psychiatrists at Bellevue Psychiatric Hospital, was a labor organization protected under the NLRA even though it was not a formal union. The NLRB reasoned that the Association was formed for the purpose of dealing with the hospital on such matters as salaries, working hours and conditions, and grievances of its members; had elected officials and dues paying membership; held membership meetings; and had actually dealt with the hospital through the director of psychiatry. Accordingly, the NLRB ruled that the hospital had violated the NLRA by impliedly threatening its employed physicians with cutbacks, layoffs, and other consequences if they continued to engage in the concerted conduct of protesting the discontinuance of certain Bellevue Hospital physician employment policies.

Bargaining Units Composed Entirely of Physicians Are Presumed Appropriate

Like other employees, employed physicians can be in a formal bargaining unit certified by the NLRB. Hospital physicians have been successful in being recognized by the NLRB as an appropriate bargaining unit. Indeed, in 1989 the NLRB promulgated regulations in creating a presumption that in acute care hospitals a separate bargaining unit for physicians (e.g., one that excludes nurses and other types of employees) is appropriate.¹⁰

Physicians Who Are Supervisors Are Not Protected by the NLRA

Individuals who fit the statutory definition of a supervisor are not protected by section 7 of the NLRA. Indeed, one event contributing to the discontinuation of the PRN project was a 2001 US Supreme Court decision in *NLRB v. Kentucky River Community Care*, 532 US 706 (2001), ruling that supervising nurses at private hospitals could not join unions because they were “management.” This decision was understood as limiting the collective bargaining rights of physicians whose role as “supervisors” were seen as similar to those of nurses. In fact, Physicians for

Responsible Negotiations, the labor organization affiliated with the American Medical Association, disbanded after the decision.

More recent jurisprudence, however, suggests that physicians may not usually be “supervisors,” even under the broader Supreme Court *Kentucky River* definition. Thus, in 2009, the NLRB held that a physician was not a “supervisor” because she was not held accountable for the performance of nurses and other employees.¹¹ Moreover, the burden to prove supervisory authority is on the party asserting it, and the NLRB has generally exercised caution not to construe supervisory status too broadly. However, the NLRB has indicated that physicians who are medical directors or have significant managerial responsibility are likely to be deemed “supervisors.”¹² As significant case law has developed surrounding the definition of “supervisors,” physicians should consult with an attorney to determine whether they have the status of a supervisor.

The Status of Physician Unions

The increasing trend of physicians as employees has by some reports re-energized the movement for physician collective bargaining.¹³ However, the number of physicians who are members of unions is very small in comparison to the size of the profession. While it is difficult to obtain accurate information about the number of physicians enrolled in unions, their numbers appear to be growing modestly. In 1998, our AMA estimated that between 14,000 and 20,000 physicians were union members. In 2014, it appears that this number has grown to 46,689 (5.7 percent of 820,152 actively practicing physicians in the United States).¹⁴

Certain substantial unions have targeted physicians, including the American Federation of State, County, and Municipal Employees (AFSCME), the Service Employees International Union (SEIU), and the American Association of University Professors-Collective Bargaining Congress (AAUP-CBC). Each of these unions is very large and well financed. AFSCME and SEIU have been successful in affiliating with existing physician unions, while AAUP-CBC has been successful in tapping into academic physician interest in pursuing unionization.

AFSCME is affiliated with the Union of American Physicians and Dentists, perhaps the largest physician union representing practicing physicians working for the State of California, California counties, non-profit health care clinics, and in private practice. AFSCME is also affiliated with the Federation of Physicians and Dentists, a union with a history of targeting for membership self-employed physicians in independent practice and challenging established labor and antitrust laws.

SEIU, the largest and fastest growing health care workers union in North America, with over 2.1 million members, is affiliated with the Doctors Council that began representing a group of physicians employed by the Departments of Health and Welfare of the City of New York. Today it negotiates for all attending physicians employed by New York City and the Health and Hospitals Corporation, the public safety net health care system of New York City. Doctors Council has expanded from New York to Illinois, New Jersey, and Pennsylvania, where it represents physicians employed by academic medical schools, hospitals, professional corporations, and national corporations. Doctors Council claims on its website to have negotiated for its members substantial wage increases, improvements in sick leave, and many other important benefits including preventing “rash hospital closures and consolidations.” SEIU is also affiliated with the Committee of Interns and Residents (CIR), the oldest and largest house staff union in the country representing more than 13,000 interns, residents, and fellows in California, Florida, Massachusetts, New Jersey, New Mexico, New York, and Washington, DC. CIR describes its mission as creating “a better and more just healthcare system for patients and healthcare workers and to improve training and quality of life for resident physicians, fellows, and their families.”

The AAUP-CBC develops and disseminates information and resources in support of the collective bargaining activities of local chapters, including those comprised of academic physicians employed by academic medical centers and clinics. For that purpose, AAUP-CBC has established a separate 501(c)(5) organization that provides its services through AAUP staff and through consultants and others with specialized expertise.

Detractors of the above physician unions point out that while physician collective bargaining may be an effective avenue for asserting physicians’ concerns with hospitals, collective bargaining usually results in an agreement that applies uniformly to all physicians who participate in collective bargaining. In particular, the level of compensation may be stratified based on seniority or obtainment of certifications, and it may be difficult to write contractual language that differentiates and addresses a significant divergence among physicians in terms of experiences and

skills. Proponents of physician unions, including an official at the AAUP-CBC, respond by asserting that their contracts are analogous to those negotiated by the Major League Baseball Players Association, which of course rewards a player's value to the team.

Union Formation by Medical Societies

Some medical societies may wish to consider whether the time has come to organize employed nonsupervisory physicians and to provide collective bargaining for them. While it should be possible for a medical society to qualify as a labor organization as defined by the NLRA and be certified by the NLRB, conflicts of interest could arise which might disqualify the society. For example, if some members of the board of trustees of the society are in positions of management of hospitals and that the society wants to engage in collective bargaining, that conflict of interest may disqualify it.

Further, acting as a labor organization may compromise the tax exempt status of a medical society. Therefore, if the medical society wishes to form a union, it may be appropriate for it to form a separate organization to act as the union.

CONCLUSION

The AMA's policies supporting a physician's right to unionize are being achieved. Thus, consistent with existing AMA policy, employed nonsupervisory physicians have the protections of the NLRA and enjoy an exemption from the antitrust laws when they engage in concerted action concerning the terms and conditions of their employment. Moreover, AMA policy supporting efforts to narrow the definition of supervisors (such that more employed physicians are protected under the NLRA) has received a boost from an NLRB decision finding that a physician was not a supervisor, a case that was decided subsequent to AMA's discontinuance of its financial support of PRN. Moreover, the NLRB has shown the tendency not to construe supervisory status too broadly and has recently classified certain faculty as nonsupervisory, setting the stage for the unionization of greater numbers of academic physicians. Finally, NLRB regulations create a presumption that it is appropriate for physicians in an acute care hospital to form a separate bargaining unit. This rule is consistent with the caveat contained in AMA policy that physicians should not form workplace alliances with those who do not share physician ethical priorities.

Although the unionized portion of the physician profession remains very small, in the many and growing number of markets where hospitals have market power and where physicians have few hospital employment alternatives, there is arguably created the need for physician countervailing bargaining power. Under these conditions, proponents claim, physician unions can achieve collective bargaining agreements that safeguard the shared interests of employed physicians wanting more control over their practices and yet, similar to collective bargaining agreements in professional sports, can reward individual achievement.

Physicians and their medical associations should be aware that unions are highly regulated and present legal issues requiring the assistance of legal counsel familiar with the highly specialized area of labor law and the number of unique legal issues arising in health care, such as whether physicians are supervisors.

