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Subject: Redefining AMA’s Position on ACA and Healthcare Reform

Presented by: Gerald E. Harmon, MD, Chair

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 though 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.
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.

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.
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.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-17

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

- 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 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](https://www.ama-assn.org). 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 Acton 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
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.
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.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-17

Subject: Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care

Presented by: Gerald E. Harmon, MD, Chair

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.

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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 Act\(^2\) 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 Act\(^3\) 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 provides. This data bank was known as the Healthcare Integrity and Protection Data Bank (HIPDB).
- Section 6403 of the Affordable Care Act\(^4\) 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 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.
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.

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.
Subject: 2018 Strategic Plan

Presented by: Gerald E. Harmon MD, Chair

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.

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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 ADVEMENT 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 identify 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 operatic 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.
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.³⁶

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:

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. Similar outcomes have been reported for other cities and states.
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. For example, studies show that children recover faster from illness when cared for by a parent, and the presence of a parent has been shown to reduce hospital stay duration by 31 percent. 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. These actions would reduce transmission of influenza, foodborne disease, and gastrointestinal infections in health care facilities. 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.

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 likeliness of worsening otherwise minor health issues. One study revealed that lack of workplace policies, such as paid sick leave, was correlated with a higher incidence of influenza-like illness. 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.

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, 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.

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. Similar research has been reported for the District of Columbia.
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

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

*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 per 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.
REFERENCES


REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-17

Subject: Anti-Harassment Policy

Presented by: Gerald E. Harmon, MD, Chair

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


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.
Subject: Amendment to E-2.3.2, “Professionalism in Social Media”

Presented by: Dennis S. Agliano, MD, Chair

INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-A-17, “Amendment to E-2.3.2, Professionalism in Social Media.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the Code of Medical Ethics.

E-2.3.2 Professionalism in Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar opportunities can support physicians’ personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunities to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

(b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.

(c) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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(d) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethics guidance just as they would in any other context.

(e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(f) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV)
It is a physician’s professional responsibility to participate in continuing medical education (CME) activities in order to sustain life-long learning and improve the care provided to patients. 1 Often, CME credits can be used to meet the CME requirements of state medical and osteopathic boards, medical specialty societies, specialty boards, hospital medical staffs, and insurance networks. Yet the tools with which physicians track their CME vary widely by state, specialty, and institution. 6

In a previous report, 2 the American Medical Association (AMA) Council on Medical Education noted that while a central repository/online reporting system that would allow a physician to track/store CME credits would be very useful for meeting requirements for licensure, certification, and credentialing, many specialty and state medical societies and other organizations already provide such services, and a central repository was perceived as duplicative (or not warranted). Additionally, research indicated that the cost of a centralized service would almost invariably be borne by physicians. Furthermore, all CME providers would need to agree upon technical and data security proposals in order to proceed with a centralized repository, and questions about which entity(ies) would fund and maintain such a service remained unanswered. Pursuant to more recent Council on Medical Education discussions, however, members agreed that a follow-up review was warranted, given the time elapsed since the adoption of the previous report.

BACKGROUND

There are three major credit systems in the United States: (1) The AMA Physician Recognition Award (PRA) credit system; (2) American Academy of Family Physicians (AAFP) credit system; and (3) American Osteopathic Association (AOA) credit system. These three established credit systems facilitate physician credentialing and the renewal of licensure by providing metrics to demonstrate that a physician has maintained a commitment to study, apply, and advance scientific knowledge through participation in appropriate CME activities. There is strong communication and cooperation among the AMA, AOA, and AAFP, and although there are differences in how credits are categorized, the CME rules followed are similar in many ways. However, there is no centralized data repository to track all CME credits earned by a physician, and physicians are generally personally responsible for tracking and documenting their earned CME credits when verification is required for licensure or other credentialing purposes.

CREDIT SYSTEMS AND ACCREDITING BODIES

AMA, ACCME, and State/Territory Medical Societies

In 2016, more than 1,800 CME providers accredited by the Accreditation Council for Continuing Medical Education (ACCME) and state/territory medical societies produced almost 159,000 educational activities that were certified for *AMA PRA Category 1 Credit*. 3 AMA PRA requirements mandate that all accredited CME providers maintain records for each physician who

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participates in their CME activities and verify this participation if requested by the physician. The vast majority of CME providers do not report the actual number of credits awarded to individual physicians at the participant level. An exception to this is a new partnership between the ACCME and three American Board of Medical Specialties’ (ABMS) Member Boards. The American Board of Anesthesiology (ABA), American Board of Internal Medicine (ABIM), and American Board of Pediatrics (ABP) have established a relationship with the ACCME’s Program and Activity Reporting System (PARS). Through this partnership, CME providers upload physician-level data to the ACCME PARS system, which then can be transmitted directly to the specialty board. However, this transmission occurs only in those instances in which the credits are accepted by the specialty boards to meet their MOC requirements.

