

REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–13, were presented by Gerald E. Harmon, MD, Chair.

1. REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which called on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of specific 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. BOT Report 6-I-13, “Redefining AMA’s Position on ACA and Healthcare Reform,” accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Efforts to repeal and replace the ACA have consumed the vast majority of health system reform efforts of the 115th Congress and, to date, have been largely unsuccessful. The AMA engaged directly with members of Congress in an effort to shape the outcome of the discussion along the lines of specified principles set forth in AMA policy and approved by the HOD. These were that any legislation should:

- Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
- Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
- Stabilize and strengthen the individual insurance market;
- Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
- Ensure that Medicaid, CHIP and other safety net programs are adequately funded;
- Reduce regulatory burdens that detract from patient care and increase costs;
- Provide greater cost transparency throughout the health care system;
- Incorporate common sense medical liability reforms; and
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

A number of factors played into the inability of Congress to advance repeal of the ACA, including the decision to act under the limitations imposed by the budget reconciliation process and efforts to go beyond ACA reform to include significantly restructuring the financing of the Medicaid program without hearings or stakeholder input. Ideological differences among Republican members of Congress and discomfort with projections of significant increases in the number of Americans without health insurance as a result of Congressional action further compromised any pathway to repeal.

The “American Health Care Act” (AHCA) was reported by the House Budget committee on March 20, 2017 and considered by the House of Representatives on March 24. As considered by the House, the bill made numerous changes to the Medicaid program, most significantly eliminating federal funding for ACA Medicaid expansion populations and converting Medicaid financing into a per-capita allotment. The AHCA effectively eliminated the individual and employer mandates established by the ACA and replaced the current premium assistance tax credit for purchasing health coverage which was based on age, income and the affordability of coverage with an advanceable, refundable credit based primarily on age and phasing out for individuals with higher incomes. Actuarial requirements for plans were eliminated and the permissible variation of premiums by age was increased from 3:1 to 5:1. To compensate for the greater instability in the individual market caused by the elimination of penalties for failure to maintain coverage and other changes, the bill established a Patient and State Stability Fund and required insurers to charge a 30 percent premium surcharge to individuals who failed to maintain coverage for

more than 62 days during the previous year. The Congressional Budget Office (CBO) estimated that the bill would result in 14 million fewer Americans with health insurance coverage in 2018, increasing to 26 million by 2026. It would also reduce federal Medicaid expenditures by more than \$800 billion over the next decade. Lacking the necessary support, House leadership pulled the bill from consideration prior to a vote.

On May 4, 2017, the House considered a revised version of the AHCA, incorporating amendments by both conservative and moderate members of the House Republican Conference, including: allowing the establishment of Medicaid work requirements; allowing a state to receive Medicaid funding as a block grant; increased funding for maternity coverage, newborn care, and services for those with mental health or substance use disorders; establishment of a risk sharing program for insurers; increased stability funding; state waiver of essential health benefits; and allowing insurers to vary premiums by health status for individuals who had a break in coverage. The modified legislation, considered prior to the availability of a CBO score, was passed by a vote of 217-213. On May 24, the CBO estimated that the House-passed bill would result in 14 million fewer Americans with health insurance coverage in 2018 and 23 million fewer in 2026 while reducing federal Medicaid expenditures by more than \$800 billion.

Lacking Senate support for the House-passed AHCA, Senate Republican leadership undertook the drafting of revised legislation. A discussion draft, the “Better Care Reconciliation Act” (BCRA) was released on June 26, 2017. The Medicaid per-capita cap was maintained, though with a more generous growth rate in the short term and a lower allowed growth rate in later years. Funding for Medicaid expansion was also eliminated, though over a longer period of time. Premium tax credits in the Senate bill more closely reflected those in the ACA and a single actuarial benchmark of 58 percent was established for plans. As opposed the AHCA’s 30 percent premium surcharge for those with a gap in coverage, the Senate bill established a six month waiting period before coverage could begin. CBO estimated that the proposal would result in 15 million fewer Americans with health coverage in 2018 and 22 million fewer by 2026. Federal Medicaid expenditures would be reduced by more than \$770 billion over the decade.

Despite these efforts, Senate leadership was unable to attract the necessary 50 votes for the proposal from the 52 Republican Senators. While moderate members, especially those from states that had successfully expanded Medicaid, remained concerned with the impact on coverage, a modified draft released on July 13 moved the Senate product decidedly to the right. The proposed amendment would allow insurers to offer plans outside of the exchanges that were exempt from ACA requirements including essential health benefits and pre-existing condition protections, as long as they also offered other compliant plans on the exchanges. To compensate for the impact on the risk pool within the exchange, additional stability funding was included. The measure also increased funding for opioid abuse treatment and allowed Health Savings Account funds to be used for premiums. Some conservative members continued to argue that the Senate proposal largely kept the structure of the ACA intact – contrary to campaign promises to completely repeal the law. On July 19, another proposal was released called the “Obamacare Repeal Reconciliation Act” (ORRA). The ORRA largely reflected the reconciliation bill passed by the previous Congress but vetoed by President Obama. ORRA would repeal all elements of the ACA allowed under reconciliation, essentially wrecking the individual markets by repealing penalties for failure to maintain coverage while maintaining requirements that insurers offer coverage to all individuals at community rated premiums with no preexisting condition exclusions. CBO estimate that 17 million fewer Americans would have coverage under the ORRA in 2018, increasing to 32 million by 2026. Furthermore, for those purchasing coverage on the exchange, premiums would be double those projected under current law by 2026 and three-quarters of all Americans would live in areas with no plans offered in the non-group market. Federal Medicaid expenditures would be reduced by more than \$840 billion over the decade.

On July 25, 2017, the Senate voted 51-50 to proceed to consideration of H.R. 1628, the American Health Care Act. Republican Senators Susan Collins of Maine and Lisa Murkowski of Alaska voted no. Vice President Mike Pence cast the tie-breaking vote. Over the next two days the Senate considered a number of secondary amendments from both sides of the aisle. On July 25, the Senate considered and rejected the “Better Care Reconciliation Act” by a vote of 43-57, with 9 Republicans joining all Democrats in opposition. The following day, the Senate also rejected the “Obamacare Repeal Reconciliation Act” by a vote of 45-55.

Still lacking the necessary 50 votes to advance ACA repeal and facing a growing backlog in the Senate agenda, Senate Majority Leader McConnell offered one last alternative, the “Health Care Freedom Act” (HCFA) or so-called skinny repeal. The HCFA reflected common provisions of previous versions – elimination of individual and employer mandate penalties, eliminate funding for the Prevention and Public Health Fund, extension of the

moratorium on the device tax through 2020, a temporary increase in HSA contribution limits, increased section 1332 state waivers, increased Community Health Center Funding, and prohibition of Medicaid payments to Planned Parenthood clinics. While most of these provisions enjoyed unanimous support among Republican senators (the Planned Parenthood provision being the exception), no Senator supported the HCFA as the final Senate position on ACA repeal. Rather, leadership promoted the idea that passage of the amendment would allow the Senate to advance ACA repeal to a conference with the House where yet another new version of the bill could be written. Several Republican senators expressed the concern that the House would instead take up the Senate-passed bill and send it directly to the President. While the House leadership tried to assure the Senate that they would go to conference, messaging from different quarters on the ultimate pathway was decidedly mixed. In the end, in the early morning hours of July 28, the Senate rejected the HCFA by a vote of 49-51, with Sen. John McCain (R-AZ) joining Sens. Collins, Murkowski and all Democrats in voting no. With no viable pathway forward, Sen. McConnell pulled the bill from consideration.

Throughout House and Senate consideration of the AHCA and the Senate substitutes, the AMA consistently advocated that Congress reject proposals that would lead to fewer Americans with access to quality, affordable health care coverage and that were inconsistent with the principles and policies adopted by the House of Delegates. The AMA also consistently acknowledged that there are shortcomings in the ACA and expressed our desire to engage with Congress and other stakeholders in efforts to address those issues. In response to a May 12, 2017 request from Senate Finance Committee Chairman Orrin Hatch (R-UT), the AMA offered a number of policy suggestions to enhance plan affordability, stabilize the individual market, and protect the safety net. The partisan nature of the debate and the limitations imposed by the budget reconciliation process, however, made advancing those proposals highly unlikely as long as repeal of the ACA remained the primary objective.

At this writing, Congress is expected to turn to efforts to stabilize the current system in the short term, likely through continuing Cost Sharing Reduction payments to health plans and reinsurance. Efforts are also likely to incorporate additional flexibilities for states in administering components of the Affordable Care Act. Members on both sides of the aisle have acknowledged that successful legislative efforts will require regular order – committee hearings, consultation with stakeholders, and compromise on all sides. The AMA will remain engaged in these efforts consistent with the principles outlined above.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-PERFORMANCE

Since the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), much of the policy making activity related to pay-for-performance programs has been subsumed by implementation activities surrounding that statute. Since the enactment of MACRA, the AMA has worked diligently with the Centers for Medicare & Medicaid Services (CMS) to ensure that the law was implemented in manner that encourages and enables successful participation of physician practices of all sizes and structures, including appropriate exemptions. Proposed rulemaking for 2018 offers further evidence of the success achieved by the AMA and organized medicine in this regard.

The 2018 proposed rule calls for important accommodations for small practices, including expanded low volume thresholds, creation of virtual groups, bonus points for small practices and a new hardship exemption from Advancing Care Information (ACI) (formerly meaningful use). New flexibilities have also been proposed for ACI, including the use of 2014 certified electronic health records technology for 2018. Quality performance will remain weighted at 60 percent and the cost category at zero.

The proposed rule also eliminates the cross cutting measure requirement, maintains the current data completeness threshold, and allows the reporting of improvement activities through attestation while maintaining the number of activities physicians must report.

On the legislative front, the AMA is engaged in efforts to ensure that CMS has the necessary flexibility to promote successful physician participation. This includes efforts to make sure measures of resource use are developed and tested prior to their required implementation and that ACI requirements do not become overly burdensome.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The IPAB was created as part of the Affordable Care Act to reduce the per capita rate of growth in Medicare spending. Recommendations from the IPAB to reduce spending in Medicare are required should the Chief Actuary of CMS Services determine that per-capita spending exceeds a specified target. Should that occur, the IPAB would be required to make recommendations to Congress to bring spending back into line with targets. In doing so, the IPAB is generally prohibited from recommending changes to cost sharing or premiums, rationing care, or changing benefits or eligibility. These limits leave few tools for controlling spending outside of changes to provider payments. The statute also prescribes a specific time table for Congressional action on these recommendations which leaves Congress the option of replacing IPAB-recommended policies with alternative savings, though Congress would still be required to produce total savings necessary to match the targets.

At this time, no members have been appointed to the IPAB nor are appointments expected. The statute contemplates this possibility by calling for the Secretary of U.S. Department of Health and Human Services (HHS) to make the recommendation directly to Congress in lieu of recommendations made by an appointed IPAB. However, it is not clear at this time what steps Secretary Price would take in response to the triggering of the IPAB requirement nor is the position of the Administration on this issue clear.

Six separate pieces of legislation have been introduced in the 115th Congress to repeal or otherwise discontinue the functions of the IPAB. Three of these bills, by Sen. John Cornyn (R-TX), Sen. Ron Wyden (D-OR), and Rep. Phil Roe, MD (R-TN) and Rep. Raul Ruiz, MD (D-CA) are consistent with legislation that has been introduced in each of the previous Congresses since the enactment of the ACA. In both the 113th and 114th Congress, bipartisan IPAB repeal legislation was considered and passed in the House of Representatives but not considered in the Senate. In each case, the bill was paired with provisions offsetting the cost that were not bipartisan in nature, therefore diminishing the opportunity for successful enactment.

The second set of proposals, introduced by the same sponsors as the IPAB repeal legislation, fulfills the requirements of an IPAB discontinuation process that was enacted as part of the IPAB itself. Section 3403 of the ACA establishes fast track procedures for discontinuing the IPAB process through a joint resolution that meets specific requirements. Unfortunately, the procedural advantages offered by these resolutions expired on August 15.

On July 13, 2017, the Medicare Trustees released their annual report. Included was the determination by the Actuary that spending targets have not been exceeded and therefore IPAB recommendations are not triggered this year, contrary to earlier predictions. While it is certainly positive that no cuts are currently required, the lack of a direct threat of cuts has tempered the urgency of repealing IPAB.

The longer Congress waits to repeal the IPAB, the more expensive it will become given the fact that the Congressional Budget Office predicts accelerating Medicare spending in future years, increasing the likelihood of required cuts that must then be offset as part of repeal legislation. This is unfortunate in that the true urgency lies not in the immediate threat of cuts but in the growing cost of IPAB repeal.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

Our AMA continues to seek opportunities to expand the use of health savings accounts and remove ACA imposed limitations on the allowed use of Flexible Spending Account funds.

Our AMA continues to work with the Health Choices Coalition in support of the “Restoring Access to Medications Act” which has been reintroduced by Rep. Lynn Jenkins (R-KS), Rep. Ron Kind (D-WI), Sen. Pat Roberts (R-KS) and Sen. Heidi Heitkamp (D-ND). This legislation would repeal ACA-imposed limitations on the use of Flexible Spending Account funds to purchase over-the-counter medications without a prescription.

Our AMA also continues to pursue opportunities to expand the availability of Health Savings Accounts (HSA) consistent with AMA objectives for continuing health system reform. In suggestions provided to Sen. Hatch on improving health care affordability, for example, the AMA suggested allowing individuals who are eligible for cost sharing reductions to forgo those reductions and instead enroll in a bronze plan with a prefunded HSA and allow

those funds to roll over from year to year. We also proposed providing individuals not eligible for cost sharing reductions with a moderately funded HSA.

The Medicare Patient Empowerment Act has not been reintroduced in the 115th Congress. AMA will continue to seek opportunities, however, to increase private contracting opportunities under the Medicare program without penalty to the patient or physician.

STEPS TO LOWER HEALTH CARE COSTS

Beyond AMA's extensive efforts to prevent chronic disease currently underway through the Improving Health Outcomes initiative, there are multiple opportunities in the policy arena to bring down the cost of care, among them are focusing on the rising cost of prescription drugs and the opportunity to lower the cost of providing care through regulatory reforms.

Though Congress' attention has been focused on the Affordable Care Act, the AMA continues to work to build support for addressing the high costs of prescription drugs. Drawing on policies adopted by the House of Delegates in 2015 and 2016, and the work of an AMA task force consisting of AMA councils, state medical associations and national medical specialty associations, the AMA continues to explore opportunities to increase transparency in the pharmaceutical sector. These efforts include a website, TruthinRx.org where patients can access information and share their stories as well as sign an online petition. We believe that Congress will turn its attention to pharmaceutical pricing in the near future and the AMA is ready to fully engage at that time.

Achieving lower cost care is also dependent on reducing the cost to the physician to provide care by eliminating administrative burdens that do not contribute to better care. Our AMA continues to engage both Congress and the new Administration on a variety of proposals to reduce regulatory burden in the areas of certification and documentation, Medicare Advantage, Part D prior authorization requirements, Appropriate Use Criteria, Meaningful Use and Electronic Health Records, Program Integrity, DEA requirements, and FDA regulation of laboratory developed tests and compounding, to name a few. Some success can already be seen in the MACRA proposals noted above as well as a recent request for information on regulatory reform ideas that was part of the 2018 Medicare Physician Fee Schedule proposed rule released in July. Additionally, the House Committee on Ways and Means has initiated an effort to collect suggestions for both statutory and regulatory changes to "deliver relief from unnecessary and burdensome mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries." The AMA is participating fully in these and other efforts to reduce regulatory burdens.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying that the section does not require "that a group health plan or health insurance issuer contract with any provider willing to abide by the terms and conditions for participation." Nevertheless, the AMA will continue to seek legislative opportunities to repeal this provision.

CONCLUSION

To date, much of the effort surrounding health system reform in the 115th Congress has been focused on efforts to repeal the Affordable Care Act. While we are pleased that those proposals have been unsuccessful to date, we will remain engaged in efforts to address the shortcomings of the ACA by vigorously pursuing the adoption of AMA policies on health care coverage and health system reform. Additionally, we will continue to seek opportunities both in the legislative and regulatory arenas to advance policies promoting the successful implementation of MACRA, the reduction of regulatory burdens on physicians, the repeal of IPAB, lowering of health care costs and other policies adopted by the House of Delegates.

2. 2017 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

BACKGROUND

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (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. The BOT has prepared the following report to provide an update on 2017 American Medical Association (AMA) advocacy activities.

DISCUSSION OF 2017 ADVOCACY EFFORTS

Health System Reform

When the 115th Congress convened on Jan. 3, 2017, it was clear that health system reform would be a top priority for both chambers. In anticipation of the coming debates, the AMA outlined our key objectives for health system reform which are based on AMA policy and sent them to the Administration and Congress urging them to align any legislative proposals with these objectives.

- Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
- Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
- Stabilize and strengthen the individual insurance market;
- Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
- Ensure that Medicaid, CHIP and other safety net programs are adequately funded;
- Reduce regulatory burdens that detract from patient care and increase costs;
- Provide greater cost transparency throughout the health care system;
- Incorporate common sense medical liability reforms; and
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

Subsequently, the House and the Senate both introduced legislation at various points that would repeal key portions of the Affordable Care Act (ACA). The AMA analyzed the House bill, the American Health Care Act (AHCA), and the Senate bill, the Better Care Reconciliation Act (BCRA), in relation to our health reform objectives and determined that both bills fell short when compared to those objectives. According to the Congressional Budget Office (CBO), the AHCA and BCRA would both have led to over 20 million or more Americans losing their health care coverage. The bills included per capita caps on Medicaid funding, which the AMA opposes based on explicit policy adopted at our 2017 Annual Meeting. The bills would have also led to increased costs for patients. Therefore, the AMA opposed the bills as originally introduced and as they were amended through the process (as did a long list of other health organizations). The AHCA eventually passed the House in May by a vote of 217-213. The Senate efforts, BCRA and other repeal bills, have stalled in the Senate as of this writing.