REFERENCES

1. Section 8(g) of the National Labor Relations Act prohibits a labor organization from engaging in a strike, picketing, or other concerted refusal to work at any health care institution without first giving at least 10 days' notice in writing to the institution and the Federal Mediation and Conciliation Service.
2. Policy E-9.025
3. Policy Research Perspectives, Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, Carol K. Kane, PhD, July 2015.
4. Gaynor M and Town R. The impact of hospital consolidation. The Synthesis Project Brief No. 9. Robert Wood Johnson Foundation. June 2012.
5. Friedberg, Mark W., Peggy G. Chen, Chapin White, Olivia Jung, Laura Raaen, Samuel Hirshman, Emily Hoch, Clare Stevens, Paul B. Ginsburg, Lawrence P. Casalino, Michael Tutty, Carol Vargo and Lisa Lipinski. Effects of Health Care Payment Models on Physician Practice in the United States. Santa Monica, CA: RAND Corporation, 2015. http://www.rand.org/pubs/research_reports/RR869. In particular, chapters 8-10 address physicians' ability to choose colleagues and coworkers, control over business and managerial decisions, the ability to earn desired income, ability to choose hours and schedule, values alignment with practice leadership, balancing leadership initiatives with physician

autonomy, and respect from practice leaders. This report may be accessed at www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf.

6. Pear R, Doctors Warned on 'Divided Loyalty,' New York Times. Dec 26, 2012.
7. Pacific Lutheran University and Service Employees International Union, 361 NLRB 157, 19-RC-102521 (2014).
8. See the Mission Statement of the Committee of Interns and Residents, which is affiliated with the Service Employees International Union. The mission statement may be accessed at <http://www.cirseiu.org/who-we-are/>
9. Lancaster Symphony Orchestra and The Greater Lancaster Federation of Musicians, 357 NLRB 152, 4-RC-21311 (2011).
10. See 29 CFR §103.30 (a) (2). See also American Hospital Association v. NLRB, 499 US 606 (1991) (upholding NLRB's rulemaking).
11. Family Healthcare Inc, 354 NLRB 254, 09-CA-044539 (2009).
12. See, Thomas-Davis Med. Ctr. v. Fed'n of Physicians and Dentists, Case 28-RC-5449, N.L.R.B. Region 28 (1996). The physician bargaining unit encompassed "all regular full-time and part-time physicians, including department chairs... excluding all other employees, physician medical directors, assistant medical directors..."
13. Leffell D. The doctor's office as union shop. Wall Street Journal. January 29, 2013.
14. Hirsh, Barry T and McPherson, David A. 2014 Union Membership and Earnings Data Book. The Bureau of National Affairs, Inc. 2014.

APPENDIX – AMA POLICY

H-385.946 Collective Bargaining for Physicians

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

H-385.976 Physician Collective Bargaining

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

H-383.988 Physicians' Ability to Negotiate and Undergo Practice Consolidation

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

H-383.999 Formation of a National Negotiating Organization

(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs; (2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians; (3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain; (4) Our AMA continue to support the development of independent housestaff organizations for resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act; (5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state-action doctrine to state medical associations and members; (6) Our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H.R. 1304) become law; (7) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers; (8) That should the BOT determine that the

Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and (9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.

D-383.988 Collective Bargaining and the Definition of Supervisors

Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc.*, et al.

D-383.983 Collective Bargaining: Antitrust Immunity

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

E-9.025 Advocacy for Change in Law and Policy

Physicians may participate in individual acts, grassroots activities, or legally permissible collective action to advocate for change, as provided for in the AMA's Principles of Medical Ethics. Whenever engaging in advocacy efforts, physicians must ensure that the health of patients is not jeopardized and that patient care is not compromised. Formal unionization of physicians, including physicians-in-training, may tie physicians' obligations to the interests of workers who may not share physicians' primary and overriding commitment to patients. Physicians should not form workplace alliances with those who do not share these ethical priorities. Strikes and other collective action may reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences raises ethical concerns. Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care. Physicians are cautioned that some actions may put them or their organizations at risk of violating antitrust laws. Consultation with legal counsel is advised. Physicians and physicians-in-training should press for needed reforms through the use of informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation, or other options that do not jeopardize the health of patients or compromise patient care. Physicians are free to decide whether participation in advocacy activities is in patients' best interests. Colleagues should not unduly influence or pressure them to participate nor should they punish them, overtly or covertly, for deciding whether or not to participate. (I, III, VI) Issued December 1998 based on the report "Collective Action and Patient Advocacy," adopted June 1998. Updated June 2005 based on the report "Amendment to Opinion E-9.025, 'Collective Action and Patient Advocacy,'" adopted December 2004.

**8. HEALTH CARE ENTITY CONSOLIDATION
(RESOLUTION 820-I-14)**

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

**HOUSE ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
(RESOLUTION 820-I-14 ADOPTED AS AMENDED)
REMAINDER OF REPORT FILED**
See Policy D-383.980

At the 2014 Interim Meeting, the House of Delegates (HOD) referred Resolution 820-I-14, Antitrust Activity, for decision. Resolution 820-I-14, introduced by the Florida Delegation, asks that our American Medical Association (AMA): (1) study the effects of monopolistic activity by healthcare entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physicians and physician practices who are confronted with monopolistic activity by health care entities.

During the 2014 Interim Meeting, reference committee testimony on Resolution 820 was largely supportive, but also urged our AMA to proceed with caution, as speakers testified that the health care landscape is evolving and the issues raised by Resolution 820 were complex. Consequently, the HOD referred Resolution 820 to the AMA Board of Trustees for decision. Due to the complexity of the issues involved and rapidly changing environment, the Board deferred issuance of this report to the 2015 Interim Meeting.

BACKGROUND

Horizontal consolidation among health care entities

Monopoly power

Horizontal acquisitions among health care entities, e.g., when a hospital acquires another hospital or a health insurer merges with another health insurer, can enable a hospital or health insurer to obtain, or enhance, its market power in a geographic market. This market power can take two forms, both of which may negatively impact the patient-physician relationship.

First, the post-acquisition or post-merger hospital or health insurer may acquire monopoly power, i.e., market power with respect to either the hospital's sale of health care services (which includes the services provided by employed physicians) or the insurer's sale of health insurance. A hospital or health insurer that possesses monopoly power can profitably raise the prices for its health care services, or insurance premiums, above competitive levels. This power to raise prices and premiums may have a detrimental effect on the patient-physician relationship. For example, if a health insurer uses its monopoly power to raise the price of insurance premiums with respect to a patient's current insurance coverage, that patient may no longer be able to afford those premiums. If so, the patient will have to drop his or her current coverage in favor of other, less costly, insurance. The patient's purchase of different coverage may result in termination of the patient-physician relationship if the physician is not in-network with respect to that coverage. And, even if the physician is in-network with respect to the alternative coverage, that insurance may not have the same level of benefits as the previous coverage, which may negatively affect the patient-physician relationship by limiting the amount or quality of services that the physician is able to provide to the patient.

A hospital's exercise of monopoly power may have a similar, negative impact on the patient-physician relationship. For example, if a hospital uses its market power to raise the prices of its health care services above competitive levels, the patient's health insurer might terminate its network contract with the hospital, i.e., no longer include that hospital within its provider network, if the health insurer determines that its customers will not accept the insurance premium increases necessary to cover the hospital's prices. If the hospital employs the patient's physician, exclusion from the health insurer's provider network may result in the termination of the patient-physician relationship. Alternatively, the health insurer might opt to keep the hospital in its provider network and charge higher insurance premiums to cover the hospital's price increase. The patient may not, however, be able to afford these higher premiums and may be compelled to select less expensive coverage that does not include the hospital, which likewise may disrupt the patient-physician relationship if the hospital employs the patient's physician.