AMA PRA policy encourages physicians to report to the AMA any accredited CME provider that fails to provide documentation to a physician of his or her earned AMA PRA Category 1 Credits.™ Additionally, physicians can choose to apply for the AMA PRA, which many state licensing boards accept as demonstrating compliance with state CME requirements.

AOA

The AOA works with approximately 170 AOA-accredited sponsors that provide AOA Category 1 credit. It is the responsibility of the sponsor to report all CME credit earned by individual physicians to the AOA. For non-osteopathic-sponsored CME activities, it is the responsibility of the physician to provide documentation to the AOA. A certificate of attendance or letter of verification from the CME sponsor must be provided. The AOA tracks earned CME credits for individual physicians in a centralized online repository, the AOA “traCME” system. AOA members may view their CME profile/activity report online or contact the AOA for an electronic copy.

AAFP

AAFP members usually self-report CME credits to the AAFP. However, this is strictly voluntary. The AAFP does not require CME providers to provide certificates to CME participants; however, the AAFP encourages providers to offer certificates, since many members need them for state licensing and credentialing. CME providers are required to have a mechanism in place to document learner participation.

Comparison of Accrediting Bodies

Appendix A reviews the credit-related services currently offered by the three major CME credit systems.

CME TRACKING SERVICES

State Medical Societies

In preparation for the writing of this report, the Council canvassed state medical societies regarding their efforts to assist physicians with tracking CME to meet state licensure requirements. Of those who responded, four indicated that they offer related services beyond providing a transcript for their own CME activities:

- The Pennsylvania Medical Society (PMS) (www.pamedsoc.org/Tracker) allows physicians to enter their AMA PRA Category 1 Credits™ and AMA PRA Category 2 Credits™ into an
electronic tracking system called Tracker. This system shows physicians when they have met the state’s licensing requirements and the PMS’s CME certificate requirements.

- The California Medical Association’s Institute for Medical Quality (IMQ) CME Certification Program (www.imq.org/continuingmedicaleducation/cmecertification.aspx) records and verifies AMA PRA Category 1 Credit™ for California-licensed physicians to meet the state medical board’s requirements for licensure. CME credits can be reported using an online form and CME transcripts can be viewed and printed from the IMQ online site. Physicians who participate in this program are not required to undergo an independent audit of their CME activities by the California Medical Board.

- The Florida Medical Association (FMA) tracks all CME it provides directly in each physician’s record in its membership database http://www.floridahealth.gov/licensing-and-regulation/ce.html. This allows the FMA to generate a transcript with all FMA directly-provided CME that a physician (member or non-member) has completed over a specific period of time. The FMA also electronically reports its CME attendance data to CE Broker, which is the official continuing education (CE) tracking system for the state of Florida. Any educational provider that is specifically approved by a medical licensing board in Florida is statutorily required to report its attendance data to CE Broker. Although organizations accredited through the ACCME system are not statutorily required to report attendance (as their approval is from an entity other than the medical licensing board), many ACCME and FMA-accredited CME providers in Florida choose to do this.

- The South Carolina Medical Association (SCMA) receives information from its accredited CME providers on a quarterly basis that is uploaded into its database, which also contains data from SCMA’s own CME activities. The SCMA provides, on a biennial basis, a report to the state Board of Medical Examiners of members who have submitted their CME for tracking and met the minimum standard for license renewal (https://www.scmedical.org/education). The SCMA also tracks all South Carolina physicians who participate in its online opioid courses and reports this biennially to the Board of Medical Examiners.

Specialty Societies

Specialty societies are more likely than state medical societies to offer CME tracking tools and capabilities to their members, and this tracking is more likely to relate to MOC requirements. Appendix B summarizes information obtained from 2013 and 2017 surveys of Council of Medical Specialty Societies (CMSS) member organizations.

Personal Digital Strategies

A number of mobile apps and online services are available to track CME credit. A simple search of the phrases “continuing medical education tracker” and “CME Tracker” in Apple’s App Store and Google Play generated multiple hits, including JoyCE, CEAgent, CE Vault Healthcare Edition, CME Tracker, eeds Mobile, My CE, and DocIt, among others. Online membership groups, such as Doximity, and products, such as UpToDate, also offer some level of CME tracking. However, the ability of these products to interface with accrediting bodies is unclear, and the product in many cases seems to be more reflective of a transcript, rather than of a comprehensive tracking system.
Institutional Tracking Systems

Some hospital systems and institutions also offer a type of CME tracking through their credentialing offices or other similar bodies, although this credit tracking may apply only to credit granted for the health system’s own events/CME offerings, and there does not appear to be aggregated information regarding which systems offer these services at the national level. The Association of American Medical Colleges (AAMC) does not officially track which of its member institutions offer CME tracking as a physician employee benefit. However, the Alliance for Continuing Education in the Health Professions (ACEHP) notes that at least one of its major hospital system members, the Cleveland Clinic, offers its employed physicians a free database tool for tracking CME (although it is the responsibility of individual physicians to manage their CME).

