EXECUTIVE SUMMARY

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.

The AMA had another strong year on the advocacy front. We were able to advance patient and physician interests in several areas. We were also able to defend against potential rollbacks of hard fought gains. Our efforts centered on the following issues.

- The AMA led medicine’s effort to protect coverage and access to quality, affordable health care for patients which were threatened in the 115th Congress.
- The AMA sought and attained numerous improvements to the implementation regulations for the Medicare Access and CHIP Reauthorization Act (MACRA) – or Quality Payment Program (QPP) as it is now known.
- The AMA continued to educate and create tools for physicians to help them with the transition to MACRA/QPP.
- The AMA pursued legislative and regulatory initiatives to reduce administrative burdens on physician practices to improve efficiency and reduce burnout.
- The AMA, in conjunction with our Federation colleagues, played a major role in the defeat of two health insurer mega-mergers – one of which could have led to physician payment cuts of $500 million per year.
- The AMA has successfully called on the Centers for Medicare & Medicaid Services to provide coverage for the Medicare Diabetes Prevention Program which directly addresses one of our nation’s most prevalent diseases.
- The AMA continues to address the opioid epidemic, and our main recommendations on physician use of Prescription Drug Monitoring Programs, continuing medical education, naloxone, and others are having positive results. However, the overdose and death rates remain staggering.
- The AMA is working to limit the inappropriate use of prior authorization which is a major impediment for physicians as they seek to provide optimal care to their patients.
- The AMA has also launched a campaign calling for greater transparency in the pricing process for prescription drugs by pharmaceutical companies, pharmacy benefit managers, and health insurers.

Staff note: This report was prepared in September 2017, and may be updated prior to the Interim Meeting based on more recent advocacy developments.
Subject: 2017 AMA Advocacy Efforts

Presented by: Gerald E. Harmon, MD, Chair

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.