Monopsony power

A hospital or health insurer through acquisition or merger may also obtain market power as a purchaser of physician or other health care services, i.e., "monopsony" power. (Usually a hospital or health insurer that possesses monopoly power will also possess monopsony power and vice versa). If the hospital employs physicians, the hospital may, through physician employment, exercise monopsony power in the market for those physicians. This monopsony power can reduce the practice options open to physicians, which may have significant, negative effects on the patient-physician relationship. For example, some physicians may feel coerced into employment with a monopsonistic hospital for fear that they will no longer have access to a sufficient number of patients or referrals if they remain independent. Additionally, a hospital's monopsony power in the market for physician employment may enable the hospital to depress the compensation of employed physicians below competitive levels, resulting in physicians leaving the practice of medicine to pursue other employment or retiring early and disrupting patient-physician relationships. Also, when a monopsonistic hospital does not compete for the services of employed physicians, the hospital no longer has the incentive to invest in the equipment, staffing, laboratory and other services in which hospitals typically invest to attract physicians. The absence of this incentive may be detrimental to the patient-physician relationship, e.g., by reducing the type of services that a physician otherwise could have provided to his or her patients had the hospital made the kinds of investments designed to make employment with that hospital preferable from a medical and professional standpoint vis-à-vis other hospitals in the market seeking to employ the physician.

Health insurers with monopsony power can similarly use their market power in a manner that compromises the patient-physician relationship. For example, through their market power in the purchase of physician services,

monopsonistic health insurers may be able to depress physician payments below competitive levels. As in the case of hospitals possessing monopsony power, health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. Similarly, compensation below competitive levels hinders physicians' ability to invest in new equipment, technology, staff training, additional staff and other practice infrastructure that could improve the access to patient care. Health insurers may also employ their market power to impose onerous contract provisions on physicians, e.g., most-favored nation, all-products, anti-assignment, and minimum enrollment clauses, which can exacerbate the negative financial impact on a physician practice and, in turn, on the patient-physician relationship. Health insurers may also use their monopsony power to dictate the items or services that physicians may furnish to their patients.

Vertical consolidation

A health care entity may also engage in vertical consolidation or integration, e.g., when a hospital creates or purchases a health insurance company or acquires a physician practice. Within the context of Resolution 820, vertical integration in the form of hospital practice acquisition currently raises the greatest concerns with respect to the patient-physician relationship. Our AMA closely monitors trends in hospital physician practice acquisition and employment, in part to help inform our AMA's antitrust advocacy strategy. More specifically, our AMA's 2012 and 2014 Physician Practice Benchmark Surveys (Benchmark Surveys) produced data from which our AMA can reliably identify trends in hospital employment of physicians. For example, using the 2014 Benchmark Survey data, in June 2015 our AMA published a Policy Research Perspective entitled "Updated Data on Physician Practice Arrangements: Inchng Toward Hospital Ownership," which found that in 2014, 32.8 percent of physicians worked either directly for a hospital or for a practice that was at least partially owned by a hospital. This percentage represented an increase from 29 percent identified in the 2012 Benchmark Survey, and 16.3 percent identified in a 2007 similar AMA survey. Nevertheless, the majority (60.7 percent) of physicians still work in small practices with 10 or fewer physicians, and 56.8 percent of physicians work in practices wholly owned by physicians, only a slight decrease from 2012 when 60.1 percent of physicians worked in physician-owned practices.

Unlike horizontal consolidation, economic theory does not provide clear predictions concerning the positive or negative effects that hospitals' acquisition of physician practices may have on health care competition generally or on the patient physician relationship specifically. Predictions may be particularly difficult in the context of hospital practice acquisition, because of the rapid evolution in health care payment and delivery markets in the US. However, as more fully discussed below, our AMA has already begun to study the possible effects that hospital acquisition of physician practices and physician employment may have on the market for physician services, physician practice options, and the patient physician relationship.

AMA POLICY

Consistent with Policies H-380.987, D-383.989, D-383.990, and H-383.992, antitrust relief that enables physicians to negotiate adequate payment remains a top priority of our AMA. Additionally, under Policy H-160.915, antitrust laws should be flexible to allow physicians to engage in clinically integrated delivery models, such as accountable care organizations (ACOs), without being employed by a hospital or an ACO. Policy D-385.962 further directs our AMA to support antitrust relief for physician-led ACOs. Policy H-215.969 also provides that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and re-credentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in the joint ventures; (k) control of medical staff boards; (l) successor in interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs in the hospitals. Under Policy H-235.995, medical staff bylaws should include successor in interest provisions to protect medical staffs from hospitals ignoring existing bylaws and establishing new bylaws post-merger, acquisition, affiliation or consolidation.

DISCUSSION

Studying the effects of monopoly and monopsony power

The negative effects that highly concentrated hospital and health insurance markets can have on consumer and physician markets are well-understood. Highly concentrated health insurance and hospital markets, in which one or more insurers or hospitals are likely to possess monopsony and/or monopoly power, is of particular concern to our AMA because, as the Benchmark Survey above shows, 60.7 percent of physicians still practice in groups of ten physicians or less. Our AMA fully understands that most physicians, therefore, lack the market position that would enable them through negotiation, to mitigate or rectify the adverse effect that monopsonistic health insurers or hospitals may have in the market for physician services and on patient care. This is why, in addition to challenging mergers that would create, or increase the concentration of, highly concentrated hospital or health insurer markets, our AMA has consistently advocated on both state and federal levels that physicians be given greater flexibility under the antitrust laws to engage in collective price negotiations.

Accordingly, antitrust advocacy for physicians has been a long-standing priority for our AMA, and close monitoring to identify markets where health care entities possess, or could possess via further acquisition, monopoly or monopsony power in consumer or physician markets is a key aspect of our AMA's antitrust advocacy. For example, our AMA has for many years tracked, and analyzed the potential anticompetitive effects of, health insurer consolidations across US markets via its "Competition in Health Insurance: A Comprehensive Study of U.S. Markets." Our AMA updates this comprehensive study annually—the most recent update occurring in August 2015—to ensure that our AMA has immediate access to the most complete and accurate information concerning the competitiveness of health insurer markets. The study has been a key element in our AMA's ability to successfully challenge proposed health insurer mergers that would otherwise have led to the creation of monopsonistic entities or a level of health insurer market concentration that would have foreclosed meaningful competition. Our AMA also analyzes the competitive effects that specific, consummated, health insurer mergers have had on competition. For example, a study by our AMA has examined the association between market concentration among insurers and health plan pricing. The authors of the study found that premiums in Nevada insurance markets rose considerably (13.7 percent) after the merger between UnitedHealth Group and Sierra Health Services, compared to markets that were not affected by that merger. Our AMA is, therefore, well-positioned to evaluate the effects of proposed health insurer consolidation on the patient-physician relationship and to mount effective challenges when it appears that the merger could negatively affect the patient-physician relationship.

A review of the literature suggests that most hospital markets are highly concentrated in most geographic areas, and that the trend toward greater concentration is expected to continue well into the future. As already discussed, our AMA is fully cognizant of the negative effect that hospitals with monopoly and/or monopsony power may have on the patient physician relationship. Our AMA tracks merger activity in hospital markets to ensure our AMA is fully equipped to identify, and where appropriate, challenge, hospital merger activity that may decrease competition and may negatively impact the patient-physician relationship.

Our AMA also actively monitors the possible effect that vertical integration like hospital practice acquisition may have on the patient-physician relationship. For example, Council on Medical Service Report 2-A-15 reviewed the literature on consolidation between hospitals and physicians; described the current empirical understanding of the effects of such consolidation on health care costs and other metrics; and provided information on Medicare payment and hospital-based facilities. It is important to note that, while some physicians may be concerned about the effect that hospital-physician practice consolidation may have on the patient-physician relationship (particularly when integrated hospital systems with large market shares are involved), our AMA's analysis must be cognizant of the preferences and varying market positions across physician specialties, demographics, and practice settings, recognizing that hospital employment may be an attractive practice option for many physicians.