DISCUSSION

Perceived Need for a National Repository

As noted in a previous report, the AMA recognizes that a centralized repository and online reporting system for CME credit would be very useful to today’s physicians. However, in addition to the duplicative nature of such a service, some CME providers might resist requirements to report information to an additional central repository as they already provide this service to their members. Furthermore, as noted, some specialty societies already have developed working relationships with their certifying boards as a member service. In addition, each CME provider is required to keep records of the credits it issues to meet the requirements of the AMA PRA Credit System, and this could create additional administrative work for their staff.

The 2013 survey of CME directors from CMSS member organizations found that the majority of specialty societies that manage a database of CME credits earned by their physician members would not prefer a centralized credit database in lieu of their services, as they considered their own CME tracking services to be a valuable member benefit. At that time, specialty societies also were concerned about the potential data integrity/ownership/security issues that could arise with the development of a centralized database.

A 2017 survey of CMSS member societies reinforced this group’s lack of support for the creation of centralized repository; respondents cited multiple reasons for their opinions. “Creating a centralized database would only create additional work for us to copy the records we have to keep into an outside system and answer member questions when the centralized system has errors or the information we provide doesn’t upload correctly,” wrote one respondent. Another noted, “We want to incentivize physicians to see our learning center as their digital home for medical education. Centralizing CME credits elsewhere would fracture that experience.” Others noted the difficulties inherent in creating and maintaining such a system: “This could potentially be a real benefit for physicians. However, it will only be beneficial if there is 100% participation by CME providers, and 100% adoption by the organizations who require CME or coordinate MOC and other elements with CME. The amount of coordination and resources it would take on the part of all organizations involved should not be underestimated.” Another responded, “We understand the AMA’s desire for greater centralization of the data. We request that a large organization like the AMA take into consideration the butterfly effect. One phrase mandating change may seem like a small improvement for the CME enterprise, but will most certainly have a significant impact on the budget for each CME provider.”
Barriers

Additional barriers to the implementation of a centralized tracking system include funding, staffing, and technical and security requirements. In order to create a central repository, all CME providers would need to agree upon technical and data security proposals to ensure interoperability and determine who would pay for database development and maintenance. On several previous occasions, the AMA has considered development of a central repository, but in-depth analysis indicated that such a repository would be impractical due to complexity and cost. A system that includes AAFP and AOA credit would be more complex still.

Opportunities

Suggestions have been made that a remedy could be achieved through the creation of a single web link, which, when followed, directs users to a page with additional links to all specialty society, state medical society, AAFP, AMA, and AOA CME pages (and their vendors that handle CME reporting services). This potentially could reduce the amount of time and frustration physicians currently experience when attempting to access multiple sites. However, this solution would place responsibility on these groups to ensure all links are accurate and up-to-date. Furthermore, simply creating a page of links to reporting sites does not ensure that all credits a physician reports to these sites are automatically shared with licensing bodies.

The AMA is currently developing its Education Center, which aims to improve health and health care and enhance professional competency and satisfaction through trusted, innovative educational resources. The Education Center will deliver education that is based on user needs and focuses on user experience. Today, the Education Center includes routine transcript functionality. In the near term, it will be developing and testing features that support improved and expanded CME tracking and reporting.

RELEVANT AMA POLICY

The AMA Code of Medical Ethics (Opinions on Professional Self-Regulation, E-9.2.6 “Continuing Medical Education”) and existing AMA policy support lifelong learning. Related policies include the following:

- The AMA Principles of Medical Ethics state, V.) A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- Policy D-300.999, “Registration of Accredited CME Sponsors,” states that our AMA will: (1) continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician’s Recognition Award (PRA) policy when designating AMA PRA credit; and (2) remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.
- Policy H-300.980, “Focused Continuing Education Programs for Enhanced Clinical Competence,” states that the AMA: (1) encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education; (2) encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs; (3) supports the collection and dissemination of information on
focused continuing medical education programs that have been developed or are in the process of development; and (4) recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians’ practice.

- Policy H-300.958, “Support for Continuing Medical Education,” states that the AMA:
  (1) Supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education; (2) Encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform; (3) Assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies; (4) Encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education; (5) Supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians; and (6) Supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location.