The AMA launched a vibrant and effective campaign to oppose both of these bills.

- The AMA created a website, PatientsBeforePolitics.org, to serve as our grassroots platform for patient and physician engagement on these issues.
- The AMA also launched an extensive grassroots campaign involving telephone calls, emails, social media contacts and meetings with key Senators. The results were very strong: 6,290,404 digital/social media engagements; 380,264 emails; and 33,618 phone calls as of this writing.
 - The AMA commissioned public opinion [polls](#) in select states, revealing that registered voters support Medicaid and opposed the proposed repeal/replace bills.

- The AMA joined collaborative efforts with patient groups, hospitals and other providers for [media events](#) held in Colorado, Ohio, Nevada, and West Virginia to share personal stories about the impact that access to affordable, meaningful health insurance coverage has had on individuals, families and communities.

The AMA will continue to offer short-term and long-term recommendations and solutions to Congress as it revisits the health reform debate. We are on the record that the status quo is unacceptable and that problems with the ACA must be fixed. The immediate focus is individual insurance market stability to provide affordable coverage and choice. We are working with both parties in Congress to advance these and other interventions.

MACRA/QPP Implementation

Addressing practice sustainability is a major objective for the AMA. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (being implemented as the Quality Payment Program [QPP]) repealed the Sustainable Growth Rate and made several improvements over previous law including aligning and reforming a number of existing Medicare programs such as Meaningful Use, Physician Quality Reporting System (PQRS) and the Value-based Modifier (VM). It also created a way for physicians to participate in alternative payment models (APMs) and provided a path to advance them. Since MACRA's enactment, the AMA has been advocating to the Centers for Medicare & Medicaid Services (CMS) to ensure that the QPP regulations implementing MACRA are workable for physician practices and do not create new hurdles. The AMA has also launched an extensive campaign to educate physicians about MACRA and to help them prepare for the transition.

On the regulatory implementation front, the AMA, working with our Federation partners, attained several major improvements in the QPP for physicians in last year's QPP rule. For example, CMS instituted the Pick Your Pace program for 2017. Under Pick Your Pace, physicians will not face a potential four percent payment reduction in 2019 if they report on one measure for one patient in 2017. Only physicians who do not report any data to Medicare in 2017 will receive a penalty. To help physicians understand how to report, the AMA created a [video](#) that explains in detail how to report and avoid the penalty. While this year's QPP rule included several positive aspects, we continued to make [recommendations](#) to CMS on how to further improve the program.

In the QPP proposed rule for the 2018 performance period, CMS has proposed several more improvements in response to issues raised by the AMA, including several concerns facing small practices.

- Expanding significantly the low-volume threshold to \$90,000 or less in Medicare Part B allowed charges OR 200 or fewer Medicare Part B patients (previously the threshold was \$30,000 in allowed charges or 100 patients) – CMS estimates that only 37 percent of clinicians who bill Medicare will be subject to the Merit-based Incentive Payment System (MIPS);
- Allowing the establishment of virtual groups to assist small practices;
- Adding five bonus points to the final MIPS scores for practices of 15 or fewer clinicians;
- Adding a hardship exception from the Advancing Care Information (previously Meaningful Use) category for practices of 15 or fewer clinicians; and
- Allowing the use of 2014 edition certified electronic health records technology (CEHRT) past 2017, and CMS will not mandate that physicians update their EHRs in 2018.

The proposed rule also contains a number of other positive provisions, such as:

- Eliminating the cross cutting measure reporting requirement;
- Not increasing the data completeness threshold requirement;
- Proposing a zero weight for costs again in the 2018 performance/2020 payment year;
- Allowing physicians to report on Improvement Activities (IA) through simple attestation;
- Not increasing the number of IAs physicians must report;
- Developing additional IAs; and
- Keeping the revenue standard for Alternative Payment Models for more than nominal financial risk at 8 percent of revenues.

The AMA continues to provide educational resources to physicians and their staff as they prepare for the QPP transition, including webinars, [ReachMD podcasts](#), and the development of resource material. An APM workshop was held in March to convene physicians engaged with their specialties in practice model development to stimulate innovation and share strategies for addressing common problems and concerns. A second workshop is planned for

October in Chicago. The [Interactive MIPS 2017 Action Plan](#) launched in July and the [Payment Model Evaluator](#) will be updated in the fall to reflect changes stemming from the 2018 final rule. For more information, please visit the [AMA MACRA/QPP page](#).

Regulatory Relief

Regulatory relief is a high priority for the AMA. It is also a top initiative for the Trump Administration. To take advantage of this enhanced opportunity to address long-standing concerns with a burgeoning regulatory burden, the AMA established a Federation work group to help pinpoint the key regulatory relief issues the AMA should pursue with the Federal government. Some of the issues include: prior authorization, Medicare beneficiary identification numbers, Medicare documentation and certification requirements, appropriate use criteria (AUC), electronic health records, physician office lab reporting, and program integrity audits. In addition, the AMA, along with members of the Federation, agreed to urge the Administration to modify prior requirements and consequently the 2018 penalties of the PQRS, MU, and VM programs. Such changes would bring these policies more in line with the design of MIPS. Concerns and solutions for these and other administrative burdens have been shared and discussed with various arms of the Administration.

As a result of these efforts, some issues are already being successfully resolved. AMA places streamlining and aligning QPP at the top of our regulatory relief agenda. As outlined above, CMS continues to respond positively to AMA advocacy by modifying QPP. In addition due to direct AMA advocacy, the Administration agreed to create a look up database for new Medicare beneficiary identification numbers that will replace the current Social Security number identifiers. The Social Security Number Removal Initiative (SSNRI), which will be phased in over a 12-month period starting in April, 2018, will affect all Medicare beneficiaries and their physicians. Consequently, agreement by CMS to establish the database and a communication plan to educate both patients and physicians is an important achievement. The Food and Drug Administration has initiated a process to reduce the administrative barriers that generic drug manufacturers face when entering the market. CMS also decided to delay public reporting of new pain measures until 2020. The AMA and other physician groups convinced the US Pharmacopeia to establish a sub-committee to more thoughtfully consider in-office compounding. Also there were several positive regulatory relief developments in the annual proposed Physician Fee Schedule rule, including reductions in 2018 PQRS, MU and VM penalties, further delays in implementation of AUC, and requests for comments on the burden associated with new physician lab reporting requirements.

In addition to these proposed policy modifications, the 2018 fee schedule proposed rule as well as several other regulations released by the Administration have also launched a broad request for information on regulatory relief. The more concrete and immediate proposals in the proposed rule represent a down payment on these broader initiatives, and while there could be modifications when a final rule is issued in November, the proposals do signal a clear intent to make a significant dent in regulatory burden in the future. The AMA will file comments on the proposed Fee Schedule rule in early September.

Independent Payment Advisory Board

A number of bills have been introduced to repeal the Independent Payment Advisory Board (IPAB). Although the controversial panel has never been formally appointed, the mandate to impose Medicare cuts through a fast-track process when total program spending exceeds a target amount remains. Although actuaries projected that recent Medicare spending trends would trigger the mandate in 2017, it did not happen this year. If it had been triggered, then provider payment rate cuts would have gone into effect in 2019 unless Congress acted. The AMA supports legislation to repeal the IPAB provisions of the Affordable Care Act, which has been introduced by Sens. John Cornyn (R-Texas) as S. 260, and Ron Wyden (D-Ore.) as S. 251. In the House, Reps. Phil Roe, MD (R-Tenn.) and Raul Ruiz (D-Calif.) introduced H.R. 849. We also submitted a statement for the record calling for IPAB repeal to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health on July 20, 2017.

Diabetes Prevention Program (DPP)

Preventing type 2 diabetes is a major goal for the AMA and our partners. We received positive news toward this goal on July 10, 2017, when CMS released the 2018 Medicare Physician Fee Schedule (PFS) proposed rule. CMS proposes payment for the Medicare Diabetes Prevention Program (MDPP), with a maximum payment per beneficiary of \$810 over three years for the set of MDPP core and maintenance sessions. CMS also proposes a two-

year time limit on Medicare coverage for ongoing maintenance sessions. AMA comments on the previous CMS proposal had expressed concern that the proposed payment model was too restrictive in linking payments to patient adherence in attending sessions and health outcomes as measured by weight loss in a short period of time. The new proposal attempts to address these concerns by providing more flexibility to DPP providers in supporting patient engagement and attendance and by making performance-based payments available if patients meet weight-loss targets over a longer period of time. CMS also defers coverage for virtual programs to a CMMI demonstration, which has to be defined. CMS proposes to delay the start date of the MDPP for three months to April 1, 2018 from January 1, 2018. We will provide comments to CMS on the proposed rule expressing support for the provisions that align with AMA objectives, and we will continue to offer suggestions to improve the proposed rule on issues where we still have concerns.

At the state level, the AMA continues to advocate for insurance coverage of the DPP, including through state Medicaid programs. This year, California enacted a budget bill allocating \$5 million from the state general fund to cover the DPP for Medicaid beneficiaries beginning on July 1, 2018.

Insurer Mergers

The AMA, with the help of 17 state medical association antitrust coalition partners from across the country, achieved two huge victories in 2017 when federal trial court judges blocked these massive insurance company mergers: the \$37 billion Aetna-Humana merger and \$54 billion Anthem-Cigna merger. Soon after losing at trial, Aetna abandoned the merger. Anthem, though, appealed the trial court judge's decision to the U.S. Court of Appeals in Washington DC. On April 28, the federal appeals court affirmed the trial court's decision to block the Anthem-Cigna merger. Throughout the appeal, the AMA and its coalition partners continued to vigorously oppose the Anthem-Cigna merger. On May 12, Anthem dropped the merger.

At trial, Anthem's own expert stated that this mega-merger would have reduced provider payments, annually, by \$2.4 billion. According to an analysis provided to the AMA, this \$2.4 billion cut included physician payment cuts of at least \$500 million per year.

Our efforts to block the two mergers included:

- Utilizing the AMA's updated gold standard Competition in Health Insurance: A Comprehensive Study of U.S. Markets;
- Preparing detailed state-specific market analysis of both the Anthem-Cigna and Aetna-Humana mergers;
- Sending comprehensive, evidence-based advocacy statements to the U.S. Department of Justice (DOJ) after the mergers were announced in July 2015 urging the DOJ to challenge both mergers;
- Leading a 17-state medical society coalition and engaging likeminded stakeholders, including the American Hospital Association and various patient coalitions;
- Testifying with the California Medical Association before the California Department of Insurance (DOI) opposing the Anthem-Cigna merger and filing a joint statement—the California DOI ended up opposing both mergers;
- Filing an evidenced-based advocacy letter with the Missouri DOI opposing the Aetna-Humana merger—the Missouri DOI later blocked the merger;
- Working closely with the Indiana State Medical Association, filed a statement with the Indiana DOI challenging the Anthem-Cigna merger;
- Supporting numerous other state medical associations in their efforts to oppose the mergers;
- Engaging the National Association of Attorneys General in an effort to convince key state AGs to join the DOJ in opposing the mergers;
- Conducting extensive physician surveys to gauge impact on patient care (in conjunction with the AMA's state medical association partners);
- Marshaling nationally-recognized economists/legal experts in support of our arguments;
- Filing an amicus brief with the federal appeals court arguing against the Anthem/Cigna merger; and
- Facilitating another amicus brief from a group of nationally-renowned health care economists.

In response to these recent merger efforts and the potential for more proposed mergers, the AMA has developed a state level campaign to ensure fairness and transparency as states evaluate future merger proposals. It will also protect physicians from retaliation by health insurers.

Opioid Epidemic

The nation's opioid epidemic continues to claim many lives, and according to the most recent Centers for Disease Control and Prevention data, deaths due to heroin and illicit fentanyl (12,957 and 9,549, respectively) outnumbered and were rising faster than deaths due to prescription opioids (12,728) in 2015. These numbers show that the nature of the epidemic is changing and that significant work still needs to be done to address the epidemic's full scope. The rising mortality due to heroin and illicit fentanyl also makes it imperative to directly address the need for further treatment resources and access to treatment for patients who have an opioid use disorder.

In 2016, the AMA strongly supported federal legislation that recently led to \$485 million being sent to states to help fund state-based treatment programs. We look forward to learning which efforts are most successful so we can build best practices throughout the nation. The AMA is also urging full funding of the Comprehensive Addiction and Recovery Act so even more resources will be available to fight the epidemic.

The AMA Opioid Task Force recently released its yearly progress report on physicians' efforts to reverse the epidemic, showing:

- Physicians and other health care professionals queried their state prescription drug monitoring program (PDMP) more than 136 million times in 2016 – a 121 percent increase over 2014. Registration to use state PDMPs has nearly tripled since 2014 to more than 1.3 million registered users in 2016. Most state-specific increases occurred prior to new policies mandating PDMP use.
- More than 118,000 physicians accessed, attended or completed continuing medical educational and other courses offered by the AMA, American Osteopathic Association, and the American Dental Association and the nation's state and specialty societies on safe opioid prescribing, pain management, addiction and related areas in 2015 and 2016.
- More than 37,000 physicians are now certified to provide office-based medication-assisted treatment for opioid use disorders across all 50 states – including more than 10,000 in the past year.
- While there remains work to do in ensuring comprehensive treatment for patients with pain, there was a national 17 percent decrease in opioid prescribing from 2012 to 2016 with decreases seen in every state. Nearly all decreases occurred prior to new state laws restricting the prescribing of opioids to certain dose and/or quantity limits.
- Nearly all 50 states have naloxone access laws, and in the first two months of 2017, more than 32,000 naloxone prescriptions were dispensed – a record 340 percent increase from 2016. Most of the new state laws were based, in part, on AMA model state legislation.

The AMA also created a new End the Opioid Epidemic Microsite to provide physicians with the state- and specialty-specific education and training to help end the nation's opioid epidemic, the AMA—in concert with the Opioid Task Force—has identified nearly 300 resources for the new [AMA opioid microsite](#). The resources are organized so that physicians and other health care professionals can access practical, relevant information about:

- How PDMPs can help improve patient care;
- State- and specialty-specific information to ensure that physicians' education is meaningful and relevant to their practice and patient population;
- Key resources to help improve pain management for acute and chronic, non-cancer pain;
- Becoming certified to provide in-office buprenorphine to patients with an opioid use disorder;
- Incorporating overdose prevention and treatment strategies in one's practice;
- Practical information about naloxone;
- How to better talk with patients about safe storage and disposal of unwanted and unused opioid analgesics and all medications; and
- New research published in *JAMA*, and new resources developed by the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration and other stakeholders.

Prior Authorization

The AMA has identified prior authorization as a major impediment for physicians as they seek to provide optimal care for their patients. In response, the AMA, in collaboration with a coalition of 16 other organizations representing physicians, hospitals, medical groups, pharmacists, and patients, released the [Prior Authorization and Utilization](#)

[Management Reform Principles](#) in late January 2017. The 21 common sense principles form the foundation of a multi-pronged campaign to “right-size” health plan prior authorization and utilization management programs. More than 100 other provider and patient organizations have requested to be listed as supporters of the principles, and this number continues to grow. The principles have received extensive press coverage and have generated nearly 300 earned media citations.

The first wave of outreach on the principles to health plans, pharmacy benefit managers, and accreditation organizations has been very productive with mutual interest in this issue from many of these groups. Further, this advocacy is making an impact across the country. Just in the last year, at least eight states have enacted laws that limit prior authorization or step therapy, and insurers are starting to change their practices.

To further our efforts, the AMA partnered with the University of Southern California Schaeffer Center for Health Policy & Economics on an academic research project to assess the growing impact of prior authorization on physician practices and patients through analysis of Medicare claims data. This project has generated two manuscripts: the first provides a broad analysis of overall prior authorization trends and the effect of utilization management policies on medication use, while the second is a case study examining the impact of prior authorization for a specific class of drugs and disease state on patient outcomes and overall medical costs. Both manuscripts have been submitted for publication to peer-reviewed journals. The anticipated articles will strengthen and enhance the AMA’s advocacy on this issue.

Pharmaceutical Cost Transparency

Our recent work on the pharmaceutical cost issue stems from a series of resolutions at I-15 calling on the AMA to tackle spiking pharmaceutical costs and the detrimental effect this trend has on patients. In response, the AMA formed a task force in 2016 consisting of representatives of AMA policy councils, state medical associations, and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and adherence to medically necessary drug regimens. The task force discussed a variety of possible approaches, including Medicare drug price negotiation and re-importation, but ultimately recommended implementation of a grassroots campaign focused on increasing drug pricing transparency. This approach aligns with long-standing AMA policy encouraging prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health insurance companies.

To implement this campaign, the AMA launched an interactive grassroots campaign microsite, TruthInRx.org, in November 2016 as the online hub for the AMA pharmaceutical pricing transparency campaign, where patients can tell stories and activists can access further tools and resources to make their voices heard with members of Congress and state legislators through email and social media communications. We also created an online petition calling on pharmaceutical companies, PBMs and health plans to be more transparent on pricing decisions. The petition has been promoted through the AMA’s Patient Action Network and other cause-oriented websites (e.g., standunited.org and care2.org), and to date, over 154,000 people have signed it. We are prepared to activate this group when federal legislation is introduced. Also, to address this issue at the state level, the Board of Trustees recently approved a new model state bill that would increase pharmaceutical price transparency and increase related areas for PBMs and health plans. The model bill has been distributed to all 50 state medical associations and national medical specialty societies, and the AMA will work with any interested society to advance this legislation.

Network Adequacy/Out-of-Network Bills

Ensuring that provider networks offer access to timely, quality care continues to be a concern in many states, as narrow networks become the norm and changes to networks take place throughout the year. This continues to be a major area of focus for the AMA at the state level. This year, Illinois was able to enact a comprehensive network adequacy bill that incorporated many provisions of the AMA’s model bill. Also, Maryland, which enacted strong legislation last year that also included many AMA model provisions, is now going through the regulatory process to implement these positive changes. Draft regulations released earlier this year suggest Maryland may end up with some of the strongest provider network requirements in the country.