Antitrust action plan

The AMA has developed a legislative and regulatory antitrust action plan laying out our AMA's antitrust advocacy agenda. The plan describes current and anticipated advocacy efforts, as well as our AMA's overriding antitrust strategy, which seeks, through all appropriate avenues, to obtain antitrust relief for physicians, maximize physician practice options, protect the patient-physician relationship, and ensure practice sustainability. These avenues include the development and/or support of legislation; advocacy before state agencies, e.g., departments of insurance and

attorneys general; advocacy at the Federal Trade Commission and the Department of Justice; and the creation of practical physician resources describing collaboration options permitted under current antitrust enforcement. While the strategy certainly encompasses challenges to the creation or exercise of health care entity monopoly or monopsony power that could threaten physicians and physician practices, the strategy includes all other viable physician antitrust relief efforts, e.g., advocacy calling for greater flexibility for physicians to conduct collective price negotiations to rectify the gross disparity in negotiating power between health care entity monopsonies and many physician practices. An action plan describing our AMA's antitrust advocacy activity and strategy is a valuable tool to help inform members of our AMA's work on this topic, and assure members that our AMA is working not only to vigorously protect physicians and physician practices from health care entities' exercise of monopoly and/or monopsony power, but that our AMA is pursuing all other viable antitrust advocacy opportunities.

CONCLUSION

In summary, the Board believes that it is imperative that our AMA continue to study the effect that consolidation in health care markets has on physician practices, physician practice options, and the patient-physician relationship. This analysis will, of course, continue to include "Competition in Health Insurance: A Comprehensive Study of US Markets." Further, while the effects of hospital employment and practice acquisition on competition and the patient-physician relationship are not yet clearly understood, our AMA will also continue to monitor and evaluate ongoing developments with respect to hospital practice acquisition to ensure that our AMA is alert to any adverse effect that any such developments may have on the market for physician services or the patient-physician relationship. The Board also believes that an antitrust action plan describing our AMA's current antitrust efforts and its current and evolving antitrust advocacy strategy will be a useful means of apprising members of our AMA's broad antitrust advocacy agenda and activities.

RECOMMENDATION

The Board of Trustees recommends that Resolution 820-I-14 be amended to read as follows and adopted and that the remainder of this report be filed.

RESOLVED, That our American Medical Association (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

9. ADVANCE DIRECTIVES DURING PREGNANCY (RESOLUTION 1-I-14)

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

IN LIEU OF RESOLUTION 1-I-14 REMAINDER OF REPORT FILED

See Policy H-85.952, H-85.968, H-140.845 and H-140.874

At the 2014 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred to the Board of Trustees Resolution 1-I-14, "Advance Directives During Pregnancy," which was introduced by the Medical Student Section. Resolution 1-I-14 asked:

That our American Medical Association (1) support that pregnant women with decision-making capacity have the same right to refusal of treatment through advanced directives as nonpregnant women; and (2) study the legality and ethics related to the circumstances under which restrictions and/or exclusions are applied to pregnant women's advance directives.

Testimony supported study of the ethical and legal implications of a pregnant patient's decision to forgo life-sustaining treatment via an advance directive. However, testimony also called for our AMA to support the autonomy

of pregnant women and their right to refuse treatment through an advance directive pending the outcome of the recommended study.

BACKGROUND

An advance directive is a legal document that outlines an individual's choices for health care in advance of a serious illness or injury that prevents the individual's ability to consent to medical treatment [1]. This voluntary document can be a "living will" that expressly states an individual's wish for specific medical actions to take place [1], or a "medical proxy" where the individual grants authority to another person to make medical decisions on her behalf while she is incapacitated [2]. Statutes in all fifty states address advance directives and give instruction about how and when directives are to be implemented [3]. States differ with respect to circumstances under which a patient's advance directive may be overridden. In particular, states differ as to whether physicians may, or must, legally decline to honor a pregnant patient's wish to withdraw or refuse life-sustaining treatment through a living will or surrogate.

STATE ADVANCE DIRECTIVES STATUTES AND PREGNANCY

Only a handful of states fully honor a woman's choice for end-of-life treatment. Of the six states that honor a woman's advance directive during her pregnancy (AZ, MD, MN, NJ, OK, and VT), only Maryland will do so whether or not she gives specific instruction relating to pregnancy. The others require that a woman expressly state in her advance directive that she wishes to withdraw or withhold life-prolonging treatment even if she is pregnant. Besides these six states, almost all others, including the District of Columbia, expressly constrain the implementation of a pregnant woman's advance directive or allow health care professionals and institutions to decline to honor her directive on grounds of conscience [4].

Numerous states refuse to honor a woman's advance directive if she is in any stage of pregnancy (AL, CT, ID, IN, KS, KY, MI, MO, SC, TX, UT, WA, and WI). For example, a Texas statute states "[a] person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient" [4]. Even if an individual expressly states her wish to have life-prolonging treatment removed during a persistent vegetative state, regardless if she is pregnant, the attending physician will be forbidden to carry out the advance directive. This version of the pregnancy exception is the most restrictive of all.

Many other states forbid the removal of life-prolonging treatment if the fetus has potential to develop to a state of "live-birth" (AK, AR, IL, IA, MT, NE, NV, NH, ND, OH, PA, RI, and SD) or viability (CO, DE, FL, and GA). The National Conference of Commissioners on Uniform State Laws drafted nonbinding suggestions to states for advance directive legislation, known as The Uniform Rights of the Terminally Ill Act, which recommends that life-prolonging treatment must not be withheld or withdrawn from a pregnant individual if it is probable that the fetus will develop to the point of "live-birth" with use of life-prolonging treatment [1]. The term "live-birth" is left undefined. Of the thirteen states that use the live-birth exception, only four (NH, ND, PA, and SD) prevent the use of the exception if forcing life-prolonging treatment against the woman's advance directive would cause her undue harm or pain.

Four states will force life-prolonging treatment if by doing so it is probable that the fetus will develop to be viable outside of the incapacitated mother. The viability standard is derived from the US Supreme Court case *Planned Parenthood of Southeastern Pennsylvania v. Casey*, where the Court found that the state's compelling interest in the fetus was greater than a woman's right to an abortion when the fetus has a "realistic possibility of maintaining . . . life outside the womb" [5]. Even though it is more specific than "live-birth," "viability" is still a vague determination ultimately left to the attending physician's judgment.

Fourteen states (CA, HI, LA, ME, MA, MS, NM, NY, NC, OR, TN, VA, WV, and WY) and the District of Columbia refrain from discussing pregnancy in their advance directive statutes. Instead, almost all of those statutes contain a "conscience clause." Such clauses allow physicians and health facilities to refuse to honor an advance directive for reasons of conscience, such as a religious or moral belief. For example, West Virginia's advance directive explains that "[n]othing in this article shall be construed to require . . . [a] health care provider to honor a health care decision made pursuant to this article if . . . [t]he decision is contrary to the individual provider's sincerely held religious beliefs or sincerely held moral convictions" [6]. While pregnancy is not specifically addressed, "conscience clauses" allow physicians to use personal reasons to refuse to honor an individual's medical directive.

The state may not be specifically condoning the use of pregnancy as a means to violate female autonomy, but it permits physicians and health institutions to do so in its wake. Only Louisiana, New York, and Virginia are silent on pregnancy and do not have conscience clauses.

ETHICS

Laws that override a pregnant woman's advance directive rank the state's interest in protecting life above individuals' well-recognized right to decline medical interventions, to control what happens to their bodies, and to express their preferences for treatment meaningfully in advance directives. These laws compromise physicians' fundamental ethical obligation to respect patients as autonomous moral agents.

All patients possess the fundamental legal and ethical right to make decisions about what medical treatment they will accept to maintain their bodily integrity [7]. Physicians must abide by the decision of an adult patient who has decision-making capacity as to whether or not to pursue a specific course of medical treatment, and any change in the plan of care must be based on the patient's informed consent [7]. In the event that a patient loses decision-making capacity and is unable to participate in treatment decisions, decisions to accept or decline care should be governed by the patient's advance directive. When the patient has not executed an advance directive, decisions should be made by an authorized surrogate in keeping with the standard substituted judgment, when the patient's wishes are known, or best interest, when the patient's wishes are not known and cannot reasonably be inferred [8].