- Policy H-275.924, “Maintenance of Certification,” states in part that: (10) In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

CONCLUSION AND AREAS FOR FURTHER STUDY

CME credit is currently tracked and monitored to a varying degree by a wide variety of organizations at the state, specialty society, and institutional level, but as a result, physicians lack a single tool to track all types of earned CME credit, including credit earned from multiple CME providers or CME earned from one provider that is applied for multiple purposes (such as state licensing renewal and MOC). Because the nature of tracking and monitoring CME credit can be so specialized, the creation and maintenance of a centralized repository—while helpful for physicians—may not be feasible at this time due to a myriad of factors. Despite these challenges, however, appropriate departments within the AMA should continue to monitor advancements in technology and changes in the CME environment that may inform future deliberations on this topic, and the AMA should continue to actively work with the ABMS, ACCME, the CME provider community including state medical and professional societies, and other CME stakeholders to address these and related issues.
## APPENDIX A: CREDIT-RELATED SERVICES OFFERED BY THE THREE MAJOR CREDIT SYSTEMS

<table>
<thead>
<tr>
<th></th>
<th>Is tracking provided for participants of credit system activities?</th>
<th>Which types of activities are tracked for inclusion in the transcript/CME report?</th>
<th>Is there a fee for tracking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Members</td>
<td>Non-members</td>
<td>Credit system’s own activities as a CME provider</td>
</tr>
<tr>
<td>AAFP(^1)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>AMA(^2)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>AOA(^3)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1 The AAFP directly certifies CME activities offering AAFP credit; these activities are listed on the AAFP website. Activity providers can report activity completion, including credits earned by members. This is optional, and not all activity providers do this; however, if done, the credits are automatically entered into the members’ AAFP transcripts. Individual physician members can also report activity completion and credits earned, and the information is entered into their AAFP transcript. For activities for which the AAFP is the accredited CME provider, the credit is automatically included in the transcript. Non-members receive a letter of participation for each activity, but not a transcript.

2 AMA transcripts include credit for CME activities for which the AMA is the accredited CME provider. However, AMA PRA Category 1 Credits\(^{TM}\) awarded by the AMA for credit conversions through international agreements, international conference recognition program conferences, and direct credit categories are not included in the transcript at this time. Anyone can self-report AMA PRA Category 1 Credit\(^{TM}\) activities from other accredited CME providers and activities for other types of credit.

3 The AOA tracks AOA credits for DO members and non-members, but only DO members are provided access to their CME report, which reflects the credits. AOA credits are reported by the AOA sponsors and posted to the CME activity report. DO members also self-report AMA PRA Category 1 Credits\(^{TM}\) and AAFP credits, and these are included on the CME activity report.
APPENDIX B: SURVEY OF CMSS MEMBER SOCIETIES REGARDING CME TRACKING

<table>
<thead>
<tr>
<th></th>
<th>2013 (N = 17)</th>
<th>2017 (N = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does your society maintain a database of CME credits earned annually for any of the following? Please check all that apply.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member physicians, for CME offered by your society</td>
<td>15 (93.8)</td>
<td>14 (100.0)</td>
</tr>
<tr>
<td>Non-member physicians in your specialty, for CME offered by your society</td>
<td>11 (68.8)</td>
<td>12 (92.3)</td>
</tr>
<tr>
<td>Member physicians, for CME offered by any CME provider</td>
<td>6 (37.5)</td>
<td>6 (50.0)</td>
</tr>
<tr>
<td>Non-member physicians in your specialty, for CME offered by any CME provider</td>
<td>3 (18.8)</td>
<td>3 (25.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If your membership organization offers this service, is there an additional fee associated with tracking the CME?</strong></th>
<th>2013</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>0 (0.0)</td>
<td>16 (100.0)</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Would you prefer a centralized database of CME credits earned by all physicians in lieu of managing such a database through your society?</strong></th>
<th>2013</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
</tr>
<tr>
<td>2 (12.5)</td>
<td>9 (56.3)</td>
<td>5 (31.2)</td>
</tr>
</tbody>
</table>

*Percentages calculated based on the number of respondents answering the individual question.
REFERENCES


9. Personal communication, Laurie Kendall-Ellis, Executive Director and CEO, Alliance for Continuing Education in the Health Professions. July 12, 2017.
EXECUTIVE SUMMARY

The recently issued executive order instituting new limitations on immigration to the United States introduced great uncertainty into the lives of many physicians in training, physician scientists, medical researchers, hospital administrators, and patients. The health care community expressed immediate concern regarding the impacts of the order, especially during a time when physician shortages are predicted and the number of patients with multiple chronic conditions is growing.

Widespread media coverage of the order and multiple court rulings regarding its legality, combined with the overall complexity of existing U.S. visa regulations, have contributed to public confusion regarding this complicated topic and its multiple implications.