State and specialty societies continue to work through legislative proposals with the AMA’s guidance that would include prohibitions on anticipated out-of-network bills or “surprise” bills. While some states proactively offered solutions that involved strong patient protections and fair out-of-network payment to physicians, most states ended

up fighting problematic bills that undercut any incentives for insurers to offer physicians fair in-network contracts. In fact, more than half of all states had at least one proposal this year on this topic, but only a handful ended up being enacted. Bills in Arizona, Indiana, Louisiana, and New Hampshire focused largely on disclosure and/or study committees. Texas expanded its current mediation process; while Maine and Oregon enacted broader bans on out-of-network billing. A problematic bill passed both chambers in Nevada, but was ultimately vetoed by the governor. The AMA sent a letter to Governor Brian Sandoval supporting the Nevada State Medical Association effort to defeat the bill.

Physician-owned Hospitals

Currently, federal self-referral limitations effectively ban construction of physician-owned hospitals and place restrictions on expansion of already-existing facilities. The Patient Access to Higher Quality Health Care Act of 2017, introduced by Rep. Sam Johnson (R-TX) and Senator James Lankford (R-OK) as H.R. 1156 and S. 113, respectively, would repeal these limits and level the playing field for physician-owned hospitals allowing them to remain competitive and continue their solid record of providing the highest quality health care to patients. The AMA is supporting these bills based on our policy against this prohibition.

Medical Liability Reform

At the federal level, the AMA offered our support for the Protecting Access to Care Act of 2017 (PACA) (H.R. 1215). H.R. 1215 is a comprehensive medical liability reform bill that would help repair our nation's liability system, reduce the growth of health care costs, and preserve patients' access to medical care. The bill passed the House by a vote of 218 to 210. PACA provides the right balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting noneconomic damages to a quarter million dollars. Importantly, H.R. 1215 includes language to protect medical liability reforms enacted at the state level. The CBO determined that H.R. 1215 would reduce federal health care spending by \$44 billion over 10 years and reduce the deficit by \$50 billion over the same period. At the time of this writing, PACA has not been acted on in the Senate.

The AMA continues to advocate for and defend medical liability reform at the state level as well. State legislatures in 2017 considered bills that promoted a variety of reforms, including expert witness guidelines, affidavit of merit requirements, collateral source reform and bills that establish structures such as pretrial screening panels or health court systems. A handful of states also considered and defeated attempts to raise caps on noneconomic damages. Iowa enacted a comprehensive bill that includes a \$250,000 limit on noneconomic damages in most cases, stronger expert witness standards, a requirement for a certificate of merit in all medical liability lawsuits, and an expansion of the state's previously passed communication and resolution framework. In addition, Arkansas' legislature approved a ballot initiative proposing an amendment to the state constitution to limit damage awards and attorneys' fees. Finally, Florida and Wisconsin both had disappointing judicial outcomes regarding their caps on noneconomic damages.

Team-based Care/Scope of Practice

State legislatures in 2017 considered over 750 bills seeking to eliminate team-based care models of health care delivery and/or expand the scope of practice of non-physician health care professionals. Though tough fights in all cases, most bills that threatened passage have been defeated with the support of the AMA and – as is often the case with scope bills – a coordinated state and specialty effort. State medical associations had particular success in defeating psychologist and naturopath prescribing legislation. In addition, the AMA and the Federation were largely successful in fending off the over 175 bills filed to expand the scope of practice of advanced practice nurses. For example, bills were defeated in Arkansas, California, Florida, Kentucky, Indiana, Mississippi, Missouri, Montana, Tennessee, Texas, and Virginia. The AMA continues to monitor state legislative activity on these and all other established and emerging scope of practice issues.

Telemedicine

The AMA actively negotiated with congressional staff and other major digital medicine stakeholders provisions of a recently introduced federal bill that would expand Medicare coverage of telehealth services. On May 3, 2017, S. 1016, the "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health

Act of 2017” was introduced by Sen. Brian Schatz (D-HI). Subsequently, the companion bill, H.R. 2556 was introduced by Rep. Diane Black (R-TN) and Rep. Peter Welch (I-VT) on May 19, 2017. The legislation would expand Medicare coverage by removing a number of Medicare restrictions to coverage that are widely criticized as being antiquated including originating site restrictions that prevent delivery of telehealth to a beneficiary’s home as well as the geographic limitation which limits access to telehealth services to rural locations, among a host of other provisions. The AMA secured changes from the draft versions to ensure: (1) state-based licensure requirements were retained; (2) telehealth was not used for Medicare Advantage network adequacy determinations; and (3) other provisions aligned closely with AMA policy. The AMA continues to work with various coalitions to advance this legislation as well as S. 870, the “Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017” which contains a number of provisions that parallel the CONNECT for Health Act provisions concerning waiver of Medicare restrictions for accountable care organizations, Medicare Advantage plans, telestroke, and home dialysis. On May 18, 2017, the U.S. Senate Finance Committee unanimously passed this bipartisan legislation. Moving forward, the AMA is actively working with Senate staff to craft another bill that would confer CMS with expanded waiver authority of current coverage restrictions conditioned on the CMS Chief Actuary certifying that the expansion would be cost neutral or costs saving in an effort to overcome Congressional Budget Office scoring obstacles that stymie passage of legislation that enjoys strong bipartisan support.

Following release of AMA model telemedicine legislation, states saw a flurry of activity in the area, with dozens of laws and regulations proposed to address telemedicine licensure, reimbursement, and practice standards. While most attention was given to debates over how to establish a patient-physician relationship via telemedicine – in person, face-to-face or over the phone – states continue to make gains in passage of coverage parity laws, ensuring that physicians will be compensated for treating their patients via telemedicine. Many of these laws were based on the AMA Telemedicine Act, which addresses these and other issues related to telemedicine.

Immigration/Travel Ban

The Trump administration’s executive order entitled “Protecting the Nation from Foreign Terrorist Entry into the United States” created significant uncertainty for the medical community and the ability to freely travel to the United States to either receive or provide care. The AMA swiftly reacted to this new policy by issuing letters to the Administration and Department of Homeland Security asking for clear exemptions for international medical graduates (IMGs), patients, and others who attend medical conferences or conduct medical research. In a joint letter with the Association of American Medical Colleges (AAMC), the AMA also noted the chilling effect this policy could have on foreign physicians entering the National Resident Matching Program (NRMP) or “Match,” and urged support for IMGs given the important role they play in providing care to rural and underserved areas. While the Supreme Court ruling clarified that students, residents, fellows, and lecturers should not be barred entry, the AMA continues to monitor the impact of the travel ban and seek greater exemptions for physicians and patients.

In addition, the AMA offered its support for S. 128, the “Bar Removal of Individuals who Dream and Grow our Economy Act” (BRIDGE Act), which would provide employment authorization and temporary relief from deportation for undocumented young immigrants who have Deferred Action for Childhood Arrivals (DACA) status. The AMA also worked to reinstate the premium processing of H-1B visas, which ensures that those in the Conrad 30 program can work in the United States without returning to their home country.

Graduate Medical Education (GME)

Congress has re-introduced GME legislation from previous sessions, entitled the Resident Physician Shortage Reduction Act (H.R. 2267/S.1301), which would create 15,000 additional Medicare-funded GME positions over five years. While this legislation appears promising, and the AMA has supported these bills, they are unlikely to be enacted given the significant cost and lack of financial offsets. Instead, Congress continues to consider cuts to GME, especially indirect medical education (IME) payments. As a result, the AMA continues advocacy efforts to maintain and protect current GME funding levels. Thus far, the AMA has avoided any significant cuts to current federal funding and is working to continue to educate lawmakers about the need for greater support for GME.

In addition to supporting legislation in Congress to increase GME funding, the AMA has established an effective grassroots campaign to educate the public about the importance of GME. Our [SaveGME](#) website has generated significant public attention as well as media response targeted at policymakers. This website allows anyone interested in supporting GME to send letters to members of Congress in support of maintaining GME funding and

increasing the number of Medicare-funded residency positions. The AMA has also drafted a compendium of GME policy alternatives. This resource can be used by legislators to consider innovative ways to increase GME funding and training positions. The AMA is also working with states to find other-payer solutions to GME funding. Examples of state laws that have been enacted include: Maryland established a tax credit for physicians or nurse practitioners who serve workforce shortage areas; Mississippi provided support for the creation of ACGME-accredited training programs based on a needs analysis of what residency programs might be necessary, while maintaining a strong and continued priority focus on family medicine; and West Virginia created a scholarship fund for medical students who commit to serve underserved areas of the state.

Conrad 30 Program

The Conrad 30 Program allows IMGs to remain in the United States in exchange for providing care in underserved areas. Currently, resident physicians from other countries working in the United States on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Many communities, including rural and low-income urban areas, have problems meeting their patient care needs and depend on the physicians in the Conrad 30 program to provide health care services. The program was set to expire this year if Congress did not act. On May 4, 2017, Congress passed an appropriations bill to fund the federal government through Fiscal Year 2017. This bill extended the Conrad 30 program through September 30, 2017. There is also bicameral legislation, S.898/HR. 2141 the “Conrad State 30 and Physician Access Reauthorization Act,” to extend the program for an additional three years. This bill would also make improvements to the program by requiring more transparency in employment contract terms and creating additional waivers per state. The AMA has issued support for this bill and is advocating for it to be passed by Congress.

Veterans Issues

The 115th Congress has held a number of hearings regarding the extension and improvement of the VA Choice program. The program was originally set to expire in August, 2017. In April, the President signed legislation to remove the sunset date and allow the program to continue to operate until those funds are expended. Recognizing that Congress was unlikely to act to reauthorize the program prior to the expiration of funding, the House in July passed additional legislation to provide more than \$2 billion in interim funding for the VA Choice program. Congress is working its way through numerous issues as part of efforts to reauthorize the VA Choice program – including the consolidation of various VA purchased care programs, appropriate provider payment levels, the use of tiered networks and value-based reimbursement, the appropriate role of telemedicine, and the interoperability of electronic medical records. The AMA will continue to work with the House and Senate Committees on Veterans Affairs to ensure that the emerging VA Choice reauthorization reflects the policy and priorities established by the HOD.

2017 AMPAC ACTIVITIES

AMPAC has once again worked closely with its state medical association PAC partners this election cycle on contribution support decisions for candidates running for the U.S. House of Representatives and Senate. A report summarizing AMPAC activities will be distributed at the Interim Meeting in Hawaii.

ADVOCACY RESEARCH

The AMA has also conducted/is conducting the following studies to assist in our efforts:

- The AMA will release an updated *Economic Impact Study* in December, 2017, which quantifies physicians’ economic impact on the state and national economies on four key economic indicators: economic output, jobs, wages and benefits and state and local tax revenue.
- This fall, the AMA published the 2017 Update to *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, its 16th edition of that work. This study provides detailed estimates of the degree of competition among health insurers in different markets. The study identifies areas where health insurer mergers may harm consumers and providers of care. Data from the two previous editions of the study were instrumental in AMA’s advocacy efforts that successfully blocked the Anthem-Cigna and Aetna-Humana proposed mergers.

- The AMA's Physician Practice Benchmark Surveys, conducted in the fall of 2012, 2014, and 2016, provide nationally representative physician-level information that supports many of the AMA's advocacy efforts. 2017 reports based on the Surveys focused on physicians' practice arrangements (e.g., ownership and practice type and size); physicians' patient-base and how the mix of patients was affected by the ACA; participation in accountable care organizations, medical homes and alternative payment models; and how frequently physicians are subject to medical liability claims.

CONCLUSION

This year has been a very successful one for the AMA on the advocacy front once again. We led the fight to protect coverage and access to quality, affordable health care for patients. We have made excellent strides on MACRA regulatory improvements, and the AMA is at the forefront of helping physicians to prepare for this transition. We also are continuing to make progress in reducing various regulatory burdens that hamper practice efficiency and contribute to physician burnout. Our collaborative effort with the Federation was vital to the defeat of the health insurer mega-mergers and stopped further insurer consolidation which would have had a host of negative effects. The AMA has also continued to make progress on public health issues such as halting the national opioid epidemic and helping physicians to provide resources to their patients at risk of developing diabetes. The AMA thanks our Federation partners for their collaboration and support, and we look forward to tackling medicine's biggest issues again in 2018.

3. REMOVING RESTRICTIONS ON FEDERAL FUNDING FOR FIREARMS VIOLENCE RESEARCH

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2016 Interim Meeting, the House of Delegates (HOD) adopted Policy D-145.994, "Removing Restrictions on Federal Funding for Firearms Violence Research," which called on our American Medical Association (AMA) to "provide an informational report on recent and current organizational actions taken on our existing AMA Policies (e.g., H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions." This report fulfills that directive.

BACKGROUND ON RESTRICTIONS ON FEDERAL FUNDING FOR FIREARMS VIOLENCE RESEARCH

Since the late 1990s, language has been inserted into either annual funding bills for the Departments of Labor, Health and Human Services, and Education or included into omnibus appropriations bills that has effectively limited federally-funded research related to firearm violence. Under the Public Health Service Act (PHSA), the Centers for Disease Control and Prevention (CDC), the lead public health agency for the federal government, is charged with conducting and providing grants for research "relating to the causes, mechanisms, prevention, diagnosis, treatment of injuries, and rehabilitation from injuries...." (42 U.S.C. § 280b(a)). From 1985 until 1996, the CDC's National Center for Injury Prevention and Control (Injury Center) researched firearm violence or funded research that studied firearm violence as part of CDC's statutory mandate. Many of these studies researched questions related to gun ownership and use. In 1993, after a CDC-funded study published in *The New England Journal of Medicine* concluded that guns in the home put people at greater risk of homicide, the National Rifle Association (NRA) argued that the CDC was advocating for gun control and that the Injury Center should be stripped of all funding.

Congress eventually decided to retain the Injury Center, but redirected \$2.6 million (the exact amount spent on gun research the previous year) from its budget. Subsequently, in September 1996, Congress included a rider in the Omnibus Consolidated Appropriations Bill for Fiscal Year ("FY") 1997 that stated that "none of the funds made available for injury prevention and control at the [CDC] may be used to advocate or promote gun control" (P.L. 104-208; September 30, 1996; 110 Stat. 3009, 3009-244). This language was sponsored by the late Representative Jay Dickey (R-AR) and is known as the Dickey Amendment or Rider. The Dickey amendment language has been included in each subsequent funding bill. Although in recent years such bills have rarely actually become law, the Dickey amendment has been included in the continuing resolutions or omnibus funding bills at the end of the year. For FY 2012, Congress expanded this limitation so that it applies to National Institutes of Health (NIH) funding as well. While attempts have been made to delete the amendment language, including in the immediate aftermath of the

Charleston, South Carolina church shooting that killed nine people, such attempts have been rejected by appropriators.

While the Dickey amendment does not specifically prohibit research on the causes of firearm violence, for the past 20 years the language has had a chilling effect on the CDC. The Obama Administration maintained the position that research on the causes of firearm violence does not constitute “advocacy” and that such research would not be in violation of the Dickey amendment, and in fact directed the CDC to conduct such research. However, the CDC did not do so. According to a white paper prepared in August 2016 by the law firm of Covington & Burling LLP for the Law Center to Prevent Firearm violence, “CDC’s interpretation of the appropriations rider has had a dramatic effect on firearm research by effectively halting federally funded research on gun-related injuries. From 1996 to 2013, CDC funding for firearm injury prevention fell 96 percent.”

AMA ADVOCACY ACTIVITIES

AMA Policy and advocacy activities have strongly urged Congress to take action on curbing firearm violence generally, and to allow and fund firearm violence research specifically. In April of 2016, the AMA, along with over 100 other medical organizations, sent a joint letter to Congress urging federal funding for research on firearm violence. In response to policy adopted at A-16 (D-145.995), the AMA issued a public statement that firearm violence represents a public health crisis that requires a comprehensive public health response and solution. That same policy directed the AMA to actively lobby Congress to lift the firearm violence research ban. Consequently, on June 15, 2016, the AMA sent a letter to the entire Senate advocating for federal support for research into the epidemiology of firearm violence and effective methods to reduce injury and death. Furthermore, the AMA continues to support two federal bills ([S. 834](#) and [H.R. 1832](#)) that would authorize federal funds to the CDC for conducting or supporting research on firearm violence prevention.

AMA policy (H-145.975) also supports increased funding for the expansion of the National Violent Death Reporting System (NVDRS) to all 50 states and U.S. territories, to inform state and federal health policy. NVDRS is a state-based surveillance system that provides jurisdictions with a better understanding of violent deaths to guide decisions about violence prevention and track progress over time. In FY 2016, CDC received funding to expand NVDRS to a total of 42 jurisdictions. The FY 2017 omnibus appropriations bill provided level funding for NVDRS. Despite the fact that the FY 2018 President’s budget request for CDC was an estimated \$1.2 billion (17 percent) below the FY 2017 continuing resolution level, the budget request maintained level funding for NVDRS.

In addition, AMA policy supports state research on firearm-related injuries and deaths (H-145.975). In the absence of federal funding for firearm violence research, at least one state has passed a budget that allocates funding for firearm violence research. In 2016, the California legislature allocated \$5 million for the creation of a Firearm Violence Research Center at the University of California, Davis.

Policy was adopted at the 2016 Annual Meeting supporting a waiting period and background check for all firearm purchasers (H-145.996). As a result, the AMA endorsed a call to action on firearm-related injury and death in the U.S. issued in 2014 by eight medical organizations—including the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics—and the American Bar Association (ABA). More than 50 organizations have since endorsed the call to action, which includes a recommendation supporting federally-funded firearms research. On March 24, 2017, the AMA and the ABA, along with a number of local, state, and specialty medical societies, presented a program in Chicago on Preventing Firearm violence: Moving from Crisis to Action. The program explored a workable public health response to reducing firearm violence, including priorities for a research agenda.