A woman's right to autonomy does not dissipate in the event she becomes pregnant. There is ongoing, impassioned debate about the moral status of the fetus, but "[t]he moral standing of women is not in question" [9]. Women, be they pregnant or not, deserve to have their wishes regarding medical care respected and followed, just as men do [id.]. As one expert has noted, "decisions that are left to patients, surrogates and families outside of pregnancy should remain theirs during pregnancy as well" [9].

Authorities in medicine and law, as well as ethics, support this position. For example, the American Congress of Obstetricians and Gynecologists maintains that "pregnant women's autonomous (end-of-life) decisions should be respected, and concerns about the impact of those decisions on fetal well-being should be . . . understood within the context of the women's values" [10]. Case law has likewise supported women's right to make independent decisions during pregnancy. In 1990, the US Court of Appeals for the District of Columbia Circuit upheld a pregnant woman's decision to decline a cesarean section at 26 weeks of gestation while facing end-stage cancer, ruling that the right of the woman to decline care was not curtailed by pregnancy [11].

CURRENT AMA POLICY

AMA policies encourage the use of advance directives and respect for patient autonomy:

- H-85.968, "Patient Self Determination Act," states that our AMA will (1) lend its administrative, legislative, and public relations support to assuring that the specific wishes of the individual patient as specified in his or her advance directive be strictly honored in or out of the hospital setting; (2) encourage all physicians and their patients to execute an advance directive prior to the time of severe acute or terminal illness; and (3) promote efforts to develop a national system to assist emergency medical personnel to rapidly ascertain a person's wishes with regard to resuscitation, regardless of his or her state of location.
- H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," urges health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies, as well as to seek other strategies to help physicians encourage all their patients to complete their durable power of attorney for health care/advance directives.
- H-140.874, "Opposition to Legislation that Presumes to Prescribe Patients' Preferences for Artificial Hydration and Nutrition," states that our AMA opposes legislation that would presume to prescribe the patient's preferences for artificial hydration and nutrition in situations where the patient lacks decision-making capacity and an advance directive or living will.

At the 2014 Annual Meeting, the House consolidated policy on encouraging the use of advance directives and educating physicians about advance care planning to create a single policy calling for our AMA to work with

physicians, nursing homes, medical schools, state and specialty societies, insurance companies, and the federal government to encourage the use of advance directives and health care powers of attorney [12]. The House also reaffirmed its support for the Patient Self Determination Act, calling on the AMA to continue to lend support to “assuring that the specific wishes of the individual patient as specified in his or her advance directive be strictly honored in or out of the hospital setting; … regardless of his or her state of location” [13].

The *Code of Medical Ethics* articulates physicians’ professional ethical obligations to respect patients’ right to make their own decisions about life-sustaining medical interventions through the use of advance care planning and advance directives and to honor patients’ expressed preferences:

- E-2.191, “Advance Care Planning,” urges physicians to proactively engage with patients on the topic of advance care planning so that patients can consider and articulate their preferences for medical care in the event of a serious illness or injury, including explicit guidance as to what interventions the patient would or would not want to pursue, and who should be given decision-making authority in the event the patient becomes incapacitated and unable to express their wishes.
- E-2.20, “Withholding or Withdrawing Life-Sustaining Medical Treatment,” states that the preferences of the patient should prevail, and that the principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity, or to respect the decision of the surrogate decision-maker should the patient lack capacity.
- E-2.22, “Do-Not-Resuscitate Orders,” encourages physicians to work in accord with a patient’s expressed desires to not receive cardiopulmonary resuscitation in the event of cardiopulmonary arrest or when resuscitation is not clinically appropriate, and to honor the wishes of a patient as expressed in an advance directive.
- E-2.225, “Optimal Use of Orders-Not-to-Intervene and Advance Directives,” advises physicians and health care institutions to make more rigorous efforts towards properly implementing and documenting a patient’s health care wishes.

These opinions highlight the important role physicians play in fostering discussion around medical decision making and preserving patients’ choices for pursuing or declining medical care. For example, E-2.191, Advance Care Planning, recognizes the importance of patient self-determination and encourages physicians to engage with patients, their families, and surrogates in timely, proactive conversations about the patient’s values, goals for care, and preferences for care in the event of life-threatening injury or illness. In addition, this opinion articulates the necessity of documenting a patient’s wishes in the medical record in order to effectively communicate this information to current and future medical personnel. Other opinions within the Code, such as E-2.20, E-2.22, and E-2.225, lay out clear step-by-step guidance for physicians on withholding or withdrawing life-sustaining medical treatment, and establishing and carrying out do-not-resuscitate orders and advance directives.

What is uniform across these opinions is the respect for patient autonomy and the recommendation that the preferences of the patient should prevail. When an instrument for communicating a patient’s decisions for treatment exists, a physician should honor those decisions whether the patient is in or out of the hospital setting, and not allow their own personal value judgments to prevent them from abiding by a patient’s wishes. Underlying these pieces of ethical guidance on safeguarding a patient’s autonomy, is Principle of Medical Ethics III, asserting that while physicians must respect the law, their fiduciary bond to their patients does not acquiesce to unjust laws, and that the physician must also “recognize a responsibility to seek changes in those [legal] requirements which are contrary to these best interests of the patient.”

CONCLUSION

A multitude of state laws across the United States refuse to honor the wishes of pregnant women as outlined in their advance directives. These laws privilege the interests of the state in protecting the developing fetus over the fundamental right of a woman to determine what medical care she will pursue or decline, including in the event of life-threatening injury or illness. Such statutes cut against the individual autonomy all patients possess in maintaining their bodily integrity, and in particular, disregard the moral agency of women. Further, these laws undermine physicians’ ethical obligation to respect the medical decisions of their patients, as well as challenge the

efforts by the medical profession to encourage patients and health care institutions to engage in deliberative discussions about advance care planning.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 1-I-14 and the remainder of the report be filed:

1. That our American Medical Association vigorously affirm the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
2. That our American Medical Association reaffirm policies of the House of Delegates that promote the use of advance directives to govern treatment decisions for all patients who lack decision-making capacity, regardless of gender or pregnancy status: H-85.968, “Patient Self Determination Act”; H-140.845, “Encouraging the Use of Advance Directives and Health Care Powers of Attorney”; and H-140.874, “Opposition to Legislation that Presumes to Prescribe Patients’ Preferences for Artificial Hydration and Nutrition.”
3. That our American Medical Association promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the *Code of Medical Ethics*.
4. That our American Medical Association recognize that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
5. That the Council on Ethical and Judicial Affairs consider examining the issue of advance directives in pregnancy through an informational report.

REFERENCES

1. Greene M, Wolfe LR. Pregnancy Exclusion in State Living Will and Medical Proxy Statutes. centerwomenspolicy.org/programs%5Chealth/statepolicy/documents/REPRO_PregnancyExclusionsinStateLivingWillandMedicalProxyStatutesMeganGreeneandLeslieR.Wolfe.pdf. Published August 2012. Accessed August 5, 2015.
2. Jones CJ. Decisionmaking at the End of Life. *Am Jurisprudence Trials*. 2015; 63: § 18.
3. Jones CJ. Decisionmaking at the End of Life. *Am Jurisprudence Trials*. 2015; 63: § 11.
4. Jones CJ. Decisionmaking at the End of Life. *Am Jurisprudence Trials*. 2015; 63: § 5.
5. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 US 833, 870 (1992).
6. W. Va. Code Ann. § 16-30-12(a)-(b)(1).
7. Gostin LO. Legal and Ethical Responsibilities Following Brain Death: The McMath and Munoz Cases. *JAMA*. 2014; 311(9): 903–904.
8. American Medical Association, E-2.20 Withholding or Withdrawing Life-Sustaining Medical Treatment. Available at ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/E-2.20.HTM. Accessed August 5, 2015.
9. Ecker JL. Death in Pregnancy—An American Tragedy. *N Engl J Med*. 2014; 370(10): 889–891.
10. Committee on Ethics. ACOG committee opinion Number 403 April 2008: end-of-life decision making. *Obstet Gynecol*. 2008; 111(4): 1021–1027.
11. *In re A.C.*, 573 A.2d 1235 (D.C. 1990).
12. Council on Constitution and Bylaws/Council on Long Range Planning and Development, Report 3-AMA Policy Consolidations. 2014 Annual Meeting.
13. American Medical Association, H-85.968 Patient Self Determination Act. Available at ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fhtml%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-85.968.HTM. Accessed August 5, 2015.