This comprehensive review characterizes the orders’ potential impacts on physicians and patients, and seeks to educate physicians so they can appropriately advocate for their patients and their profession. The report explains the content of the executive order; characterizes the reaction from physicians and scientists; reviews visa implications; discusses potential impacts to international research and data sharing; describes institutional staffing and patient access implications; and offers suggestions regarding areas for further study.

The introduction of the order has prompted extensive and very public discussions regarding the physician workforce in multiple venues, all of which provide an excellent opportunity to educate the American people regarding the crucial, life-saving role played in this country by foreign-born physicians. Additional dialogue regarding the importance of collaborative, international research is also valuable and necessary. The Council on Medical Education will continue to follow this issue and report back to the House of Delegates as necessary.
Subject: Impact of Immigration Barriers on the Nation’s Health

Presented by: Lynne M. Kirk, MD, Chair

American Medical Association (AMA) Policy D-255.980, “Impact of Immigration Barriers on the Nation’s Health,” was adopted by the AMA House of Delegates (HOD) at its 2017 Annual Meeting. It states the following:

1. Our American Medical Association (AMA) recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

During the HOD meeting, Reference Committee C heard universal support for the timely and salient resolutions that were introduced regarding these topics, which sought to address and rectify the multiple implications of restricting U.S. travel for foreign-born physicians, trainees, and researchers. Testimony also noted that any travel restrictions could negatively affect patient access to care, especially in areas of need. These same implications hold true for patients served by other foreign-born clinicians and trainees employed in this country.

Restricting travel on the basis of country of origin or religion goes against the principles and policy of our AMA, which has worked to enhance physician diversity and to address the quality of care received and experienced by diverse patients and populations. Additionally, many communities, including rural and low-income areas, face challenges attracting physicians to meet their health
care needs. International medical graduates (IMGs) often fill these openings. Currently, one out of every four physicians practicing in the United States is an IMG. In certain specialties, that number is even higher. These physicians are trained and licensed by the same stringent requirements applied to U.S. medical school graduates. They are more likely to practice in underserved and poor communities, and in primary care and other specialties that face significant workforce shortages.

Concerns related to additional limitations on immigration also have been voiced by the biomedical research community. Restriction of travel can constrain the free flow of ideas and hamper the international cooperation that has historically led to advancements in the delivery of care.

AMA delegates collectively introduced seven related resolutions to the HOD for the 2017 Annual Meeting; an umbrella resolution, which incorporated elements of all seven resolutions, was subsequently adopted. This report addresses Resolves 6 and 7 of that umbrella resolution. The issue of physician immigration also was highlighted by the Council on Medical Education during the Annual Meeting—with support from the Council on Science and Public Health, Academic Physicians Section, International Medical Graduates Section, Integrated Physician Practice Section, and Medical Student Section—through development of an educational session that called attention to and addressed these important concerns.

Individuals eligible for Deferred Action for Childhood Arrivals (DACA) status face related, but not entirely similar, concerns. Council on Medical Education Report 4-A-17, “Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages,” offers a comprehensive review of DACA-eligible individuals, their prospects, and their potential impact on the U.S. workforce. This report was submitted to and adopted by the HOD (see D-350.986), and interested parties are encouraged to review the report and its findings. The Council on Medical Education continues to monitor DACA and will report back to the HOD as needed.

INTRODUCTION

The executive order issued by President Donald J. Trump on January 27, 2017—“Protecting the Nation from Foreign Terrorist Entry into the United States”—introduced great uncertainty into the lives of physicians in training, physician scientists, other medical researchers, and hospital administrators. Many in the health care community expressed immediate concern regarding the impacts of the proposed order on physicians, institutions, researchers, and patients on multiple levels, especially during a time when physician shortages are predicted and the number of patients with multiple chronic conditions is growing.

A recent article published in JAMA effectively frames these legitimate concerns. The article notes, “At least 1 in 4 physicians [in the U.S.] are foreign born. Research demonstrates that foreign-born physicians offer high-quality care, with low mortality rates among their patients. Due to critical health worker shortages, special visas are offered to foreign physicians who practice for 3 years in rural, underserviced communities. More than 13,000 physicians from the 6 Muslim-majority countries with suspended entry practice in the United States, including 9,000 from Iran and 3,500 from Syria. In 2015 alone, 453 foreign nationals from these countries were admitted to residency programs. If this group of physicians were not replaced, given the size of the average primary care patient panel (2,500 patients), the ban could affect more than 1 million patients nationally.”