The AMA continues to seek opportunities to advocate for federally-funded firearm violence research. The current leadership in Congress and the current Administration, however, oppose federal funding for such research. Thus, in the current political environment there is little expectation that federal legislation, such as S. 834 and H.R. 1832, could pass in Congress, or that the Administration would direct the CDC to conduct such research. Your Board has reviewed our extensive policy and believes that the AMA is well positioned to support any future legislative or regulatory proposals to provide funding for research, and to engage with other stakeholders to continue to educate policy leaders and the public that firearm violence remains a public health crisis and requires a comprehensive public health response and solution. Therefore, the Board is not recommending additional policy on this topic at this time.

4. LIMITATIONS ON REPORTS BY INSURANCE CARRIERS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2016 Interim Meeting, the House of Delegates (HOD) adopted Policy D-355.996, “Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care,” with a progress report back at the 2017 Interim Meeting. This policy asks that:

Our AMA will seek legislation and/or regulation that would require the Health Resources and Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services.

Our AMA will seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity’s settlement of a claim that included the names of those physicians in their administrative roles at the entity.

Our AMA will seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.

Our AMA will provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA’s interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.

In addition to this resolution, the HOD also adopted new policy at the 2017 Annual Meeting that directly relates to reporting on physicians who were not involved in treatment or patient care.

Policy H-355.976(7), “National Practitioner Data Bank,” states that:

Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians’ provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.

This report provides background on the NPDB, including its history and the integration of the Healthcare Integrity and Protection Data Bank into the NPDB; analyzes the reporting requirements in medical liability payments and medical staff appointments; highlights related AMA policy; and discusses AMA’s interactions with HRSA.

Background: national practitioner data bank

The NPDB is a United States Government program that collects certain negative information on health care providers, including adverse licensure or clinical privileges actions, medical malpractice actions, and exclusion from participation in Medicare and Medicaid. The NPDB provides access to this negative information to only authorized users, such as hospitals and medical boards, but not the general public. The NPDB is managed by the Bureau of Health Workforce of the Health Resources and Services Administration in the U.S. Department of Health and Human Services.

History

The NPDB was created by Congress to restrict the ability of health care providers to move from state to state without disclosure or discovery of the provider’s previous disciplinary actions, licensure restrictions, or settled or

adjudicated liability lawsuits. In addition, due to the threat of private money damages liability under federal laws, Congress wanted to provide incentives and protection for health care providers engaging in effective professional peer review.

The NPDB was established by the Health Care Quality Improvement Act of 1986 (HCQIA)¹ and subsequent laws expanded the information collected and disclosed by the NPDB and modified its operations.

- Section 1921 of the Social Security Act² authorizes the federal government to collect information concerning certain adverse licensure actions taken against any authority of the state responsible for the licensing of such practitioners or entities and reporting any negative action or finding that a state licensing authority, a peer review organization, or a private accreditation entity had taken against a health care practitioner or health care entity.
- Section 1128E of the Social Security Act³ established a national care fraud and abuse data collection program for the reporting and disclosing of certain final adverse actions taken against the health care providers. This data bank was known as the Healthcare Integrity and Protection Data Bank (HIPDB).
- Section 6403 of the Affordable Care Act⁴ amended sections 1128E and 1921 of the Social Security Act to eliminate duplication between the HIPDB and the NPDB. It also required the transferring of data collected in the HIPDB to the NPDB and to cease HIPDB operations. Information previously collected and disclosed by the HIPDB is now collected and disclosed by the NPDB. The transition of data from the HIPDB to the NPDB was completed in May 2013. This transition means that the NPDB jurisdiction is broader than its original intent and now includes all adverse actions from a medical licensing authority and any health care-related civil judgments or criminal convictions.⁵

When a health care provider is subject of a NPDB report, the individual can—at any time—add a statement to the report or initiate a dispute. The statement becomes part of the report and remains with the report unless the individual edits or removes it. The statement is sent to the reporting entity, all queriers who received a copy of the report within the past three years, and is included in the future query responses.

An individual can also initiate a dispute and enter the report into “dispute status” to disagree with either the factual accuracy of the report or whether the report was submitted in accordance with NPDB requirements. Once in dispute status, the individual must contact the reporting entity and attempt to resolve the dispute directly. If the reporting entity fails to respond or responds unsatisfactorily, the individual can elevate the case to “dispute resolution.” In dispute resolution, HRSA will review and determine whether the information is accurate and reportable to the NPDB. If the information is inaccurate, HRSA will direct the reporting entity to revise or void the report.

While NPDB was established to improve health care quality, protect the public from incompetent providers, and reduce health care fraud and abuse, HRSA needs to provide clarification to stop unnecessary reporting to the NPDB when the physician’s conduct or competency in question is not related to the health or welfare of a patient. Unnecessary reporting is damaging to a physician’s reputation, employment status, hospital medical staff privileges, and future employment opportunities. Specifically, AMA policy shows concerns regarding unnecessary reporting of medical liability payments and medical staff appointment denials.

Reporting of Malpractice Payments

The NPDB requires medical malpractice payers to report medical malpractice payments. The payment is for the benefit of a health care provider in settlement of a written claim or judgment for medical malpractice against that practitioner. A payment made as a result of a suit or claim solely against an entity (e.g., hospital) that does not identify an individual practitioner should not be reported to the NPDB. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. A medical malpractice payer also reports a supervisory practitioner that is named in a complaint based on the actions of a subordinate practitioner (e.g., resident, student).

The written complaint or claim must be based on a provider’s provision of or failure to provide health care services. However, the NPDB statute, regulation, guidebook, or FAQs do not further define “provision of or failure to provide health care services.” Without any further clarification from HRSA, malpractice payers are reporting instances to the NPDB where the physician serves in an administrative only capacity and has no direct contact or relationship with the plaintiff that is demanding payment. In these instances, physicians are not providing health care services or

failing to provide health care services. Therefore, these payments should not be reported to the NPDB because NPDB's statutes and regulations limit the filing of medical malpractice reports based on whether a physician provided or failed to provide health care services.

Reporting Medical Staff Appointment Denials

The NPDB requires hospitals and other health care entities to report adverse clinical privileges actions. An adverse action includes any professional review action that adversely affects the clinical privileges of a physician for a period of more than 30 days. It also includes the acceptance of the surrender or restriction of clinical privileges while the physician is under investigation relating to possible incompetence or unprofessional conduct or when the surrender occurs in lieu of conducting an investigation. Clinical privileges include privileges, medical staff membership, and other circumstances in which a physician is permitted to furnish medical care by a health care entity. Thus, a medical staff denial is a type of clinical privilege.

Adverse clinical privileges actions are based on a physician's competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Whether an action affects or could affect patient health or welfare is generally a determination that must be made by the hospital or other entity taking the action. If, in the opinion of the entity, the provider's actions could adversely affect the health or welfare of a patient, and the action is the result of a professional review, the action must be reported to the NPDB. Potential actions include lying on an application, not completing medical records, outbursts of anger, throwing charts and instruments in the operating room, and cutting and pasting notes and lab results from one patient's electronic health record (EHR) to another patient's EHR.⁶

Administrative actions that do not involve a professional review action should not be reported to the NPDB. Thus, if an individual is denied clinical privileges because the individual failed to meet a hospital's established threshold criteria (e.g., board certification), the hospital should not report this action to the NPDB. Furthermore, matters not related to the professional competence or professional conduct of a practitioner should not be reported. For example, adverse actions based primarily on a practitioner's advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

While the NPDB Guidebook states that actions that do not involve a professional review action should not be reported, physicians are still being reported based on administrative and eligibility reviews. HRSA needs to provide further clarification as to what constitutes a professional review action and what constitutes an administrative or eligibility-based action. In addition, although HRSA states that it is the opinion of the reporting entity as to whether an action affects or could affect patient health or welfare, it would be beneficial to both reporting entities and health care providers to state factors that a hospital should consider in making this determination.

AMA OUTREACH WITH HRSA

AMA has consistently reached out to HRSA involving the NPDB, including proposed rule and guidebook comments.⁷ Because of the duplicative reports and often misleading information that can be found in the NPDB, previous correspondence has helped ensure that the NPDB remains unavailable for public access. Moreover, AMA's comments on the draft guidebook ensured that censures, reprimands, or admonishments are not reported to the NPDB. Furthermore, AMA advocacy led to inclusion of the following language in the 2015 revision to the NPDB guidebook: "Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services."

In August 2017, the AMA sent a letter to HRSA seeking clarification regarding malpractice payments and medical staff appointment denials and reiterating concerns surrounding the surrendering of clinical privileges while a provider is unaware of an ongoing investigation.⁸ The letter also requests a meeting between AMA and HRSA to discuss these issues. While Policy D-355.996 suggests that the AMA also seek potential legislation, advocating for a legislative change would provide an opportunity for some members of Congress and other groups to open the NPDB to the general public. Your Board believes a more prudent and practical approach is to continue to work with HRSA to provide the necessary clarifications for reporting to the NPDB.

CONCLUSION

As of the date this report was drafted, HRSA has not responded to AMA's request for a meeting. The AMA will continue to urge HRSA to provide clarification and potentially remove individuals who were improperly reported to the NPDB.

REFERENCES

1. 42 U.S.C. 11101 et seq.
2. Section 1921 of the Social Security Act as amended by section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93, and as amended by the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508.
3. 42 U.S.C. 1320a-7e as added by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
4. Section 6403 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148.
5. 75 Fed. Reg. 4656 (Jan. 28, 2010).
6. HRSA, *NPDB Guidebook*, pp. E-42, E-44, E-45, E-49, E-52 (Apr. 2015).
7. Comment Letter from AMA to HRSA, *Notice of Proposed Rulemaking Concerning Privacy Act; Exempt Record System*, Apr. 18, 2011; Letter from AMA to HRSA; *The National Practitioner Data Bank Public Data File*, Sept. 23, 2011; Comment Letter from AMA to HRSA, *Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank*, Apr. 16, 2012; Comment Letter from AMA to HRSA, *Draft Revised Guidebook for the National Practitioner Data Bank*; Jan. 31, 2014; Comment Letter from AMA to HRSA, *National Practitioner Data Bank Surrendering of Privileges*, Nov. 8, 2016.
8. Letter from AMA to HRSA, *NPDB Clarification on Medical Malpractice Payments and Adverse Clinical Privileges Actions*, August 3, 2017.

APPENDIX – CURRENT AMA POLICY

Policy H-355.976, "National Practitioner Data Bank"

1. Our AMA believes that (A) the National Practitioner Data Bank requirements should be modified so that settlements and judgments of less than \$30,000 are not reported or recorded; (B) reports, other than licensure revocation, in the Data Bank should be purged after five years; (C) proctoring of physicians for the purpose of investigation should not be reportable; (D) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank; and (E) any physician's statement included in the Data Bank file should automatically accompany any adverse report about that physician in distributions from the Data Bank.
2. Our AMA will (a) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; and (b) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners.
3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee.
4. Our AMA supports using all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail return receipt requested, and supports using all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the sixty day appeal process from the date the physician receives notification.
5. Our AMA will work with the appropriate federal agencies to ensure that the National Practitioner Data Bank reflects all disciplinary actions on appeal, and to remove from the physician's record reported decisions which have been overruled.
6. Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians.
7. Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians' provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.

Policy H-355.975, "Opposition to the National Practitioner Data Bank"

1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.
2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank.

3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office.
4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.
5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;
6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.
8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.

Policy H-355.990, "National Practitioner Data Bank"

- (1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB).
- (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than \$30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992.
- (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.

Policy H-355.974, "National Practitioner Data Bank"

1. Our AMA will advocate to the Health Resources and Services Administration that a physician's surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.
2. Our AMA: (a) recommends that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and (b) include this recommendation in our AMA Physician's Guide to Medical Staff Organization Bylaws.

5. EFFECTIVE PEER REVIEW

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policy H-225.942, H-375.962 and D-375.986

INTRODUCTION

At the 2016 Interim Meeting, the House of Delegates adopted Policy D-375.987, “Effective Peer Review.”

[o]ur AMA study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by physicians and to consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review.

Testimony spoke of the increasing number of physicians who are employed by, or affiliated with, large hospital systems or healthcare organizations, where physicians are concerned that they exert less and less control over their employment and/or practice situations and patient care. As a result, having effective, legitimate peer review processes in place is vital to safeguarding patient care and safety. Further, physicians in the peer review process need protection from retaliation by hospitals and other lay organizations that might be at odds with the role, actions, or decisions taken by those participants. Although the amended language above was originally contained in a resolution, the House of Delegates adopted this language as a “Directive to Take Action.” This report responds to the study requested by AMA Policy D-375.987.

DISCUSSION

AMA Definition of Peer Review

AMA [Policy H-375.962](#), “Legal Protections for Peer Review,” defines peer review, in part, as:

... the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice.... Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care...

Because peer review can involve close scrutiny of all aspects of patient care and safety, both with respect to organization-wide patient care and safety issues and issues concerning individual physicians and health care practitioners, the peer review process may bring to light serious patient care and safety issues that are systemic to a hospital or other lay organization. Exposure of such issues could damage the hospital’s or organization’s reputation in its community or its other business interests. Consequently, a physician may be reluctant to participate in a peer review proceeding for fear of retaliation if the physician believes that the hospital or lay organization will take issue with the result of, or the physician’s role in, that proceeding. This fear is exacerbated if the hospital or lay organization dominates the physician’s community. Thus, to ensure effective peer review, physician peer review participants must be protected from the possibility of retaliation.

Market Developments: Physician Employment by Hospitals and Non-physician Entities and Increasing Hospital Consolidation

Physician concerns about retaliation against physician peer review participants have grown as hospitals employ more physicians and hospital markets become more concentrated. Many communities in the United States are dominated by only a few hospitals, or even by a single hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or other powerful lay organizations, some physicians increasingly fear retaliation for expressing patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer review process, that the hospital or organization perceives as being contrary to its financial interests. For employed

physicians, employment contract termination may be the greatest concern, since termination may have an immediate and detrimental effect on the physician's ability to continue practicing medicine in the community, e.g., if the termination triggers a broad restrictive covenant.

Independent physicians may also fear retaliation. Although retaliation against an independent physician would not involve employment termination, retaliation could take other forms, e.g., ending other kinds of contracts with the physician, such as a medical directorship or co-management agreement; attempting to reduce or withdraw the physician's clinical privileges; manipulating call, surgery, or procedure scheduling; or any other myriad means of making it difficult, if not impossible, to fully and freely utilize hospital facilities and staff. If the hospital dominates the physician's community, these kinds of retaliatory conduct could make it difficult, if not impossible, for even an independent physician to maintain his or her medical practice in the community.

Peer Review Immunity under Federal Law: The Health Care Quality Improvement Act of 1986

The Health Care Quality Improvement Act of 1986 (HCQIA), promotes peer review by immunizing¹ those who participate in the peer review process from damages.² This immunity applies if a decision by a professional review body, e.g., a decision to revoke hospital privileges, is made using the following standards:

1. In the reasonable belief that the action was in the furtherance of quality health care;
2. After a reasonable effort to obtain the facts of the matter;
3. After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).³

Decisions made by a peer review body are presumed to have met standards (1) through (4) above, although this presumption may be rebutted by a preponderance of the evidence.⁴

HCQIA was enacted over 30 years ago, when most physicians practiced independently and hospital markets were not nearly as concentrated as they are today. HCQIA immunity is designed to protect peer reviewers and others who participate in the peer review process, e.g., those who provide information to peer review committees, from damage awards that might result from lawsuits filed by individuals who have been adversely affected by peer review decisions. HCQIA does not explicitly limit immunity from damages solely to lawsuits brought by adversely affected physicians. Consequently, it is possible that a court could interpret HCQIA immunity to extend to damages resulting from lawsuits filed by other parties, e.g., a hospital. However, court decisions have up to this point focused on damage claims by adversely affected physicians, so it is unclear if, and how, HCQIA immunity would apply in the context of lawsuits filed by other parties. Likely a greater concern within the context of AMA Policy D-375.987 is that HCQIA immunity applies when a lawsuit is involved. Consequently, immunity would seem not to apply to a wide variety of retaliatory actions that a hospital or other lay organization might take against a peer reviewer, for example, terminating an employment agreement or hindering an independent physician's ability to fully and freely utilize hospital facilities or practice amenably in association with other physicians employed by, or affiliated with, the hospital or organization.

Amending HCQIA

Although it is possible that an attempt could be made to amend HCQIA to pursue the goals of AMA Policy D-375.987 your Board of Trustees does not, at this time, recommend attempting to amend HCQIA to address a peer review-related retaliation. First, Congressional attention is entirely taken up with a backlog of urgent "must pass" legislation. In this challenging and rapidly changing environment, it would be extremely difficult to draw Congressional attention to yet another major piece of health care legislation, particularly since amending HCQIA has not in recent years been an issue with which Congress has been actively interested. Second, pursuing a HCQIA amendment strategy at this time could have significant, negative unintended consequences, especially with respect to the National Practitioner Data Bank (NPDB). The enactment of HCQIA created the NPDB. In the past, some parties, whose interests are not aligned with those of organized medicine, have strongly urged Congress to amend HCQIA so that the information in the NPDB would be publicly available. Our AMA opposes such efforts. In fact, AMA Policy [H-355.976](#), "National Practitioner Data Bank," states in part:

... 3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee...

Our AMA has taken this position because information in the NPDB is often incomplete and inaccurate, not organized in a way that patients will understand, and is thus highly likely to be misunderstood or misinterpreted by patients. For these reasons, then, your Board of Trustees does not recommend attempting to amend HCQIA. However, while your Board does not believe that pursuing a HCQIA amendment would be appropriate at this time, your Board feels strongly that our AMA should provide assistance to any state medical association or national medical specialty society that wants to explore or pursue a state legislative strategy to protect physician peer review participants from retaliation.