10. 2016 STRATEGIC PLAN

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

In 2013, our AMA launched a multi-year strategy aimed at achieving significant positive impact for physicians, medical students and patients. The strategy identifies three areas of focus: Improving Health Outcomes, Accelerating Change in Medical Education, and Shaping Care Delivery and Payment for Professional Satisfaction and Practice Sustainability. These focus areas provide for tangible and meaningful implementation of our AMA's mission to promote the art and science of medicine and the betterment of public health. Through this report, the Board of Trustees affirms AMA's multi-year strategic focus. This report summarizes what is on the horizon for each of the focus areas in 2016 with special attention to content crossover among and integration between focus areas. It also describes how, across the AMA, plans for 2016 emphasize constructive health sector collaborations, lifelong physician education, innovation, and an enhanced experience for physicians and others who interact with the AMA.

CARE DELIVERY AND PAYMENT: PRACTICE SUSTAINABILITY AND PROFESSIONAL SATISFACTION

The passage of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) marked the culmination of nearly two decades of work, led by our AMA, to repeal the sustainable growth rate (SGR) formula. There is much work ahead to ensure that MACRA's implementation supports a health care system that delivers better care, more visible value, and supports a sustainable practice environment. Its implementation must allow for physician and patient choice and must curtail the administrative overload that currently detracts from patient care. AMA will continue to lead national efforts to streamline quality reporting and incentive programs, modify faulty constructs for meaningful use and EHR certification, and unwind certain provisions of the Affordable Care Act, such as the Independent Payment Advisory Board (IPAB). The ultimate goal is to create a pathway for physicians to choose from a broad array of alternative payment and health care delivery models, including viable fee-for-service options.

In parallel to payer system changes, digital health and digital medicine (and the tsunami of data they generate) are becoming a more visible force in health care and are expected to figure prominently in new delivery and payment models. In 2016, AMA will step up its involvement in this sector of the industry in order to influence data and technology development in a way that supports "good medicine" and strengthens the physician-patient relationship. Plans also include new research to examine how developments in digital medicine are affecting the physician-patient relationship.

The AMA STEPS Forward™ platform, launched in 2015, will be central to the distribution of new tools and resources to help physicians across all modes of practice successfully navigate an evolving payment environment. These tools will be informed by 2015 field research that is capturing data on how practicing physicians divide their time between patient care and other administrative responsibilities. Expanded offerings will also respond to the needs of individual physicians facing opportunities and challenges that demand rapid development of leadership capability. Access to these tools and educational programming will be structured in a way that enhances the value of AMA membership.

IMPROVING HEALTH OUTCOMES

The Improving Health Outcomes (IHO) focus area links directly to AMA's commitment to improving the health of the nation. Concentrating on risk factors for cardiovascular disease and type 2 diabetes, our AMA has set out to help physicians and care teams control and prevent conditions affecting millions of Americans. In addition to the heavy toll these conditions place on patients and families, the related costs are staggering: more than 75% of our health care spending is for chronic disease management.

In 2016, we will continue to spread evidence-based interventions to improve health outcomes among the 30 million people who have high blood pressure and a usual source of care, yet for whom high blood pressure remains uncontrolled. The AMA and the Centers for Disease Control and Prevention (CDC) jointly analyzed national survey data to better understand the characteristics of this population and published their findings in the *Journal of Clinical Hypertension*. Previous pilot work informed a framework for practice interventions that emphasize Measuring accurately, Acting rapidly, and Partnering with patients (MAP). Significant effort in 2016 will be devoted to

spreading these interventions in adoptable formats to additional clinical sites, with an emphasis on those serving populations experiencing disparities in care. The data collected through these programs and a formal evaluation will further develop the evidence base to support effectiveness of the MAP interventions.

Media exposure in 2016, cosponsored by AMA, will raise physician and patient awareness of the imperative to reduce the number of patients with prediabetes whose condition progresses to type 2 diabetes. The media campaign will complement a multi-year initiative AMA launched with the CDC in 2015 to Prevent Diabetes STAT: Screen, Test, Act - Today™. The goal is to spread awareness, referral and participation in CDC-recognized evidence-based diabetes prevention programs, including virtual programs that deploy new technologies. AMA will expand its efforts in 2016 to assist physicians and teams in targeted states to synchronize screening, testing and referral processes for prediabetes with practice workflow. Aided by growing evidence of the economic and health benefits of these programs, our interaction with payers and employers to advocate for coverage of diabetes prevention programs will also intensify.

As payment models cast a brighter light on population health, adoption of these practice-based interventions provides practical ways for physicians to use data to identify at-risk patients, adjust interventions, and document outcomes. Guidance will be available through the STEPS Forward platform to help physicians complete hypertension- and prediabetes-related measurement and improvement projects that qualify for maintenance of certification.

ACCELERATING CHANGE IN MEDICAL EDUCATION (ACE)

The 11 medical schools participating in AMA's five-year, \$11 million ACE grant program comprise a Consortium tasked with testing innovations and developing best practices that can be shared and implemented in schools across the country. In 2016, they will be joined by up to 20 additional schools competing for modest grant awards to develop, adopt, enhance and/or implement innovations emerging from the work of the founding members of the Consortium.

Work of the Consortium underpins a new textbook, now in development, which covers the science of healthcare delivery as a complement to the traditional basic science and clinical science components of medical education. Some of this content will be adapted and repurposed for the benefit of practicing physicians through STEPS Forward and other AMA platforms. Further indication of focus area crossover will come to life in 2016 as the ACE schools are invited to adapt the IHO frameworks and tools for use in their curricula and community-focused programs.

CONSTRUCTIVE COLLABORATIONS

Encouraging physicians to work together for the good of the profession and the patients they serve has been a hallmark of AMA for nearly 170 years. In the coming years, AMA's leadership will necessarily expand to encompass multi-stakeholder coalitions including patients, providers, employers, payers and others. Current examples are plentiful:

- Following years at the helm of a national movement to repeal the SGR, AMA remains a highly respected partner among groups seeking to shape successful implementation of the MACRA legislation. We will commit our expertise and resource to work with those closely aligned with AMA policy objectives and on projects having strong prospects for success.
- Federation societies continue to provide front-line support alongside AMA in recruiting diverse practices to participate in AMA-sponsored research, pilot-test new focus area tools, and support a common advocacy agenda both locally and nationally.
- In close collaboration with the CDC, our AMA encourages physicians to be assertive in screening patients for prediabetes and refer those at risk to CDC-recognized diabetes prevention programs ranging from the local YMCA to new digital/virtual offerings. In rolling out related resources, AMA has partnered with the National Association of Chronic Disease Directors, several state medical societies, large employers and others to promote the "business case" for preventing diabetes.
- AMA is facilitating cross-campus testing, refinement and adoption of medical education innovations among and beyond those schools that formally participate in the ACE Consortium.

- AMA collaborated with the American Hospital Association on a set of principles that guide healthy relationships between institutions and physicians, and is working on assessment tools to increase transparency of institutions' performance relative to those principles in 2016.
- Communities of physicians, via QIN-QIO networks, are adopting the tools and frameworks co-developed by AMA and Johns Hopkins University to improve blood pressure control for patients with hypertension.

In 2016 we anticipate continued expansion of our collaborator networks. By engaging with others, AMA seeks to amplify the impact of AMA's work, bring resources and capabilities that complement those of AMA, and provide external validation of our approaches and results. Collaboration is expected to be broad yet selective, with careful consideration of the interests of AMA membership, intellectual property, reputation and brand. We will foster relationships that expand the national base of support for AMA's mission as well as the means to achieve it.