*1*
UNDERSTANDING THE ORDERS: “PROTECTING THE NATION FROM FOREIGN TERRORIST ENTRY INTO THE UNITED STATES”

• On January 27, 2017, President Donald J. Trump signed the executive order titled “Protecting the Nation from Foreign Terrorist Entry into the United States.” The order barred entry to the United States to all individuals with immigrant and non-immigrant visas from Iraq, Iran, Libya, Somalia, Sudan, Syria, and Yemen for a period of 90 days. Refugees worldwide were subject to an entry ban for 120 days, and refugees from Syria were indefinitely banned. In subsequent days, federal lawsuits were filed in New York, Massachusetts, Virginia, and Washington on behalf of travelers denied entry into the U.S. from one of the seven affected countries.

• On February 3, a Federal District Court halted the implementation of the executive order with a temporary restraining order; also that day, the state of Hawaii filed a lawsuit asking the court to block the order’s implementation.

• On February 4, the Department of Justice appealed the February 3 restraining order to the Ninth Circuit Court of Appeals.

• On February 9, the Ninth Circuit Court of Appeals unanimously ruled to deny the Justice Department’s request for a stay.

• On March 6, rather than continue to litigate the first executive order, President Trump withdrew the first executive order and signed a revised order, which was intended to go into effect on March 16. The revised order removed Iraq from the list of countries facing the 90-day travel ban. Additionally, the order removed the indefinite ban on Syrian refugees and clarified that individuals with a valid visa to enter the U.S. would be permitted to do so, regardless of their country of origin.

• On March 8, Hawaii filed another legal challenge to this revised ban.

• On March 15, a U.S. District Judge issued a temporary restraining order, blocking the executive order from taking effect on March 16. On March 16, a second judge issued a preliminary injunction related to the order.

• On March 29, a federal judge in Hawaii extended an order that blocked the ban from nationwide implementation until Hawaii’s lawsuit was decided.

• On June 12, the Ninth Circuit Court largely upheld the injunction on the revised travel ban.

• On June 26, the U.S. Supreme Court allowed parts of the revised order to go into effect; oral arguments are scheduled to be heard in October 2017 (after drafting of this report). The Supreme Court’s decision upholds the revised order with the exception of those with “any bona fide relationship with a person or entity in the United States,” which is being defined as those with certain family connections in the U.S. (guidance from the State Department indicated that only parents, step-parents, spouses, children, step-children, adult sons/daughters, sons-/daughters-in-law, and siblings apply, but later added fiancées and grandparents as well); students accepted by a U.S. university; individuals with job offers at U.S. companies; and lecturers invited to address an American audience.

• The partial ban went into effect the evening of Thursday, June 29, and expired on September 24. A new ban was then instituted, scheduled to take effect on October 18, which struck the country of Sudan from the list but added Chad, North Korea, and Venezuela (limited to government officials and their families).

• On October 10, the U.S. Supreme Court dismissed one of two pending lawsuits related to the travel ban based on the argument that the ban in question had expired.

• On October 17, a federal judge in Hawaii blocked the revised travel ban, scheduled to go into effect on October 18. As of the writing of this report, restrictions on North Korea and Venezuela will be permitted to go into effect.
REACTION TO THE ORDER

The U.S. medical and scientific community responded immediately and forcefully to both executive orders. Leading national medical groups, including the AMA,\(^9,10\) Accreditation Council for Graduate Medical Education (ACGME),\(^11\) American Association of Colleges of Osteopathic Medicine (AACOM),\(^12\) Association of American Medical Colleges (AAMC),\(^13,14\) American Hospital Association (AHA),\(^15,16\) American Medical Student Association (AMSA),\(^17\) American Osteopathic Organization (AOA),\(^18\) Committee of Interns and Residents (CIR),\(^19\) and National Medical Association (NMA)\(^20\) all registered their serious concerns, often multiple times, over the following months. The Educational Commission for Foreign Medical Graduates (ECFMG), the body that evaluates and certifies qualified graduates of foreign medical schools prior to their entry into the U.S. graduate medical education system, dedicated an entire page of resources on its website related to the executive order.\(^21\)

Individual specialty societies also spoke out. The American College of Cardiology (ACC),\(^22\) American College of Physicians (ACP),\(^23\) American Society for Clinical Oncology (ASCO),\(^24\) American Academy of Family Physicians (AAFP),\(^25\) American Academy of Pediatrics (AAP),\(^26,27\) among others, all expressed unease with the content and implications of the executive orders.

On June 12, the AAMC filed an amicus brief with the Supreme Court in opposition to the government’s petition for a stay against lower court injunctions against the executive order. Twenty-one organizations joined the brief: the AAFP; AAP; American Association of Colleges of Nursing (AACN); American Association of Colleges of Pharmacy (AACP); American College of Healthcare Executives (ACHE); American College of Obstetricians and Gynecologists (ACOG); ACP; American Dental Education Association (ADEA); American Nurses Association (ANA); American Psychiatric Association (APA); American Public Health Association (APHA); Association of Academic Health Centers (AAHC); Association of Schools and Programs of Public Health (ASPPH); Association of Schools of Allied Health Professions (ASAHP); Association of University Programs in Health Administration (AUPHA); Greater New York Hospital Association; Hispanic-Serving Health Professions Schools, Inc. (HSHPS); NMA; National Resident Matching Program (NRMP); Physician Assistant Education Association (PAEA); and Society of General Internal Medicine (SGIM).