Peer Review Immunity under State Law

The vast majority, if not all, states, have enacted peer review immunity laws. The conditions for immunity are usually less demanding or specific compared to HCQIA's. HCQIA immunity is available only if a decision by a peer review body satisfies standards (1) through (4) above. Under most state peer review laws, immunity is available to peer review participants who act in good faith.⁵ State peer review immunity extends to damages. In some circumstances, states go further, immunizing peer review participants from civil liability generally, which would also protect peer review participants from injunctions.⁶

State peer review laws are designed to protect peer review participants from lawsuits by physicians or health care practitioners who feel that they have been aggrieved by a peer review decision. In many states, immunity protections may not be explicitly limited to lawsuits filed by these individuals. In such cases, like HCQIA, it is uncertain if, or to what extent, immunity would apply if a party other than the individual adversely affected by a peer review decision filed a lawsuit against one or more peer review participants. However, the more important issue with respect to AMA Policy D-375.987 is that, like HCQIA, state peer review immunity protections apply to lawsuits. Consequently, state peer review laws would likely not protect physician peer review participants from the gamut of retaliatory actions short of a lawsuit that might be taken against them for their role in, or a decision resulting from, a peer review proceeding.

Unlike HCQIA, most, if not all, states protect the confidentiality of peer review information. This means that peer review information, documents and records cannot lawfully be disclosed to anyone except those conducting the peer review and any other specific individuals or entities identified in the peer review statute. Similarly, states often privilege peer review information, documents and records of peer review proceedings, meaning that such information, documents and records are not admissible in lawsuits, such as those involving medical liability allegations.

State Court Decisions

Although state court decisions involving state peer review statutes have focused on lawsuits by persons adversely affected by a peer review decision, there is a reported case that does involve a situation where a hospital retaliated against a peer review participant. The New Mexico Supreme Court case of Yedidag, MD, v. Roswell Clinic Corp., 346 P.3d 1136 (2015) involved Emre Yedidag, MD, a surgeon employed by Eastern Medical Center (EMC) and his alleged conduct during a peer review proceeding. The proceeding focused on another physician's role in a patient death. During the proceeding, Dr. Yedidag asked the physician a number of pointed questions to clarify the circumstances of the patient's death, some of which the physician refused to answer.⁷ A staff assistant to the peer review committee, who was not a committee member, attended the meeting and later told hospital administration that Dr. Yedidag's questioning had been inappropriately aggressive (even though physician peer review committee members found nothing untoward about Dr. Yedidag's conduct).⁸ EMC subsequently fired Dr. Yedidag because of alleged "unprofessional behavior."⁹ Dr. Yedidag sued EMC, claiming that EMC violated New Mexico's peer review law. The New Mexico Supreme Court sided with Dr. Yedidag. The Court recognized that the New Mexico peer review law did not "explicitly preclude employer retaliation for peer review participation."¹⁰ Nor did the statute explicitly authorize Dr. Yedidag to file a lawsuit for violations of the peer review law. However, the law did protect the confidentiality of peer review information. The law also permitted use and disclosure of such information only for specific reasons listed in the statute, and those reasons did not include the hospital's acquisition and use of peer

review information as part of its personnel decisions. Consequently, the Court ruled that the hospital violated Dr. Yedidag's right to confidentiality under New Mexico's peer review law.

Although Dr. Yedidag won his lawsuit, this decision does not sufficiently address the issues raised by D-375.987. First, the Yedidag case is a single decision under one state's law. Although most, if not all, states protect the confidentiality of peer review information, state laws can vary significantly in the scope of this protection. There is, therefore, no guarantee that other states would reach the same result. Second, hospitals and other lay organizations do not necessarily need access to confidential peer review information to retaliate against peer review participants. Thus, even if all states ultimately followed the Yedidag decision, doing so would probably not cover all of the instances in which a hospital or other lay organization could retaliate against a physician peer review participant. Consequently, physician advocates wanting to address the issues identified by D-375.987 may want to explore or pursue a state-based legislative strategy to ensure that physician peer review participants are protected from all forms of retaliation.

State Legislative Efforts to Protect Physician Peer Review Participants from Retaliation

While it is extremely unlikely that HCQIA could be successfully amended at this time, the prospects of amending a particular state's laws might be more promising. Your Board of Trustees understands the serious concerns that AMA Policy D-375.987 raises. Your Board believes, therefore, that our AMA should make its Advocacy Resource Center staff and resources available to assist state medical associations and national medical specialty societies that may be interested in considering or pursuing a state legislative strategy to protect physician peer review participants from any retaliatory conduct by hospitals, lay organizations or other parties.

AMA Policy

AMA policies call for retaliation protections. The following is a list of relevant portions of AMA policies. First, AMA Policy [H-225.950](#), "Principles for Physician Employment," states, in part, that:

... 1.b. [e]mployed 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...

Next, AMA Policy [H-225.952](#), "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs," states that:

[o]ur AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights.

Further, AMA Policy [H-230.965](#), "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators," states that:

[t]he AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics.

AMA Policy [H-225.942](#), "Physician and Medical Staff Member Bill of Rights," asserts, in part, that:

... II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities: ... b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body...

AMA Policy [H-225.942](#) also contains the following:

... IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization: ... c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body...

In addition, AMA Policy [H-225.957](#), "Principles for Strengthening the Physician-Hospital Relationship," states that:

... 6. The organized medical staff has inherent rights of self-governance, which include but are not limited to: ... c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter...

Finally, it is notable that our AMA also has policies calling for peer review immunity, two of which are most relevant to this report. First, AMA Policy [H-375.962](#), "Legal Protections for Peer Review," states, in part, as follows:

... Peer Review Immunity. To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability...

Likewise, AMA Policy [H-225.942](#), "Physician and Medical Staff Member Bill of Rights," states, in part, that the rights of individual medical staff members must include: "... f. The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities..."

Although protection from any kind of retaliation because of peer review participation might be implied from AMA policies, AMA policies do not explicitly call for such protection in the context of peer review participation. This report, therefore, recommends amending AMA Policies H-225.942 and H-375.962 to explicitly include protection from any retaliatory conduct.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted per AMA Policy D-375.987, and that the remainder of the report be filed:

1. That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition as follows:

... IV. f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

2. That AMA Policy H-375.962, "Legal Protections for Peer Review," be amended by addition as follows:

... Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in good faith peer review activities.

3. That our AMA will provide guidance, consultation and model legislation concerning protections from retaliation for physician peer review participants, upon request of state medical associations and national medical specialty societies.

REFERENCES

1. Unlike state peer review laws, HCQIA does not address the confidentiality of peer review information or records of peer review proceedings. Nor does HCQIA address the issue of whether, or to what extent, peer review information, documents, or records may be admitted into lawsuits or administrative proceedings. The Confidentiality and admission of peer review information is determined by courts on a case-by-case basis.
2. See 42 U.S.C. §§ 11101, et seq.
3. 42 U.S. Code § 11112(a)
4. *Id.*
5. See e.g., Rev. Code of Wash. § 4.24.240.
6. *Id.*
7. Yedidag, at 1143.
8. *Id.* at 1143-1144.
9. *Id.* at 1144.
10. *Id.* at 1151.

APPENDIX

D-235.984, “Medical Staff Non-Punitive Reporting Processes”

Our AMA will provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

H-285.910, “The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community”

Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician’s right or ability to advocate on behalf of patients’ interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician’s exercise of his/her rights under this paragraph.

6. ELECTRONICALLY PRESCRIBED CONTROLLED SUBSTANCES WITHOUT ADDED PROCESSES (RESOLUTION 216-A-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 216-A-17 REMAINDER OF REPORT FILED

See Policy H-120.957, D-120.956 and D-120.958

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 216-A-17, “Electronically Prescribed Controlled Substances without Added Processes,” was referred for report at the 2017 Interim Meeting. Resolution 216-A-17, sponsored by the Illinois Delegation Association, asks our American Medical Association (AMA) to advocate for full electronic prescribing of all prescriptions, without additional cumbersome electronic verification, including Schedule II-V controlled substances, eliminating the need for “wet signed” paper prescriptions and faxes for specific classes of prescriptions. The reference committee heard testimony strongly supportive of the intent of Resolution 216. The reference committee noted that current Drug Enforcement Administration (DEA) requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as

fingerprint readers on laptop computers and mobile phones, from being used for two-factor authentication in Electronically Prescribed Controlled Substances (EPCS). The reference committee acknowledged the frustration heard in testimony regarding how two-factor authentication and other rules contribute to cumbersome workflows and applications and noted that EPCS uptake is slow precisely due to these barriers. The reference committee also heard testimony that our AMA continues to have discussions with key stakeholders to work toward improving the integration of EPCS and the interoperability of Prescription Drug Monitoring Programs (PDMP) and electronic health records into practice workflows and clinical decision-making. The reference committee noted that our AMA has made and continues to make these points at both the federal and state levels.

AMA POLICY

Current AMA policy provides:

Policy D-120.956, “Electronic Prescribing and Conflicting Federal Guidelines”

Our American Medical Association will address with the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration the contradictory guidance, issued respectively by those two federal agencies, relating to electronic transmission of physicians prescriptions to pharmacies—commonly referred to as “e-prescribing”—for Schedules III, IV and V drugs, as those current guidelines add rather than reduce administrative paperwork and defeat the purpose of electronic handling of prescriptions.

Policy D-120.958, “Federal Roadblocks to E-Prescribing”

1. Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form. 2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs. 3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of E-prescribing. 4. Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions. 5. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption. 6. Our AMA will: (A) investigate regulatory barriers to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances; and (B) work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply. 7. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications. 8. Our AMA will petition the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished.

Policy H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission”

Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the confidentiality and integrity of the information. (2) Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic prescriptions should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and nonrepudiation. (3) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, the AMA does not support the use of “hard copy” facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.

DISCUSSION

The barriers to implementation of e-prescribing of controlled substances have been significant, but due to ongoing AMA advocacy a number of impediments have been addressed at the state and federal levels. The current challenge

to streamlining adoption rests primarily with antiquated and burdensome DEA restrictions that the AMA continues to challenge. In addition, federal Medicaid regulations also drive state law impediments to electronic prescribing.

State Laws

All states allow electronic prescribing of controlled substances, and three go so far as to actively mandate it. New York mandated use of electronic prescribing of all prescriptions as of March 27, 2016. Maine's mandate for e-prescribing of controlled substances went into effect July 1, 2017. Virginia's EPCS mandate, which does not go into effect until July 1, 2020, is limited to drugs containing opiates. Both New York and Virginia allow prescribers to apply for waivers. Also, at the time this report was drafted, several other states are considering legislation to mandate EPCS. However, in order for prescriptions to be reimbursable by Medicaid, a physician must certify in his or her own handwriting that a specific brand is medically necessary for a particular recipient. The state requirements are mandated by federal regulations. The state Medicaid programs must decide what certification form and procedure are used. Federal regulations provide that a checkoff box on a form is not acceptable, but a notation like "brand necessary" is allowable. Thus, there are state laws that require specifying "brand necessary," particularly for Medicaid patients, and must be done in a physician's handwriting.

Centers for Medicare & Medicaid Services (CMS)

CMS does not currently have a role in regulating EPCS. Beginning in 2009 there was a Medicare e-prescribing incentive program, but 2013 was the final program year for participating and reporting in this program. In addition, the CMS e-prescribing incentive program exempted EPCS, so controlled substance prescriptions were not an issue. CMS does have oversight responsibility for the Medicare Part D prescription drug benefit program, and it requires all Part D plan sponsors to support e-prescribing. Instead of developing its own e-prescribing standards, CMS adopted the standards developed by the National Council for Prescription Drug Programs (NCPDP), most recently the NCPDP Formulary and Benefits 3.0 transaction standards. In addition, CMS does have oversight of the Medicaid program, and as discussed above, federal regulations that require physicians to submit handwritten statements when a substitution is not permitted represent a barrier to electronic prescribing without a legitimate justification, as the information could be efficiently and securely transmitted through electronic prescribing.

U.S. Drug Enforcement Administration

The AMA continues concerted engagement to address barriers to e-prescribing of controlled substances due to overly burdensome DEA regulations. In 2010, the AMA provided comments as part of the DEA's rulemaking process and raised concerns with a number of regulations and requirements that should be modified to facilitate widespread e-prescribing of controlled substances. More recently, the AMA again met with the DEA and reinforced and expanded on those recommendations that would enhance security (and decrease diversion) while streamlining the administrative burden. The AMA noted that many physicians have reported that a well-designed electronic medication prescription (eRx) system adds value to their practice of medicine and supports better patient care. The AMA stated that improving on the utility of EPCS to match that of current eRx capabilities will benefit physicians and patients alike. The AMA communicated the points below.

Two-factor authentication. While authentication through a combination of personal identification numbers (PINs), passwords, and biometrics increases the security of EPCS, it also contributes to frequent workflow disruptions and increases costs for many physicians. An AMA survey found that primary care physicians write up to 100 prescriptions per day. Other specialists usually write an average of 10 to 25 prescriptions per day. This volume of prescriptions makes compliance with two-factor authentication, particularly as a distinct process from e-prescribing of non-controlled substances onerous and a significant strain on practice workflows. Few health information technology (health IT) vendors currently support EPCS, and those that do often require physicians to purchase add-on modules or pay separate monthly service fees outside those of normal product maintenance. In speaking with many DEA-registered physicians, the AMA has found that many methods and processes health IT vendors utilize for EPCS are not well-aligned with normal eRx workflows. In most instances, physicians must initiate an entirely new set of computer programs and windows each time they wish to use EPCS. The AMA shared with the DEA that cumbersome workflows and applications that do not take physician needs into account are the primary impediment to physician EPCS uptake and should be squarely addressed by system designers and product implementers. The DEA requirement that biometric devices comply with Federal Information Processing Standards (FIPS) compounds this problem by limiting many user-friendly consumer electronics already found in physicians' offices from being

utilized. The AMA asked that the DEA reexamine the scope of technology that is compliant with EPCS requirements and allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.

Identity proofing. For individual physicians in private practice, identity proofing (verifying that the authenticated user is who he/she claims to be) must occur by an authorized third party that will, after verifying the physician's identity, issue the authentication credential to the DEA registrant. The current identity proofing process is complex and must be performed for each location a physician wishes to employ EPCS. The AMA recommended that the DEA allow a physician's hospital credentialing to be used for his or her EPCS identity proofing instead of requiring a separate process for EPCS. The AMA also suggested that DEA engage with initiatives like the Administration's National Strategy for Trusted Identities in Cyberspace federated identity management program. Current regulations further require that, once the authentication credential has been issued to the DEA-registered physician, logical access controls must be established to verify that the authenticated user has the authority to perform the requested operation. The AMA communicated to the DEA that there is not a rational basis for requiring two-person access controls for EPCS on top of the other requirements and the AMA recommended that it be eliminated.

Audit requirements. The current DEA regulation provides that any person designated to set logical access controls is responsible for determining whether any identified auditable event represents a security incident that compromised or could have compromised the integrity of the prescription records (e.g., an unauthorized person attempting to sign or alter a prescription would be an auditable event; a pharmacist annotating a record to indicate a change to a generic version of a drug would not be). EPCS applications must run the internal audit function daily to identify any auditable events. When one occurs, the application must generate a readable report for the physician or pharmacist. If a physician or pharmacy determines that there is a potential security problem, it must be reported to the DEA within one business day. The AMA shared with the DEA that the one day requirement for physicians to report a compromised authentication protocol is impractical. Longer reporting timeframes, such as those required for HIPAA breaches, can be used as a precedent for revising this requirement. Additionally, the AMA urged the DEA to consider how health IT vendors may better support the review of audit logs and reduce the need for manual review by physicians.

PDMP. PDMPs have the promise to be an essential tool for physicians to help prevent drug misuse, diversion, and overdose. Currently, most PDMPs have limited or no ability to connect with and share information to third-party applications. The AMA urged the DEA to work with its state and federal partners to encourage the interoperability of PDMP databases, electronic health records, and other health IT products to improve the integration of data on controlled substance use into practice workflows and physicians' clinical decision-making.

DEA fees and EPCS compliance costs. The AMA pointed out to the DEA that physicians often face excessive costs for complying with EPCS requirements. Many physicians—especially those in small and solo practices—face high fees associated with the extensive technical, security, and other standard requirements (e.g., costs for identity proofing, access control training and the setting of access controls, hardware, software or application purchase and maintenance, reprogramming, and audit requirements), along with workflow adjustments needed for EPCS. In addition to the costs of compliance with EPCS, there are also monthly fees levied by health IT vendors. These fees and costs pose a significant barrier to EPCS adoption. As DEA registration fees (\$731 for three years) are set to cover the costs of its diversion control program and a major purpose of EPCS is to lower the risk of drug diversion, the AMA urged the DEA to consider reducing registration fees for those who employ EPCS.

Clearer guidance. The AMA also shared with the DEA that the current regulations are difficult to comprehend. The AMA strongly urged the DEA to provide clarity and simplified guidance, including examples, to help physicians understand exactly what is required of them for EPCS compliance.

Recent Efforts

The AMA met with Surescripts, a health information network that connects health information technology (electronic health records, pharmacy systems) used by pharmacies, health care providers, and benefit managers, because Surescripts is often cited as one of the best examples of interoperability in the health care industry today. One of the meetings focused on EPCS where AMA staff reviewed the recommendations submitted to the DEA outlined above. Surescripts noted general agreement with the AMA concerns and AMA suggested solutions. More recently, on May 18, 2017, the AMA submitted comments to the President's Commission on Combating Drug

Addiction and the Opioid Crisis. The AMA again reiterated that the DEA requirements for biometric devices limit user-friendly consumer electronics already found in physicians' offices, such as fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor authentication in EPCS. The AMA noted that this and other rules contribute to cumbersome workflows and applications that do not take physician needs into account, which are an impediment to physician EPCS uptake. Furthermore, the AMA stated that encouraging EPCS uptake and interoperability of PDMP databases and electronic health records would improve the integration of controlled substance use data into practice workflows and clinical decision-making. AMA staff are preparing to follow-up directly with DEA.

CONCLUSION

During consideration of Resolution 216 there was consensus that it raised legitimate concerns. On the other hand, there was testimony in the reference committee urging reaffirmation of existing policy. In addition, during the HOD's consideration of the resolution and reference committee recommendation, a number of delegates noted that current AMA policy, while largely still relevant, should be updated.