LIFELONG PHYSICIAN EDUCATION

Physician education is a cornerstone of the strategy for activating the focus area objectives, which require changes in physician (and team) knowledge, skills and practice. The focus area objectives call for AMA to provide physicians and their teams pragmatic educational offerings, tools, and leadership training designed to address real-world practice and care delivery issues.

In 2016 AMA will continue efforts to modernize its physician education offerings in response to the increasing pace of change in medical knowledge, documented gaps in care quality, and rapid evolution of the systems in which physicians practice. This multi-year initiative aims to serve physicians who seek to achieve and maintain competency throughout their professional lifetime, foster a return to identification with the profession (not just their specialty), and increase membership through improved engagement with and connection to the AMA. AMA will seek to influence external processes, such as maintenance of certification, so as to ensure relevance to and avoid interference with high-quality patient care.

The new learning platform will improve the user's experience by integrating core AMA offerings that are currently delivered in a fragmented manner. Under the new model, physicians will have unified access to programs ranging from AMA-developed education on safe prescribing of opioids, to topics grounded in the AMA *Code of Medical Ethics*, to modules developed under the STEPS Forward platform, to new content emerging from work in IHO and ACE, to journal CME offered to readers of the JAMA Network. Convenient, integrated access to and reporting of journal CME complements the 2016 planned launch of new title(s) under the JAMA Network, following the successful introduction of JAMA Oncology in 2015.

INNOVATION

AMA's mission objectives demand that an unprecedented level of industry innovation be informed and shaped by physician ingenuity. We seek ideas that will allow physicians to spend more quality time with patients, manage chronic disease, benefit from lifelong learning, and create thriving practices under a wide range of care delivery settings.

Already, AMA members with an interest in entrepreneurship have benefited from AMA's partnership with MATTER, a high-tech incubator for health care startups. Taking a page from the crowdsourcing playbook that has been so effective in the commercial arena, AMA will announce winners of our first Practice Innovation Challenge, co-sponsored by the Medical Group Management Association, in the fall of 2015. Best-of-the-best ideas will subsequently be built out and delivered via STEPS Forward in 2016. The ACE Consortium will launch a similar challenge in late 2015 to solicit ideas from medical students; awards will be announced in spring 2016 for adoption consideration across the Consortium and beyond.

Further embracing innovation, AMA has invested in the startup of an innovation lab focused on the healthcare sector to activate a pipeline of solution prototypes and pilots. Priority will be given to ideas that accelerate success in our focus areas, meet the needs of AMA members, or offer new revenue potential for AMA.

ENHANCED EXPERIENCE

By design, implementation of this strategy draws upon and reinforces AMA's touchpoints with physicians through the House of Delegates, membership, practice tools, research and education, and advocacy. In 2016, AMA will refresh and modernize both content and delivery of these touchpoints.

Many avenues for enhancing the physician experience have been described above: modernized education platform, flexible on-demand access to tools and resources, and novel ways to participate in AMA's innovation agenda. Other examples include a new interactive sharing platform for schools participating in the ACE Consortium and a modern, readily searchable AMA policy database that replaces the legacy PolicyFinder application.

The key is for AMA to interact effectively with physicians on their terms, reaching them where they are, offering service and content options that are responsive to their preferences and needs. AMA will offer more and better options for physician engagement, such as a welcoming and easy-to-use online experience, interesting and relevant conferences, and facile communication via social media. More sophisticated monitoring of interactions also will yield insight into physician preferences so that we can continuously improve services to physicians, residents and fellows, and medical students so as to retain and grow our membership base.

In summary: Collaboration, lifelong education, innovation and enhanced experience will be visible operational enablers of AMA's 2016 focus area progress, all for the advancement of the art and science of medicine and the betterment of public health.

11. 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
REMAINDER OF REPORT FILED**
See Policy 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 2015 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020 and AMA Bylaw 8.5.

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 is also required as set out in AMA Bylaw 8.2.

The following organizations were reviewed for the 2015 Interim Meeting:

- American College of Occupational and Environmental Medicine
- American Gastroenterological Association
- American Geriatrics Society
- American Orthopedic Association
- American Psychiatric Association
- American Roentgen Ray Society
- American Society of Abdominal Surgeons
- Heart Rhythm Society
- National Association of Medical Examiners
- Triological Society

The Heart Rhythm Society and National Association of Medical Examiners were reviewed at this time because they failed to meet the requirements of the review in 2014.

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 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: American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Abdominal Surgeons, Heart Rhythm Society, National Association of Medical Examiners, and the Triological Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

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

That the American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Abdominal Surgeons, Heart Rhythm Society, National Association of Medical Examiners, and the Triological Society retain representation in the American Medical Association House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

<u>Organization</u>	<u>AMA Membership of Organization's Total Eligible Membership</u>
American College of Occupational and Environmental Medicine	531 of 2,597 (20%)
American Gastroenterological Association	1,614 of 9,169 (18%)
American Geriatrics Society	904 of 3,717 (24%)
American Orthopedic Association	299 of 1,152 (26%)
American Psychiatric Association	7,332 of 30,103 (24%)
American Roentgen Ray Society	2,307 of 14,468 (16%)
American Society of Abdominal Surgeons	262 of 919 (29%)
Heart Rhythm Society	619 of 2,797 (22%)
National Association of Medical Examiners	164 of 769 (21%)
Triological Society	146 of 507 (29%)

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

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 percent (20%) 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 percent (20%) 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.

Exhibit C

- 8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:
 - 8.2.1 To cooperate with the AMA in increasing its AMA membership.
 - 8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
 - 8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
 - 8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
 - 8.2.5 To provide information and data to the AMA when requested.

Exhibit D - AMA Bylaws on Specialty Society Periodic Review

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

- 8.5 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 8.2. 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 8.2.
 - 8.5.1 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.
 - 8.5.2 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 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.
 - 8.5.3 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 8.2 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.

8.5.3.1 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 8.2, 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.

8.5.3.2 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 8.2, the House may take one of the following actions:

8.5.3.2.1 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 8.5.3.1.

8.5.3.2.2 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.

8.6 Discontinuance of Representation. A specialty society or a professional interest medical association that has been granted representation in the House of Delegates will automatically have its representation terminated if it is not represented by a properly certified and seated delegate at 3 of 5 consecutive meetings of the House of Delegates. The specialty society or the professional interest medical association may continue as a member of the SSS pursuant to the provisions of the Standing Rules of the SSS, and may apply for representation in the House of Delegates after 3 additional years as a member of the SSS, under all of the provisions for a new application.

12. AFFILIATE MEMBERSHIP

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy G-635.064

This report is in response to Policy G-635.065 which stemmed from the Council on Constitution and Bylaws Report 4-A-14 Moratorium on AMA Affiliate Members. Policy G-635.065 asked that the Board of Trustees study the issue of affiliate membership and address the rationale for affiliate memberships. The House of Delegates instituted a moratorium in consideration of any other affiliate members until the Board had studied the issue and report back to the HOD.

BACKGROUND

Historical

Affiliate membership has been in existence since at least the 1940s when our AMA convened clinical sessions and affiliate members were able to enjoy the privileges of the Scientific Assembly without the right to vote or hold office. In the late 1950s, nonphysicians were nominated and approved for affiliate membership by the section councils. Physicians who were members of the chartered national medical societies of foreign countries adjacent to the United States, and American physicians located in foreign countries and engaged in medical missions and similar educational and philanthropic labors, were nominated by the Judicial Council (predecessor to the Council on Ethical and Judicial Affairs). The Judicial Council's rules required an application to be accompanied by a statement from a responsible and qualified person attesting to the nominee's qualifications.

During the 1960s, listings of nominees for affiliate membership by either the Judicial Council and/or the section councils took up several pages of double columns in multiple Proceedings of the House of Delegates. In the mid-1960s, the Judicial Council rather than the section councils became responsible for nominating all affiliate members, and the affiliate membership category was expanded to include teachers of medicine or of the sciences allied to

medicine who were citizens of the United States and not eligible for other categories of AMA membership. In the late-1960s the bylaws were amended to require the approval of the state or county medical society for selected categories of nominees for affiliate members, and in the 1980s to require physicians in foreign countries to belong to a medical society or other organization that would verify their professional credentials.