As the brief noted, “Individuals from outside the United States play a critical role in the delivery of healthcare in America…Non-U.S. health professionals hail from around the world, including from the six countries subject to the Executive order’s suspension of entry. Economists estimate that more than seven thousand physicians currently working in the United States received training in the six countries, and that those doctors collectively provide fourteen million patient visits each year…Physicians from outside the United States ‘situate [themselves] on the front lines of medical need,’ including rural and other underserved communities, Native American communities, and U.S. Department of Veterans Affairs hospitals. In Alabama, for example, ‘Syria ranks fourth as a source of doctors for medically-needy areas . . . behind India, Pakistan and the Philippines’.”\(^28\)

The brief goes on to describe additional implications: “Collaborative international efforts, especially strengthening the capacity of national health systems, are essential to prevent and prepare for an array of threats, from infectious disease pandemics to the silent killers of chronic non-communicable diseases. Any constraint on the participation of recognized experts in the free exchange of scientific research and collaboration impairs the collective knowledge of our healthcare community and jeopardizes American lives.”\(^29\)
Innovation and medical research were also highlighted in the brief: “The Executive order also has the potential to adversely affect patient care by constraining medical research and innovation. In 2016, all six American winners of the Nobel Prize in economics and scientific fields were immigrants. Moreover, since 2000, immigrants have been awarded 40%—or 31 of 78—of the Nobel Prizes won by Americans in chemistry, medicine, and physics. An analysis of the U.S. Patent and Trademark Office’s online database shows that 76% of patents awarded to the top ten patent-producing U.S. universities in 2011 listed at least one inventor who had been born in another country. During that same period, 56% of all patents were awarded to inventors who were students, postdoctoral fellows, or staff researchers from another country. Because non-U.S. post-doctorate students are increasingly relied upon to counter a decrease in U.S. students pursuing biomedical research in this nation, chilling their participation could adversely affect biomedical research and our health security.”

VISA IMPLICATIONS

As noted in Council on Medical Education Report 11-A-09, “Rationalize Visa and Licensure Process for IMG Residents,” the two most commonly used temporary, nonimmigrant classifications by IMGs are the J-1 Exchange Visitor program and the H-1B Temporary Worker classification.

Most IMGs in graduate medical education (GME) programs arrive under the J-1 Exchange Visitor Program, although the H-1B Temporary Worker category has been increasingly utilized. Data collected via the AMA’s National GME Census reflect changes in the ease or difficulty of obtaining different visas. Between 2001 and 2008, there was an increase in IMGs in residency programs under H status from 1,474 to 4,777. Meanwhile, IMGs under J status declined over the same period from 5,473 to 4,152. Since then, however, more IMGs have been training with J-1 visas. In 2012 there were 4,059 residents with H visas, and 5,200 with J visas; by 2015 there were 2,889 IMG residents with H visas and 6,394 with J visas.

Additional analysis of the AMA’s National GME Census reveals that during the 2016/2017 academic year, 2,477 physicians who were born in the seven countries affected by the original executive order were participating in GME in the U.S. Of those, 615 (24.8 percent) were training here with a visa.

The J-1 visa is a temporary, non-immigrant visa, meant to enhance educational and cultural exchange and promote mutual understanding between the U.S. and other countries. The ECFMG is the only authorized J-1 visa sponsor of foreign national physicians in U.S. clinical training programs. In 2016/2017, the ECFMG sponsored more than 10,000 individuals who are training in U.S. GME programs in 48 states plus the District of Columbia and Puerto Rico. The majority of these physician trainees were in primary care programs: 50 percent in internal medicine, 10 percent in pediatrics, and 7 percent in family medicine. The ECFMG also reports that in the 2017 NRMP Match, while the overall match rate of non-U.S. citizen IMGs increased slightly, fewer IMGs participated in the Match process.