RECOMMENDATIONS

The Board of Trustees recommends that the following policies be amended in lieu of Resolution 216-A-17 and the remainder of the report be filed.

1. That current AMA Policy D-120-956, "Electronic Prescribing and Conflicting Federal Guidelines,"
Our American Medical Association will continue to advocate before relevant federal and state agencies and legislative bodies for the elimination of address with the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration the contradictory cumbersome, confusing, and burdensome requirements guidance, issued respectively by those two federal agencies, relating to electronic transmission of physicians' controlled substance prescriptions to pharmacies—commonly referred to as "e-prescribing"—Electronic Prescribing for Controlled Substances (EPCS). This includes for Schedules II, III, IV and V drugs, as those current guidelines add rather than reduce administrative paperwork and defeat the purpose of electronic handling of prescriptions.
2. That current AMA Policy D-120.958, "Federal Roadblocks to E-Prescribing,"
Our AMA will initiate discussions work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, "brand medically necessary" or the equivalent on a paper prescription form.
~~2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs.~~
 3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of eE-prescribing.
 34. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.
 45. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.
 56. Our AMA will: (A) investigate work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances; and (B) work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply.
 67. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.
 78. Our AMA will petition work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished.

3. That current AMA Policy H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission,”

Our AMA: (1) encourages the Drug Enforcement Administration to ~~rewrite Section 1306 of Title 21 of the Code of Federal Regulations to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the confidentiality and integrity of the information.~~ (2) ~~Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic using prescriptions should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and.~~ (23) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, ~~the AMA~~ does not support the use of “hard copy” facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.

7. MEDICAL REPORTING FOR SAFETY-SENSITIVE POSITIONS (RESOLUTION 14-A-16)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

Board of Trustees Report 8-I-16, “Medical Reporting for Safety Sensitive Positions,” which sought to address Resolution 14-A-16 of the same title, was referred at the 2016 Interim Meeting of the AMA House of Delegates. Testimony indicated that the report content missed the resolution’s original intent. Although there are systems in place to screen pilots and others in safety sensitive positions for serious medical conditions, it was stated that these patients often look for medical care outside of these systems, and subsequently fail to be reported.

The Board of Trustees conferred with the authors to clarify the intent of Resolution 14-A-16. This report alerts physicians that they may have new responsibilities as a result of changes in regulations of the Federal Aviation Administration (FAA) regarding medical certification of pilots. It addresses the implications of these changes for pilot and public safety.

BACKGROUND

Effective May 1, 2017, pilots of certain small aircraft may elect to participate in the FAA’s new “BasicMed” program, which allows any licensed physician to evaluate a pilot’s medical fitness to fly. If pilots meet conditions for participating in BasicMed, they are no longer *required* to obtain third class medical certification specifically from an FAA-designated Aviation Medical Examiner (AME) [1]. Pilots in the designated category may continue to seek third class medical certification from an aviation medical examiner if they choose.

To be eligible for privileges in BasicMed, pilots must have a valid U.S. driver’s license, have held third class medical certification at some time since July 15, 2006 (which must not have been revoked, suspended or withdrawn), and not have been denied third class certification on their most recent application [2]. The individual must have documented completion of an FAA-approved online medical education course within the past 24 months; have had a physical examination by a licensed physician, who reviewed the FAA’s Comprehensive Medical Examination Checklist completed by the patient, within the past 48 months; and must consent to a National Driver Register check.

Individuals who have a medical history or clinical diagnosis of personality disorder repeatedly manifested by overt acts, psychosis, bipolar disorder, or substance dependence (within the previous two years) must obtain a “special issuance medical certification” from an aviation medical examiner before they may exercise privileges under BasicMed [2]. Similarly, a history or diagnosis of epilepsy or disturbance of consciousness or transient loss of control of nervous system function absent satisfactory medical explanation of cause entails that the individual obtain a special issuance medical certification before he or she may exercise privileges under BasicMed. Further these individuals must be under the care of a physician for the condition.

Individuals are prohibited from exercising privileges under BasicMed if their driver's license has been revoked as a result of the diagnosed condition or if, "in the judgment of the individual's state-licensed physician," the individual is unable or "may reasonably be expected to be unable" to safely exercise those privileges as a result of the condition [2].

PILOT SAFETY — PUBLIC SAFETY

The goal of medical certification, for all classes of pilots, is to ensure public safety. Recent aviation incidents, notably the crash of Germanwings Flight 9525 in 2015, which killed 150 passengers and crew, have raised questions about whether oversight of pilots' medical status and safety to fly is sufficiently rigorous. FAA requirements covering pilots who fly for commercial airlines, i.e., who hold transport pilot certification, or those who hold commercial pilot certification and may fly for hire, are not affected by the regulatory changes that created BasicMed. Even under the more stringent standards governing these classes of pilots there is concern that pilots with potentially impairing medical conditions may be permitted to fly when they are in fact unsafe [3]. These questions form the backdrop to challenges that BasicMed poses for physicians in the U.S.

Medical Certification of Aviators

Aviation Medical Examiners are specifically authorized by the FAA to carry out pilot medical examinations for purposes of protecting the public. To become an AME, physicians must apply to and complete training developed by the Aerospace Medical Education Division of the FAA Civil Aerospace Medical Institute [4]. Prospective AMEs are required to complete online course work as well as four and a half days of in-person training and to complete refresher training every 36 months [4]. Among other objectives, in-person training is intended to:

- Review the latest medical and technical information and clinical examination techniques in the various medical specialty fields that an AME will need to use to assure that aviators meet the medical certification standards for the class of aviator medical certificate applied for [and]
- Recognize the basis for disqualification of the aviator with a medical problem and the conditions necessitating deferral or denial as outlined in Federal Aviation Regulations [5]

In 2012, the Aerospace Medical Association Ad Hoc Working Group on Pilot Mental Health noted that "serious mental health issues involving sudden psychosis are relatively rare, and their onset is difficult to predict," but that "more attention should be given to mental health issues during the aeromedical assessment of pilots" [6]. The group recommended that "physicians performing aeromedical assessments receive additional periodic training in aviation mental health issues" [6]. In a letter to the FAA of September 2015 following the report on the Germanwings incident, the working group reiterated its recommendation that more attention be given "to less serious and more common mental health conditions," including grief, psychosocial stress, depression, anxiety, panic disorders, personality disorders, and substance misuse/abuse, noting that these conditions "show patterns that facilitate early detection, and have proven effective treatment strategies" [6,7].

The working group also reiterated and expanded on its previous recommendation to create a "safe zone" to encourage frank discussion of mental health issues [6], urging that "methods be used to build rapport and trust with the pilot in a nonthreatening environment" [7]. It also more explicitly identified barriers to frank discussion, noting that pilots are "highly independent, value control, and fear losing their medical certification." The 2015 guidelines reiterated the call for additional training in aviation mental health issues for physicians who conduct aeromedical assessments, and called for training to include guidance for when the aeromedical examiner should consult with or refer the pilot to "a mental health specialist provider or other aeromedical resource."

The Challenge for Non-AME Physicians

When AMEs who are under contract to commercial air carriers or other commercial entities conduct examinations of pilot-employees, they are required to report their findings to the pilot's employer as well as to the FAA. When they conduct examinations of aviator applicants independently (i.e., not while under contract to the employer), AMEs must report all findings to the FAA without fail. In the latter situation, individuals who do not receive medical certification are expected to voluntarily refrain from piloting aircraft pending further evaluation by FAA medical experts. On a few occasions the aviator applicants are permanently restricted from medical certification and cannot legally fly any aircraft.

A pilot exercising the privileges of BasicMed may be examined by any physician licensed by any U.S. state, territory or possession. The physician is required to report potentially impairing conditions in keeping with state regulations governing the issuance of motor vehicle licenses. The examining physician must review the individual's completed FAA Comprehensive Medical Examination Checklist with the pilot, but is not required to report to the FAA.

Questions have been raised about how well this process protects both pilots and the public interest. Non-AME physicians may not be adequately prepared to fulfill this new responsibility. Non-AME physicians need to be made aware of the responsibility itself and of resources available to them, including consulting with or referring a patient to a regional Aviation Medical Examiner.

In addition, laws governing reporting of medical conditions that may impair an individual's ability to operate a motor vehicle safely vary from state to state. Whether pilots who are eligible for privileges under BasicMed, but may be impaired, present a greater risk to safety than drivers who may be impaired is not necessarily at issue. What is of concern are data suggesting that even in jurisdictions where physicians are required to report potentially impairing conditions for motor vehicle operators they do not uniformly do so [8].

Confidentiality & Trust

Effective patient-physician relationships require that patients be willing to share sensitive information with their physicians. Patients must be able to trust that information they give to their physicians in confidence will be protected, and physicians have a corresponding duty to protect the confidentiality of patients' personal information [9–12]. Patients who fear the consequences of disclosure, particularly disclosure of stigmatizing conditions, may be reluctant to seek treatment. However, the right to confidentiality is not without limits. In many situations, physicians may be required to breach confidentiality for purposes of protecting the health or safety of the community, as in mandatory reporting of infectious disease to public health authorities or required reporting of potentially impaired drivers [13].

Physicians may also disclose personal health information without patients' consent when in the physician's professional judgment there is a reasonably probability of serious harm to the patient or serious harm to other identifiable individual(s) [15]. Industry-employed physicians and independent medical examiners may likewise disclose to third parties [16]. In all instances, however, physicians are expected to restrict disclosure to the minimum information necessary for the specific purpose at hand and, whenever feasible, to notify the patient in advance of the disclosure.

RECOMMENDATION

In light of these considerations, the Board of Trustees recommends that the following be adopted and the reminder of this report be filed:

1. That our American Medical Association (AMA) promote awareness among all licensed physicians of the safety implications of mental health and other potentially impairing conditions for their patients who are aviator. Physicians need to be aware that for some patients the FAA's BasicMed program now makes the treating physician a gatekeeper for pilot and public safety. Physicians who are not FAA Aviation Medical Examiners should be educated about when to seek guidance from colleagues with aeromedical expertise. Physicians should also recognize that the range of mental health conditions in particular that may compromise an aviator's ability to fly safely is more extensive than the specific conditions identified in the FAA Comprehensive Medical Examination Checklist.
2. That our AMA urge physicians to screen routinely for factors that may compromise pilot safety by the least intrusive means reasonable and take steps with the patient to mitigate identified risks. Physicians should be encouraged to consult with or refer the patient to the appropriate FAA Aviation Medical Examiner or FAA Regional Flight Surgeon.
3. That our AMA advocate for adoption of a uniform mechanism for reporting aviators who have potentially compromising medical conditions.

4. That the Council on Ethical and Judicial Affairs be encouraged to review implications for existing ethics guidance in light of the FAA's alternative requirements for pilot physical examination and education codified in BasicMed.

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8. 2018 STRATEGIC PLAN

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Our AMA continues to execute its multi-year strategy to achieve significant positive impact for physicians, medical students and patients. The strategy, launched in 2013, identified three areas of emphasis in our mission focused areas: 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 is devoted to what is on the horizon for each of the focus areas in 2018 and highlights other work to modernize the means through which physicians can engage in advancement of the mission.

CARE DELIVERY AND PAYMENT: PROFESSIONAL SATISFACTION AND PRACTICE SUSTAINABILITY

With the successful repeal of the sustainable growth rate (SGR) in 2015 through the Medicare and CHIP Reauthorization Act of 2015 (MACRA), our work has refocused--with even greater intensity--to ensure that MACRA's implementation supports a health care system that delivers better care and more visible value while also supporting a sustainable and professionally satisfying practice environment. The 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.

Successful navigation and implementation of evolving public and private payment systems requires heightened physician awareness, informed assessment of options, and, potentially, new strategic and operating methods to optimize success.. To support physicians through this changing landscape and improve care delivery and professional satisfaction, AMA will work in 2018 to:

- Advocate for legislative and regulatory changes that enhance prospects for physicians to succeed.
- Generate awareness and encourage physicians to prepare for evolving payment model changes.
- Provide multi-modal, multi-channel physician education about what new payment model options mean for physicians and patients.
- Guide physicians toward the best outcome in value-based care systems and establish the AMA as a valued source of support on issues spanning a wide range of care delivery and payment models.
- Expand the resources delivered through the STEPS Forward: Practice Improvement Strategies program and other tools to help physicians in a variety of practice settings learn new techniques to improve practice workflow, patient care and professional satisfaction.
- Increase the awareness and importance of professional satisfaction and support the Quadruple Aim through additional research, partnerships, and resources to assist physicians throughout the various settings and stages of their careers.
- Discover and promote the physician perspective across health technology sectors, directing development for improved usability, productive access to data, and respect for the patient-physician relationship.

In addition taking the longer perspective in 2018 AMA will build on its 2017 research and development work to further assess opportunities for diagnostic, prognostic, and predictive tools for patient care that will modernize health and medical information systems to give physicians access to data needed for enhanced clinical, operational, and administrative effectiveness.

IMPROVING HEALTH OUTCOMES (IHO)

Initiatives focused on health outcomes, particularly in the area of prevention and management of chronic care, underscore AMA's foundational commitment to improving the health of the nation. Concentrating on risk factors for cardiovascular disease and type 2 diabetes, our AMA is working with physicians and care teams to bring new approaches for anticipating, preventing, and managing widely prevalent chronic conditions.

To achieve the scale required for this ambitious set of programs, AMA has developed multi-year strategic relationships with the Centers for Disease Control and Prevention (CDC) and the American Heart Association (AHA), whose national reach and influence reinforce and complement AMA resources. Our shared goals with the CDC and the AHA include significantly increasing the number of physician practices, health care systems and federally qualified health centers that:

- Screen patients for prediabetes and refer eligible patients to CDC-recognized diabetes prevention programs (DPPs) as the preferred option for preventing type 2 diabetes, and
- Improve care for patients with hypertension to achieve and sustain 70 percent or higher blood pressure control rates within the communities they serve.

AMA's partnerships with the CDC and AHA are solid and we are complementing them with collaborations with medical societies, business groups, payers, technology companies, and medical schools (through the ACE consortium) to offer evidence-based products, tools and services to support physicians, care teams, health system leaders and medical students in achieving the health outcomes we seek. Materials have been developed and distributed for use in practice settings ranging from small private practices to large integrated systems. The material and programs have been empirically demonstrated to be effective and our main focus is to create the environmental, distribution, and awareness elements conducive to wide spread scaling. In this regard, we continue to define and promote the "business case" for public and private payer coverage of proven interventions such as diabetes prevention programs (for which Medicare announced coverage in 2016) and self-measured blood pressure monitoring devices.

Public and physician awareness is a key ingredient to success. Beginning in 2017 and extending through 2018, we will refresh the successful pre-diabetes public campaign launched in 2016 and add a physician oriented pre-diabetes awareness campaign. A blood pressure awareness program is planned for 2018.

ACCELERATING CHANGE IN MEDICAL EDUCATION (ACE)

Since 2013 the AMA has supported a Consortium of medical schools, now 32 in number, to accelerate change in medical education by creating a system that trains physicians to meet the needs of today's patients and to anticipate future changes. Facilitated by the AMA through individual and collaborative work the consortium schools have created new and innovative programs and technologies that are increasingly adopted by medical schools throughout the nation. Of particular note is the successful application of the chronic care curriculum based on work done in our Improving Health Outcomes area. This is an example of the growing application of work emanating from one strategic area to another critical arena.

Highlights of major plans for 2018 include:

- Ensuring the ongoing viability and maintenance of the Consortium beyond the termination of the AMA funding cycle.
- Building on the AMA Consortium health system science textbook to create a product and service line applicable to all stages of physician and other health care providers' lifelong learning.
- Collaborating with other focus areas on student and trainee wellness; resilience/burnout; and new models for linking students, physicians and communities in shared goals of chronic disease management and health equity.
- Based on the experience and learning from the work in undergraduate medical education, plans will be developed for subsequent work in graduate medical education likely emphasizing the transition from undergraduate to residency status.

ENGAGING PHYSICIANS IN ADVANCEMENT OF THE MISSION

Effective and responsive lifelong physician professional development is a cornerstone to activating the focus area objectives. These objectives and other national imperatives--such as reducing opioid-related harm and increasing access to treatment for patients with opioid use disorders, responding to physician burnout and wellness issues, responding to the quality and cost issues in our health care environment--require AMA to provide physicians and their team members pragmatic educational offerings, tools, and leadership training designed to address real-world practice and care delivery issues.

The AMA's Education Center portal and platform is a crucial component of AMA's commitment to lifelong professional development. New capabilities and an improved user experience were introduced in 2017. The GME Competency Education Program (formerly Introduction to the Practice of Medicine), currently deployed in approximately 150 residency settings across the country, was modernized and incorporated into the Education Center in 2017. As the multi-year effort progresses, our physician stakeholders will have access to educational tools and resources from diverse sources through a highly functional platform tailored to individual needs, accessible from desktops and mobile devices, with streamlined support for transcripts, reporting to boards, employers and payers to serve credentialing, licensing and certification requirements. We anticipate completing the majority of the Education Center refresh in 2018.

Evidence of AMA mission impact continues to grow, creating an opportunity for AMA to refresh its brand identity among physicians and other stakeholders. We will achieve this by linking relevant offerings and activities throughout the career lifecycle of students, residents, and practicing physicians and more refined approaches to identifying and responding to the particular interests and needs of the physician population. The goal is to strengthen the AMA brand through deeper stakeholder engagement. Traditional and interactive/social/digital media will be deployed to create new connections, awareness, and opportunities to interact with the AMA. 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 2018 we will build on our initial experience with social networks and community groups started in 2017 by further refined exploration and integration of this strategy into our overall physician engagement effort.

The three focus areas have made much progress since their inception in 2013. As they have matured and moved from the early stages of innovation and learning to more operative models of impact and scaling we have begun to extend the conceptualization and connection of their work to other important aspects of our AMA's efforts under three general strategic arcs: 1) Vital practice resources; 2) Lifelong professional development; and 3) Improving the health of nation. Closer connection of the focus areas with other critical AMA activities will stimulate more collaborative and synergistic planning and operations enhancing our effectiveness and impact.