Eligibility

Individuals eligible to become affiliate members are identified in AMA's bylaws in Section 1.1.2 Affiliate Members as follows:

- a) Physicians in foreign countries who have attained distinction in medicine and who are members of their national medical society or such other medical organization as will verify their professional credentials.
- b) American physicians located in foreign countries or in territories or possessions of the United States who are engaged in medical missionary, educational or philanthropic endeavors.
- c) Dentists who hold the degree of DMD or DDS who are members of the American Dental Association and their state and local dental societies.
- d) Pharmacists who are active members of the American Pharmaceutical Association.
- e) Teachers of medicine or of the sciences allied to medicine who are citizens of the United States and are ineligible for active membership.

Admission into the AMA

Membership is conferred by majority vote of the House of Delegates following nomination by the Council on Ethical and Judicial Affairs. Nominations for the c, d, and e categories must also be approved by the appropriate state medical society. The election of affiliate members shall take place at a time recommended by the Committee on Rules and Credentials and approved by the House of Delegates.

Recent Moratorium

Most recently, up until the moratorium was approved at the 2014 Annual Meeting, the Council on Ethical and Judicial Affairs considered AMA affiliate membership applications. The application was available on the AMA website and allowed self-nominees.

DISCUSSION

There are several factors to consider in evaluating the viability and relevance of affiliate membership in the AMA.

- Interest in affiliate membership is minimal and the number of applications received averages about 5 per year. In total there are 881 affiliate members of the AMA.
- There has been no known negative impact from the moratorium.
- AMA Affiliate members do not pay dues, do not receive membership benefits other than being allowed to attend meetings, are not included in our AMA's membership count, and do not receive communications from the AMA.
- Other professional associations do offer affiliate or associate membership; however there is a wide range of requirements. Many organizations require the applicant to be in the profession (dentist, accountant, physician, etc.) and pay membership dues. In some cases affiliate or associate membership categories may be included in their overall count.
- The background information and validation supporting affiliate member applications is often difficult to obtain; an example would be a medical society's reluctance to endorse a nonphysician they do not know.

- There is potential reputational risk to the AMA when self-nominating individuals seek to use affiliate membership for their personal gain.

Affiliate membership does not provide the American Medical Association with member count or revenue, and overall demand is low. However, it does create the potential for reputational risk if an individual uses their affiliation with the AMA to promote their own product, service or agenda. In addition, physicians in foreign countries are already entitled to AMA membership as an Honorary Member or an International Member (AMA Bylaws sections 1.1.3 and 1.1.4 respectively).

RECOMMENDATION

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

1. That our American Medical Association (AMA) eliminate the pathway to future membership under the affiliate membership category while preserving the status held by individuals who have already met the requirements and have been approved for affiliate membership, category or status and that the Council on Constitution and Bylaws draft appropriate amendments to the Bylaws to effect such.
2. That our AMA rescind Policy G-635.065, which has been accomplished by this report.

REPORT OF THE SPEAKERS

The following report was presented by Susan R. Bailey, MD, Speaker; and Bruce A. Scott, MD, Vice Speaker:

RECOMMENDATIONS FOR POLICY RECONCILIATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Recommended actions accomplished

At the 2012 Annual Meeting, the Council on Constitution and Bylaws and the Council on Long Range Planning and Development issued four joint reports dealing with AMA policymaking and noting problems with obsolete, redundant and inconsistent statements in our AMA's policy compendium. One of those reports, CCB-CLRPD Report 2-A-12, developed policy that allows the speaker to propose changes dealing with policies that present such problems and encouraging members of the House to suggest policies that merit review, consolidation or some other "remedial" action (Policy G-600.111).

One of the issues the councils noted is that policies not infrequently contain outdated references. This is a particular problem when a policy is adopted mandating a report at some specified future meeting. Oftentimes the request for a report remains in policy despite a report actually having been considered by the House.

Your speakers present this report dealing with such obsolete references to reports. This report will amend several policies to delete references to reports that have been presented to the House. While these changes might be considered editorial corrections, your speakers believe they should be made transparently, hence this report. The deletions that will be made are not intended to change the substance or intent of any policy statement, nor do they remove a request for a report that has not been fulfilled. They simply delete references to reports that have been presented to the House. Each change cites the report that fulfilled the request.

Because these changes are essentially editorial, the sunset clock will not be reset for these policies.

RECOMMENDED RECONCILIATIONS

1. Policy G-640.005, AMA Advocacy Analysis, calls for a report at each Interim Meeting on the past year's advocacy efforts. The policy was adopted at the 2014 Annual Meeting and specified details to be included in the initial report at the 2014 Interim Meeting. Those details appeared in Board of Trustees Report 8-I-14, so the specific reference will be deleted. Your speakers would note that Board of Trustees report 3-I-15 on our AMA's advocacy efforts in 2015 is before the House at this meeting.

Our AMA Board of Trustees will provide a report to the House of Delegates at each Interim Meeting highlighting the prior year advocacy activities to include efforts, successes, challenges, and recommendations / actions to further optimize advocacy efforts, ~~and that the 2014 Interim Meeting report include a summary of the review of the Advocacy Group that was performed in 2012.~~

2. Policy D-75.994, Tubal Ligation and Vasectomy Consents, included a call for a report on mandated waiting periods for informed consents for Medicaid patients undergoing tubal ligations and vasectomies. The requested report was provided by Board of Trustees Report 17-A-14, thus satisfying paragraph 3 of the policy, which will be deleted.
 1. Our AMA will work closely with the American Congress of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure.
 2. Our AMA will work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures.

~~3. Our AMA will study the current ramifications of the existing regulations mandating a waiting period for informed consents for Medicaid patients undergoing tubal ligations and vasectomies, specifically noting potential financial costs regarding bureaucratic enforcement, unintended pregnancies, public health and ethical considerations and concomitant health care inequity/disparity issues and report back to the AMA House of Delegates at the 2014 Annual Meeting.~~

3. Policy D-295.936, Educational Implications of the Medical Home Model, mandated a report on the medical home model at the 2010 Annual Meeting. That report was provided by Council on Medical Education Report 8-A-10.

Our AMA:

- (1) encourages the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects;
- (2) will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards so as not to impede education in and about the PC-MH model;
- (3) will advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models; **and**
- ~~(4) will monitor the evolution of the concept of the medical home and track the implementation by teaching programs, with a report back at the 2010 Annual Meeting.~~

4. Under Policy D-305.956, AMA Participation in Reducing Medical Student Debt, our AMA is investigating the development of an affinity program for members that would facilitate student loan financing. The policy called for a report at the 2014 Interim Meeting, which was provided in Board of Trustees Report 4-I-14, and a follow up report, Board of Trustees Report 27-A-15, was provided this past June.

Our AMA will explore the feasibility of the development of an affinity program in which student, resident and fellow members of our AMA could obtain new educational loans and consolidate existing loans from one or more national banks or other financial intermediaries. Membership in our AMA would be required during the life of the loan (typically 10 years or more following medical school). Such activities or program would neither result in our AMA becoming subject to regulation as a financial institution nor impair our AMA's ability to continue to be treated as a not-for-profit entity. ~~Our AMA HOD will receive a progress report on these discussions by the 2014 Interim Meeting.~~

5. Policy D-385.963, Health Care Reform Physician Payment Models, deals with several aspects of new payment models. Paragraph 1 of the policy called for a report at the 2011 Annual Meeting. The Council on Medical Service prepared CMS Report 1-A-11 in response to that mandate and has continued to provide updates since that time, including a number of reports that have established significant AMA policy on the matter. The only change to this extensive policy will be the deletion of the reference to the 2011 report.

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.**

The changes outlined above will be implemented when this report is filed.