The momentum that supports this multi-year strategy is a reflection of collaboration and shared commitment across the AMA and the Federation of medicine, academic institutions, public and private health sector organizations, technology innovators, physicians, and physicians in training. Together we will chart a course for health care delivery that will improve the health of the nation.

9. PARENTAL LEAVE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2016 Interim Meeting of the House of Delegates (HOD), Policy H-405.954, "Parental Leave," was adopted. The policy states the American Medical Association (AMA) will: (1) encourage the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction in the number of employees from 50 employees; (b) an increase in the number of covered weeks from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA expansion on physicians in varied practice environments. This report serves as a summary of the FMLA, proposed expansion of the law and potential for study of the effects of future expansion, with a focus on the effects on physicians.

BACKGROUND

The FMLA provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. Eligible beneficiaries of FMLA include employees who have been employed by their employer at least 12 months, worked at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Private employers with at least 50 employees (employed for at least 20 weeks in the preceding or current calendar year) and public employers with any number of employees are covered by the FMLA.¹

Several proposals for expansion of the FMLA at the federal level have been considered. Expansion of employee eligibility, covered leave time or employer requirements would undoubtedly result in various impacts on employees and employers,² including physicians who are employed or employ others. Another proposed form of expansion, the creation of a required paid parental leave benefit, would also have significant implications for employers, employees, and new parents and infants.³⁻⁶

AMA POLICY

AMA policy supports voluntary employer policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave becomes necessary due to documented medical conditions (Policy H-420.979). The AMA recognizes the public health benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not specifically endorsed by the AMA. Council on Medical Service Report (CMS) 3-A-16 provided a comprehensive review of sick leave and paid leave policies. The HOD adopted the recommendations in the report that established policy supporting employer policies that provide employees with unpaid sick days to care for themselves or a family member (Policy H-440.823).

The AMA recognizes that physicians, as employees and employers, are impacted by the FMLA and other medical leave regulations. AMA Policies for Parental, Family and Medical Necessity Leave (Policy H-405.960) established guidelines that encourage medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement. This policy also encourages staff scheduling to allow for coverage during a physician's leave without creating intolerable increases in other physicians' workloads, particularly in residency programs, and that physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

DISCUSSION

Expansion of the FMLA

Proposals to expand the FMLA have been presented by legislators and advocacy organizations who assert that the U.S. lags behind other industrialized nations in its existing laws related to employee leave. On the federal level, proposals for expansion have attempted to:²

1. expand employee eligibility by removing the 1,250 hour requirement, eliminating the requirement that an employee work for the employer for at least 12 months, or lowering the employer threshold of 50 employees within 75 miles;
2. cover more employers by including those with 15 or 25 employees;
3. increase the number of covered weeks; and
4. establish a mandated paid leave benefit.

One proposed federal expansion law is the Family and Medical Insurance Leave Act (the FAMILY Act) S. 337/H.R. 947, which would, among other things:

- create a national program to provide all workers, regardless of company size, with up to 12 weeks of partially paid leave; and
- enable workers to receive up to 66 percent of their monthly wages, up to a capped amount, during their time of leave.

Many states have already enacted laws that provide benefits in excess of those provided under the FMLA. Currently, three states—California, New Jersey and Rhode Island—have required paid family leave. New York will be the fourth in 2018 when its Paid Family Leave Benefits Law will be effective. Additionally, five states and several cities have implemented paid sick leave laws. The laws in these cities and states go beyond the required unpaid leave of the FMLA to provide employees with guaranteed pay during various types of approved medical leave. Benefits to both employees and employers have been reported in the states providing paid family leave.

In California, for example, the Paid Family Leave program provides employees with up to six weeks of paid leave to care for a new child or ill family member. The program is funded by employee payroll contributions, so while employers do not face financial burden as a result of the law, they are faced with ensuring the employees' workload is covered and that gaps in staffing are filled. The program in California, however, does not assure job protection during leave, provides wage replacement at only 55 percent, and does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-year review of California's expansion demonstrated that the Paid Family Leave benefit promoted family well-being, improved family economic security, equalized access to leave across occupations and income levels, and bolstered businesses by reducing workforce turnover. It was also noted that overall awareness of the program among those most likely to utilize it was low, implying that utilization rates

could be higher if education and outreach were improved upon.⁷ Similar outcomes have been reported for other cities and states.⁸⁻¹⁰

Existing Research

There is an abundance of literature about the benefits of employee access to medical leave provided under existing law, much of which was summarized in CMS Report 3-A-16.¹¹ For example, studies show that children recover faster from illness when cared for by a parent,¹² and the presence of a parent has been shown to reduce hospital stay duration by 31 percent.¹³ A national health impact assessment demonstrated that paid sick leave policy would result in more workers taking needed leave to recover from illness, receive preventive care, and care for ill children.¹⁴ These actions would reduce transmission of influenza, foodborne disease, and gastrointestinal infections in health care facilities.¹⁴ Some proponents of paid sick leave policies claim companies can experience cost savings, increased productivity, and disease and illness prevention when employees are able to take time off when they or a family member are ill.¹⁵

In addition to evidence showing the benefits of leave policies, *lack of* paid sick leave can have significant and adverse effects on public health. Workers without paid sick leave are more likely to work while ill and delay medical care, which can lead to prolonged illness and likelihood of worsening otherwise minor health issues.¹⁶ One study revealed that lack of workplace policies, such as paid sick leave, was correlated with a higher incidence of influenza-like illness.¹⁷ A 2007 study estimated that the annual flu season results in over 3 million hospitalized days and costs employers \$10.4 billion in direct medical costs for hospitalizations and outpatient visits.¹⁸

Also outlined in CMS Report 3-A-16 are the concerns employers and employer groups have expressed with the prospect of expanding medical leave benefits. Some employer groups oppose expanding FMLA benefits due to the potential for increased costs. Others claim paid leave policies or policies that provide coverage for more employees may burden and negatively impact employer operations,¹¹ with hospitals and physician practices being no exception.

Although it is limited, research does exist that demonstrates projected effects of various types of expansion upon family leave policies. An analysis published by IMPAQ International, Inc. and the Institute for Women's Policy Research summarizes a simulation of five paid family and medical leave model programs based on working programs in three states and a federal proposal, all applied to the national workforce. The findings suggest that upon expansion of FMLA laws, through covering more eligible workers, replacing a larger percentage of usual earnings, and offering more weeks of paid leave increase the estimated costs. If based on any of the five models in the simulation, the cost for benefits would range from \$31 billion to \$43 billion. This report also projects that a national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually.¹⁹

Another report by the Institute for Women's Policy Research estimates costs for a series of policy scenarios for employers in New Hampshire. Using a simulation model, the authors estimated the total program costs for the Family Medical Leave Insurance (FMLI) policy proposal if the law was changed to require *all* employers to provide benefits, *only* firms with 25 or more employees, and *only* firms with 50 or more (current policy). The total costs were estimated at \$163.5 million when all employees are covered, \$133.8 million when only firms with 25 or more employees are covered, and \$124.1 million when only firms with 50 or more employees are covered. In addition to the cost implications of covering more employees, the authors projected an increase in the number of leaves taken and a decrease in the average weekly benefit.²⁰ Similar research has been reported for the District of Columbia.²¹

Implications for Physicians

Expansion of FMLA benefits to include more employers or employees would undoubtedly affect physicians who employ others or are employed. Upon any form of expansion of FMLA, physicians who employ others and physicians in small practices would be expected to experience some changes in the operations of their practices. In 2016, 37.9 percent of U.S. physicians worked in practices with less than five physicians, 19.9 percent in practices with five to 10 physicians, and 13.3 percent with 11 to 24 physicians.²²

Number of physicians in practice	Distribution of physicians by practice size ²²	Estimated full-time employee count*	Affected by expansion in FMLA coverage from 50 to 25 minimum FTE	Affected by expansion in FMLA coverage to ALL employees
1-4	37.9%	5-20	No	Yes
5-10	19.9%	25-50	Yes	Yes
11-24	13.3%	55-120	No	No
25-49	7.4%	125-245	No	No
50+	13.8%	250+	No	No

**Number of full-time staff members per physician varies according to specialty, practice setting and other factors. This full-time employee count assumes an average of four full-time staff members per full-time physician and includes the physicians.²³*

As of 2016, most physicians (57.8 percent) work in practices with 10 or fewer physicians. Given there is an average of four full time support staff for every full-time practicing physician,²³ it would likely be the practices with 10 or fewer physicians that would be impacted by any reduction in the threshold to include more employees under FMLA. (Those with 11 or more physicians are already likely covered under current legislation.) For example, if FMLA coverage were expanded to include employers with 25 or more employees, or all employers regardless of size, these practices with 10 or fewer physicians may be required to make changes in scheduling, staffing processes or other aspects of practice operations. Reports on business' experiences with FMLA compliance are limited and mixed, suggesting that these changes could be burdensome for some practices, but may pose no issues for others. One survey concluded employers report little negative impact of complying with FMLA,²⁴ but another report indicates a high number of complaints about the record keeping and coordination of state and federal leave policies.²⁵

A study conducted by the National Federation of Independent Business (NFIB) used a regulatory impact model to calculate the projected costs of an expanded FMLA leave program on small businesses. Their findings showed small businesses would be faced with an additional cost of approximately \$30,000 to \$50,000 in reduced sales, mandatory overtime payments, and diversion of management attention.²⁵ This study focused on manufacturing, construction, and various service industries and did not include data for health care employers; therefore, assuming correlations that suggest similar impacts in health care settings is cautioned against.

As outlined in the previously mentioned reports, the effects on employees, including physicians, would be dependent on many factors including practice size and whether expansion of the law would change the employer's existing coverage. As more and more physicians move from solo or small practices to employment within health systems or hospitals, some may gain coverage under FMLA law. The personal effects of FMLA expansion on physicians would likely be similar to the overall public health benefits described earlier in this report and in CMS Report 3-A-16. There is no research or literature to suggest that physicians employed by organizations subjected to expanded FMLA requirements would experience benefits that are significantly different than those experienced by employees in other professions.

CONCLUSION

Our review of existing research has demonstrated that expansion of FMLA laws could increase the cost of benefits to employers. Depending on the type of expansion, the costs could range from \$31 billion to \$43 billion. A national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually. Finally, any expansion of FMLA coverage would likely predominantly affect physician practices with 10 or fewer physicians.

The first directive in Policy H-405.954 states the AMA will encourage the study of the health implications among patients if the FMLA law was modified. The AMA recognizes the importance of effects changes in the law may have on patient outcomes. In addition to the federal law, states may have, or may enact in the future, any variety of family leave laws that provide benefits to more employees. Patient demographics and health care needs also vary across states and regions. It is for these reasons that the AMA will continue ongoing collaborations with state medical societies to observe and track the variety of local and state family leave laws and study the related health implications for patients.

The second directive of Policy H-405.954 states the AMA will study the effects of FMLA expansion on physicians. Upon enactment of federal laws that provide more expansive coverage or coverage to a larger number of people,

there should be opportunities to study the effects on physicians and health care employers more expansively than the simulations discussed herein.

The AMA recognizes the importance and benefits of access to medical and family leave, and existing policies H-420.979 and H-405.960 are demonstrative of this cognizance. While the AMA does not endorse policies requiring paid leave, it does encourage medical group practices to incorporate leave policies, including parental, family, and medical leave policies, in their standard benefit structure.

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10. HIGH COST TO AUTHORS FOR OPEN SOURCE PEER REVIEWED PUBLICATIONS (RESOLUTION 604-A-17)

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 604-A-17
REMAINDER OF REPORT FILED
*See Policy D-478.964***

At the 2017 Annual Meeting, the House of Delegates referred Resolution 604, “High Cost to Authors for Open Source Peer Reviewed Publications,” to the Board of Trustees. Resolution 604, introduced by the Pennsylvania Delegation, asked:

That our American Medical Association (AMA) investigate the high dollar costs open source publication rules currently present to the dissemination of research, especially by less well-funded and/or smaller entities; and

That our AMA make recommendations to correct the imbalance of knowledge suppression based solely on financial considerations.

It is important to note that the above resolution indirectly addresses the Open Access Movement (OA) and the fees associated with OA journals. Our AMA publishes some journals that charge these fees. This report aims to explain OA and our AMA’s involvement with this practice.

Additionally, our House of Delegates has adopted relevant policy. Policy G-630.090, AMA Publications, “affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.”

BACKGROUND ON THE OPEN ACCESS MOVEMENT

OA refers to research published online that is free of all restrictions on access (e.g., subscriptions and other usage fees) and of some restrictions of use (e.g., certain copyright and license restrictions). Widespread public access to the internet in the late 1990s and early 2000s fueled the OA movement.

Active debate over the economics and reliability of various ways of providing OA continues among researchers, academics, librarians, university administrators, government officials, publishers, and editorial staff. Still, OA is gaining acceptance, and many US and all EU research funders now require that journals offer OA options to the authors supported by their grants.

Conventional non-open access journals cover publishing costs through fees, such as subscriptions, site licenses, and pay-per-view charges. However, OA journals do not sell subscriptions, charge for site licenses, or sell advertising. Their only revenue is from Article Processing Charges (APCs), which help cover costs to review, edit, process, distribute, and host the articles online. These fees typically range between \$3,000 and \$5,000 per document. Therefore, OA journals shift the expense of publishing to the investigators and authors.

OPEN ACCESS AND THE JAMA NETWORK®

JAMA does *not* offer OA in exchange for APCs. All original research articles published in *JAMA* are made free to everyone six months after the official date of publication, whether or not the research was publicly funded by the National Institutes of Health (NIH). This release date is well within the NIH Public Access Policy’s mandate of 12 months. All specialty journal original research articles are released for public availability after an embargo period of 12 months in accordance with the NIH Public Access Policy.

With the launch of *JAMA Oncology* in 2015, however, our AMA began to offer an OA option to authors. Through a “hybrid” journal model, authors whose research funders require OA are able to choose the OA option. Our AMA charges APCs around \$4,500 to \$5,000. However, authors who cannot or do not want to pay for the OA option are

not required to pay anything. Approximately 10% of authors to date have chosen the OA option. Generally, funders, not authors, desire OA, and the vast majority of authors select the conventional subscription model.

Because this hybrid model approach appears to balance the demands of funders, changing markets, and business models, it was extended to *JAMA Cardiology*, which was launched in 2016. This model also recognizes the needs and limited resources of independent researchers and authors. Therefore, the hybrid model approach was applied to all 11 of our AMA's specialty journals across The JAMA Network on April 1, 2017.

DISCUSSION OF THE RESOLVEDS

The reference committee rightfully believed that our AMA is not in a position to direct or recommend that other medical journal publishers reduce or eliminate their OA fees, especially when fees are a necessary component of OA model journals. Likewise, our AMA cannot instruct international research funders to abandon their OA requirements and support only subscription based journals.

Our AMA Publishing division has investigated the range of OA fees charged by commercial and medical society publishers; the fee charged by The JAMA Network specialty journals falls within this spectrum. The JAMA Network journals require adequate revenue to process, peer review, and publish articles of high quality. As such, current OA fees of \$4,500 to \$5,000 are reasonable, given journal production and hosting expenses. Moreover, our AMA continues to offer a no-fee option for authors, while providing the OA option for research funders that require and will pay for OA.

Further still, according to a recent investigation commissioned by our AMA, several OA journals, whether purely OA or a hybrid, offer discounts or waivers for their APCs. Discounts or waivers are often considered on a case-by-case basis or offered to authors from low-income or developing countries, based on the HINARI Access to Research Initiative or World Bank figures. This finding highlights the idea that many publishers are cognizant of some authors' financial hardships and are willing to consider each author on an individual basis.

During testimony on the resolution, concern with "predatory publishers" emerged as a central theme. While this concern about predatory publishers is not found in the resolution itself, it became a significant focus of testimony, with findings and materials on predatory publishers entered into testimony. Predatory publishers, as they have come to be known, hold themselves out as OA journals and purport to offer traditional services, such as peer review, editing, and publication in return for APCs. Unfortunately, authors soon realize that their submissions receive little or no peer review or that the editors listed are not actually on the editorial board. Further still, some predatory publishers fail to adequately inform authors of any charges or fees before their submissions are approved for publication; some of these publishers deny authors the ability to withdraw their submissions, forcing authors to either pay the fees or make their research ineligible for publication in another journal under academic ethics standards.

Understandably, these predatory publishers pose a great cause of concern for the medical profession and our AMA. While estimates as to the number of predatory publishers vary, the problem has become significant enough for the Federal Trade Commission to take action. On August 25, 2016, the Commission filed a complaint against OMICS Group Inc. and two affiliated companies, alleging that OMICS failed to disclose publishing fees until after submissions were approved for publication and then would not allow researchers to withdraw their articles, invented an Impact Factor and falsely informed authors that their journals are indexed by federal research databases (e.g., PubMed and Medline).

Our AMA has advocated for and will continue to lead the movement for widespread dissemination of medical knowledge and research. *JAMA's* Key Objective aims "[t]o promote the science and art of medicine and the betterment of the public health." *JAMA* and its specialty journals are committed to this mission.

RECOMMENDATION

The Board of Trustees recommends that Resolution 604-A-17 not be adopted and that this report be filed. AMA Publishing, however, plans to implement a process for waiving or reducing Open Access (OA) fees when authors are not supported by funders or cannot afford to pay OA fees.

The Board of Trustees will continue to monitor the Federal Trade Commission's actions in relation to predatory publishers and will disseminate the information to our AMA members.

11. ANTI-HARASSMENT POLICY

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy H-140.837, "Anti-Harassment Policy" (see Appendix for full text), which provided that:

Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

The policy was proffered by Board of Trustees Report 23-A-17, which noted that AMA Human Resources policies establish zero tolerance regarding harassment with respect to AMA personnel, agents, and nonemployees, including AMA members. This informational report of the Board of Trustees provides an update to the House of Delegates. At the 2018 Annual Meeting, the Board will recommend procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC) and CPT Editorial Panel.

DISCUSSION

Professional associations' anti-harassment policies are designed to support the open exchange of ideas central to their mission and to ensure that those who participate in association activities "enjoy an environment free from all forms of discrimination, harassment, and retaliation" [1]. Surprisingly few professional associations have published anti-harassment policies. These Associations have established mechanisms to address allegations of harassment that designate the association officer(s) or other association authority to whom incidents should be reported, provide for confidential investigation of alleged inappropriate conduct, and define sanctions that may be imposed if conduct is found to violate association policy [1-5].

The AMA recently extended mandatory recurring anti-harassment training to include not only staff, but also members of all AMA councils. The Board believes such training is appropriate for section governing councils and Board members as well. It is the Board's hope that this training will eliminate harassing behavior in connection with meetings of AMA entities, but given our zero tolerance policy for such behavior we believe that a formal process for reporting, investigation and resolution should be established.

There are numerous complexities involved in implementing processes for reporting and investigation and discipline in the event of harassment complaints. The Board is studying best practices and reviewing potential avenues for the above called for in Policy H-140.837. Myriad issues have arisen with any of the types of processes discussed. Thus, the Board will make recommendations on reporting, investigating, and enforcing instances of harassment at the 2018 Annual Meeting.

REFERENCES

1. American Astronomical Society. *Anti-Harassment Policy for AAS & Division Meetings & Activities*, nd. Available at <https://aas.org/policies/anti-harassment-policy>. Accessed July 21, 2017.
2. American Nuclear Society. *Respectful Behavior Policy*, 2016. Available at <http://www.ans.org/about/rbp/>. Accessed July 21, 2017.
3. American Wind Energy Association. *Event Anti-Harassment Policy for all AWEA Events*, nd. Available at <http://www.awea.org/About/content.aspx?ItemNumber=6388>. Accessed July 21, 2017.

4. Biophysical Society. *Code of Conduct, Anti-Harassment Policy*, nd. Available at <http://www.biophysics.org/AboutUs/Overview/CodeofConduct.AntiHarassmentPolicy/tabid/6866/Default.aspx>. Accessed July 21, 2017.
5. Popular Culture Association/ American Culture Association. *PCA/ACA Anti-Discrimination Policy*, nd. Available at <http://pcaaca.org/pcaaca-anti-discriminationpolicy/>. Accessed July 24, 2017

APPENDIX - AMA Policy H-140.837, “Anti-Harassment Policy”

1. Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA’s Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.

12. 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 2017 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, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2017 Interim Meeting:

- American Academy of Sleep Medicine
- American Association of Neuromuscular & Electrodiagnostic Medicine
- American College of Rheumatology
- American Society for Dermatologic Surgery, Inc.
- American Society of Clinical Oncology
- American Society of Cytopathology
- American Society of Maxillofacial Surgeons
- American Society of Plastic Surgeons
- Radiological Society of North America
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons

The American Academy of Sleep Medicine, American Society of Cytopathology and the American Society of Plastic Surgeons were reviewed at this time because they failed to meet the requirements of the review in 2016.

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 Association of Neuromuscular & Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery, Inc., American Society of Clinical Oncology, American Society of Maxillofacial Surgeons, American Society of Plastic Surgeons, Radiological Society of North America and the Society of Thoracic Surgeons meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicated that: the Society of Nuclear Medicine & Molecular Imaging, American Academy of Sleep Medicine and the American Society of Cytopathology did not meet all guidelines and are not 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:

1. That the American Association of Neuromuscular & Electrodiagnostic Medicine, American College of Rheumatology, American Society for Dermatologic Surgery, Inc., American Society of Clinical Oncology, American Society of Maxillofacial Surgeons, American Society of Plastic Surgeons, Radiological Society of North America and the Society of Thoracic Surgeons retain representation in the American Medical Association House of Delegates.
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the Society of Nuclear Medicine & Molecular Imaging be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Academy of Sleep Medicine and the American Society of Cytopathology not retain representation in the House of Delegates.

APPENDIX - Exhibit A, Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Sleep Medicine	871 of 5,061 (17%)
American Association of Neuromuscular & Electrodiagnostic Medicine	778 of 3,214 (24%)
American College of Rheumatology	1,111 of 5,981 (19%)
American Society for Dermatologic Surgery, Inc.	1,001 of 3,455 (29%)
American Society of Clinical Oncology	2,363 of 12,588 (19%)
American Society of Cytopathology	220 of 1,194 (18%)
American Society of Maxillofacial Surgeons	102 of 392 (26%)
American Society of Plastic Surgeons	1,001 of 5,189 (19%)
Radiological Society of North America	2,240 of 18,263 (12%)
Society of Nuclear Medicine and Molecular Imaging	243 of 1,452 (17%)
Society of Thoracic Surgeons	935 of 4,438 (21%)

Exhibit B, Summary of Guidelines for Admission to the House of Delegates for 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.

13. CERTIFIED TRANSLATION AND INTERPRETER SERVICES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2017 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-385.957, “Certified Translation and Interpreter Services,” which calls on our American Medical Association (AMA) to “work to relieve the burden of the costs associated with the translation services implemented under Section 1557 of the Affordable Care Act (ACA)” and “advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.” The policy also requires a progress report at the 2017 Interim Meeting of the AMA HOD. This report serves to satisfy that aspect of the resolution as well as provide a brief overview of the language access provisions of Section 1557.

BACKGROUND ON SECTION 1557

The U.S. Department of Health & Human Services (HHS) Office of Civil Rights (OCR) issued a final rule implementing Section 1557 of the ACA in May 2016, which became effective in July 2016. Section 1557 makes it unlawful for any health care provider who receives funding from the federal government to refuse to treat an individual—or to otherwise discriminate against the individual—based on race, color, national origin, sex, age, or disability. It builds upon longstanding nondiscrimination laws and provides some new civil rights protections. As such, many of the rule’s provisions are familiar to physicians, while others may require physicians to implement new policies and procedures. The rule applies to physicians and other entities receiving federal financial assistance from HHS; however, it does not apply to physicians who participate only in Medicare Part B.

Under Section 1557, a covered physician must take reasonable steps to provide meaningful access to each individual with limited English proficiency (LEP) eligible to be served or likely to be encountered in their practice. Covered physicians must provide language assistance services free of charge, in an accurate and timely manner, and must protect the privacy and independence of the individual with LEP. Required language assistance services include offering a qualified interpreter to an individual with LEP for oral interpretation and a qualified translator when translating written content in paper or electronic form. Specifically, covered physicians may not:

- Require an individual with LEP to provide his or her own interpreter;
- Rely on an adult accompanying an individual with LEP to interpret, except:
 - In an emergency situation involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with LEP immediately available; or
 - Where the individual with LEP specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate;
- Rely on a minor child to interpret or facilitate communication, except:
 - In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with LEP immediately available;
- Rely on unqualified staff members to communicate with individuals with LEP; or
- Utilize poor-quality video interpreting services to provide language assistance services.

FEDERAL ADVOCACY EFFORTS

The AMA has taken a number of steps to educate physicians about Section 1557’s language translation and interpretation requirements, including the development of a fact sheet posted on the AMA’s website and a presentation by OCR leadership for members of the Federation. The AMA has maintained a regular dialogue with OCR to relay that physicians often struggle with the costs of language assistance services and asked for strategies we could provide to physicians to address this concern. Based on OCR’s responses, we incorporated some cost-sharing strategies into our Section 1557 fact sheet—for example, a group of covered physicians could contract with

a telephonic translation service and pay for the services on a pro-rated basis, and covered physicians may try to negotiate with translation service providers whether the provider must pay a charge in the event that the patient is late or does not show up for his or her appointment.

Additionally, AMA members have reported to the AMA that individuals with LEP often bring trusted adults with them to an appointment to facilitate communication. However, as noted above, Section 1557 regulations state that a physician may rely on an adult accompanying an individual with LEP to interpret or facilitate communication only if reliance on that adult for such assistance is “appropriate under the circumstances.” This standard remains unclear to physicians, causing them to take on the additional burden and expense of interpreters out of an abundance of caution when it may not be always necessary to do so. Accordingly, the AMA has spoken with OCR in attempt to clarify the circumstances in which a physician may rely on an adult accompanying a patient to interpret or facilitate communication. For example, when a physician sees an adult male patient presenting with flu-like symptoms, who is accompanied by his brother, and the patient requests that his brother translate, a physician may find this request appropriate under the circumstances. Conversely, if a female patient presenting with a broken arm is accompanied by her husband, the physician may have concerns about domestic abuse. In this case, it may be inappropriate to rely on the husband to provide accurate interpretation services. The AMA intends to draft a suggested “Frequently Asked Question” (FAQ) addressing this matter for OCR to post on its website as a resource for physicians. While OCR cautioned that such a posting may not be possible, the AMA will nevertheless urge OCR to issue guidance on this topic in light of the Trump Administration’s stated goals of physician burden reduction and regulatory relief.

Finally, in its comments on the proposed 2018 Medicare Physician Fee Schedule (PFS) and Medicare Hospital Inpatient Prospective Payment Systems (IPPS) rules, the AMA included information about the burden of providing language assistance services absent reimbursement for such services. The AMA requested that the Centers for Medicare & Medicaid Services (CMS) work with OCR to clarify the circumstances under which an adult accompanying an individual with LEP may interpret or facilitate communication. The AMA submitted the same language to the U.S. House of Representatives Committee on Ways and Means in response to its call for regulatory and legislative relief requests, and to senior staff in the HHS Secretary’s office and the White House. The AMA will continue to pursue opportunities to advance this issue, including cost burdens on physicians, both on Capitol Hill and within the administration.

OUTREACH TO STATES AND SPECIALTIES

From a state and specialty perspective, the AMA has recently reached out to the Federation of Medicine to determine which, if any, state and specialty societies are interested in working on this issue from a state regulatory perspective. Indiana, Vermont, the American Academy of Otolaryngology–Head and Neck Surgery, and the American Academy of Orthopaedic Surgeons all expressed interest. The AMA convened a call with the interested groups to discuss the scope of the problem, the opportunities at both the federal and state levels, and potential resources and collaborations. While some groups (e.g., Indiana) have had success in mandating coverage for interpreters under their Medicaid managed care program, all groups agreed that broader coverage was an uphill battle and not a top priority for them this year. It was determined that states would collaborate with the AMA and specialty societies when an opportunity to advance the issue at the state level arose, and model contract language from successful Medicaid Managed Care coverage efforts was circulated along with additional AMA resources. The groups were also appreciative, and interested in supporting, the AMA’s related request to CMS in its Medicare PFS and IPPS comments.

CONCLUSION

The AMA will continue to identify opportunities to work with Congress and the administration to implement Policy D-385.957, “Certified Translation and Interpreter Services.” The AMA will urge OCR to issue guidance on the ways in which adults accompanying LEP patients may facilitate communication, and will support the efforts of state and specialty societies to advance the issue at the state level by providing model language for Medicaid Managed Care coverage and other needs as identified by the societies.

REPORT OF THE SPEAKERS

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

1. RECOMMENDATIONS FOR POLICY RECONCILIATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

RECOMMENDED ACTIONS ACCOMPLISHED

Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," states in relevant part that the Speakers should "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report, the second of 2017, to deal with policies that were affected by actions taken at this past June's Annual Meeting.

Suggestions on other policy statements that are thought to be outdated or needing revision for any other reason should be sent to hod@ama-assn.org. That address may also be used to contact your Speakers on any House-related matter.

RECOMMENDED RECONCILIATIONS

References to completed directives to be deleted from policy statements

The following change will delete a reference to reports that have been completed but otherwise do not affect existing policy.

1. Policy G-600.035, "The Demographics of the House of Delegates" includes a directive that has been accomplished. The Council on Long Range Planning and Development provided the requested information in Report 2-A-17. Having been completed, the directive will be dropped.

Policy G-600.035, "The Demographics of the House of Delegates"

1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. 2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. 3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations. ~~4. Our AMA will convene a group of stakeholders at a forum in conjunction with the 2016 Annual Meeting to identify viable solutions with which to promote diversity, particularly by age, of state and specialty society delegations, with a summary of the findings to be included in the next CLRPD report on the demographic characteristics of the House of Delegates.~~

Policies to be rescinded in full

Five policies should be rescinded in full because they have been superseded by newer policies and, where necessary, bylaws amendments. Three policies deal with specialty society representation, a process that has been completely revised over the last year. Two other policy statements are directives dealing with the Council on Ethical and Judicial Affairs; both have been accomplished and should be rescinded.

2. Two policies deal with the now abandoned balloting system used for apportioning delegates to specialty societies. In light of amendments to the bylaws and Policy G-600.027 at the 2017 Annual Meeting, these older policies should be rescinded. The first is Policy G-600.023, "Designation of Specialty Societies for

Representation in the House of Delegates,” which was adopted at the 2013 Interim Meeting. Although the final paragraph of the policy has some merit, your Speakers believe that it is incumbent on them to monitor the delegate allocation process and no explicit requirement is needed. Moreover, in the event of a perceived problem, any delegate may propose a resolution to address the matter. As such, the policy as a whole is no longer viable and will be rescinded.

Policy G-600.023, “Designation of Specialty Societies for Representation in the House of Delegates”

1. Specialty society delegate allocation in the House of Delegates shall be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof. 2. Specialty society membership data shall be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates. 3. The current specialty delegation allocation system (ballot and formula) will be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates. 4. This system shall be tested with all specialty societies with more than one delegate seated in the House of Delegates. 5. Organizations that would lose or gain one or more delegates through this pilot delegate allocation system shall assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting. 6. In the future, any system of delegate allocation will continue to be monitored and evaluated for improvements.

3. Likewise, Policy G-600.021, “Specialty Society Representation in our AMA House,” which dates from 1996 and was altered in 2012, will be rescinded.

Policy G-600.021, “Specialty Society Representation in our AMA House”

The number of AMA delegate positions allocated to the specialty societies in our AMA/Federation House will be determined in the following manner: (1) The number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1000 AMA members, or portion of 1000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to our AMA; and (2) Each specialty society that meets the eligibility criteria and is represented in our AMA/Federation House will be assured of at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA. (3) Our AMA will: (a) continue to include the ballot postcard in the Member Welcome Kit; (b) continue to promote the online ballot application to increase specialty society designations; (c) work with all willing specialty societies to solicit additional specialty society designations, using both printed ballots and electronic communications vehicles; and (d) continue to send email ballot solicitations to members who have not yet cast a ballot. (4) The current ballot system will remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

4. Policy G-600.135, “Specialty Society Delegate Representation in the House of Delegates,” will be rescinded as it has been superseded by the new procedure to apportion specialty society delegates that will be implemented in 2018.

Policy G-600.135, “Specialty Society Delegate Representation in the House of Delegates”

1. Our AMA will continue efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation. 2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will: (a) establish annual targets for the overall proportion of AMA members from whom designations should have been received; (b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations; (c) limit the number of delegates a society can acquire to the number that would be obtained if all the society's AMA members designated it for representation; (d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and (e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally. 3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing

progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports: (a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and (b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion. 4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates. 5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. 6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

5. The multi-year effort by the Council on Ethical and Judicial Affairs to modernize the *Code of Medical Ethics* culminated with the adoption of CEJA Report 2-A-16. At that same meeting, and partly because of the lengthy and somewhat tortuous effort to achieve consensus on the *Code*, the House also adopted Policy D-600.957 calling for an evaluation of the deliberative processes surrounding CEJA reports. The initial response to that policy came in CEJA Report 3-I-16, which was referred because important underlying issues of the relationship between the Council and the HOD required further study. At the 2017 Annual Meeting, the Board of Trustees submitted Report 19, providing the requested evaluation and establishing Policy G-600.009, “CEJA and House of Delegates Collaboration.” Given the Board’s report, the following policy has been accomplished and will be rescinded.

D-600.957, “CEJA and House of Delegates Deliberation”

1. Our AMA will evaluate how the collaborative process between the House of Delegates and the Council on Ethical and Judicial Affairs can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy and report back at the 2016 Interim Meeting. 2. Our AMA will evaluate how a periodic review of Code of Medical Ethics guidelines and reports can best be implemented, and report back.

6. Policy D-478.969, “Social Media Trends and the Medical Profession,” asked that CEJA examine how physicians may ethically use social media for educational and advocacy purposes. CEJA submitted Report 2 at this past June’s meeting, which included a section dealing specifically with uses of social media for education or advocacy. The policy will be rescinded as having been completed.

D-478.969, “Social Media Trends and the Medical Profession”

Our AMA will ask the Council on Ethical and Judicial Affairs to reconsider AMA Ethical Opinion E-9.124, Professionalism in the Use of Social Media.

Policies to be modified

The most recent policy dealing with the apportionment of specialty society delegates requires relatively minor modifications to bring it up to date.

7. G-600.027, “Designation of Specialty Societies for Representation in the House of Delegates,” was modified at 2017 Annual Meeting to clarify the formula that will be used to apportion delegates to specialty societies in the House of Delegates. The policy will be modified to delete a call to study bylaws changes necessitated by the policy change and the date of the initiation of the policy as those elements are no longer relevant.
 1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will

be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.

2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process:
 - (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof.
 - (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.
 - (b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies.
 - (i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.
 - (ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.
 - (iii) In the case of a tie, the previous year's data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.
3. ~~The Council on Constitution and Bylaws will investigate the need to change any policy or bylaws needed to implement a new system to apportion national medical specialty society delegates.~~
4. ~~This new specialty society delegate apportionment process will be implemented at the first Annual Meeting of the House of Delegates following the necessary bylaws revisions.~~
5. ~~Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.~~

The policy below requires a slight change to use the preferred language consistently. The change is presented here in the interest of transparency. The original sponsor favors the change.

8. In June the House adopted policy supporting the use of "person-first" language in addressing the needs of patients affected by obesity, which is catalogued as Policy H-440.821, "Person-First Language for Obesity." The language in the third paragraph is slightly inconsistent as adopted and will be changed from "patient-first" to "person-first."

Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of ~~patient~~ person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.