The ECFMG further reports that the number of J-1 visa applications it has received for the 2017/2018 year has declined 33 percent from Iran and 60 percent from Syria, while remaining flat in Libya and Yemen. As of August 15, 2017, 97.8% of the 2,766 physicians initially sponsored by ECFMG for J-1 visa status had successfully secured this status and arrived at their U.S. training programs. Of the 57 initially-sponsored J-1 physicians who are nationals of the countries identified in Executive Order 13780, 50 (87.7%) have successfully secured J-1 status and reported to their training program. Of the 7 (12.3%) who have not yet reported to their programs in J-1 status, 5
already are in the United States in another visa status and awaiting a change of status through U.S. Citizenship and Immigration Services.36

A program known as the Conrad 30 Waiver program, which is intended to lessen physician shortages in medically underserved areas, allows physicians with J-1 status to apply for a waiver for the two-year residence requirement upon completion of the J-1 program (individuals with J-1 status are otherwise required to return to their country of last permanent residence for two consecutive years prior to being permitted to apply for permanent resident status in the U.S.). Participants in the Conrad 30 Waiver program are required to practice medicine for a minimum of three years in an area designated by the U.S. Department of Health and Human Services (HHS) as a health professional shortage area (HPSA), medically underserved area (MUA), or medically underserved population (MUP). At the conclusion of that three-year period, waiver recipients can apply for an immigrant visa and permanent resident status.37

The Conrad State 30 and Physician Access Act (S. 898 and H.R. 2141) is intended to address the most recent extension of the Conrad State 30 Program, which was scheduled to expire on April 28. The AMA strongly supports adoption of the Act, writing that “J-1 visa waivers play a significant role in placing physicians in communities that face healthcare access challenges. Many communities, including rural and low-income urban areas, struggle to attract physicians to meet their patient needs. This legislation will help ensure continued access to care in medically underserved communities across the U.S.”38 As of the writing of this report, these bills had been referred to both the Senate and House Committees on the Judiciary.

**J-1 Visas and the 2017 Match**

The timing of the executive order was extremely disruptive to IMGs applying for residency training programs through the NRMP match, as well as for institutions and program directors seeking to fill their slots. The NRMP was concerned enough to issue a February 3 statement: “We ask the medical education community to support all international medical graduates and their families during these difficult times. Please be assured that NRMP will do all it can to address the uncertainties the order has created. As for the current Match cycle, we hope that applicants and programs will continue to rank each other in the order of true preference, based on the qualifications and qualities each seeks in the other.”39 Although no data exist to support this claim, the Council on Medical Education has heard anecdotally that some GME programs struggled to justify ranking qualified applicants from the list of countries affected by the executive order because of concerns about filling their programs and having enough resident staff on hand to fully serve their local patient populations.

**H-1B Visas**

In March, U.S. Citizenship and Immigration Services (USCIS) reported that it would temporarily suspend premium processing of H-1B visas beginning on April 3.40 H-1B visas grant temporary work status for immigrants who work for a specific employer. A recent *JAMA* article41 noted that physicians practicing in the U.S. with H-1B status accounted for 1.4% of all physicians actively delivering patient care nationwide in 2016 (more than 10,000 physicians). Physicians with this visa status, however, make up much larger percentages of the practicing physician workforce in certain states. For example, of practicing physicians in the following states, 4.7 percent in North Dakota are authorized to work through the H-1B visa program, 4 percent in Rhode Island, 3.9 percent in Michigan, and 3.6 percent in Delaware. It is worth noting, however, that USCIS typically suspends premium processing annually. The primary difference in this suspension, and likely the reason why
it garnered more attention, is that this year’s suspension period was longer (potentially up to six months).

On June 23, USCIS announced that the department would resume the expedited processing of H-1B visas for physicians seeking such status under the Conrad 30 waiver program. As of the writing of this report, premium processing remains suspended for other categories of H-1B petitions.

IMPLICATIONS FOR RESEARCHERS AND GLOBAL DATA SHARING

Physician scientists and researchers were quick to note the obstacles the executive order would introduce into the heretofore collaborative nature of scientific research, which has led to life-saving medical advancements at home and abroad. There were concerns that existing research partnerships might be threatened or terminated and that the next generation of U.S. researchers and biomedical engineers might be depleted as talented individuals from other countries choose to settle and work outside of the U.S.

A group of almost 200 organizations, ranging from professional scientific, engineering, and education societies, as well as leading research universities, signed a letter to President Trump vocalizing their concerns regarding the January executive order. The letter notes, “Scientific progress depends on openness, transparency, and the free flow of ideas and people, and these principles have helped the United States attract and richly benefit from international scientific talent... The Executive order will discourage many of the best and brightest international students, scholars, engineers and scientists from studying and working, attending academic and scientific conferences, or seeking to build new businesses in the United States. Implementation of this policy will compromise the United States’ ability to attract international scientific talent and maintain scientific and economic leadership.”

Furthermore, since the first order was signed in January, more than 41,000 academics and researchers from a variety of fields, including 62 Nobel Laureates, have signed a statement attesting that “The EO [Executive order] significantly damages American leadership in higher education and research... The proposed EO limits collaborations with researchers from these nations by restricting entry of these researchers to the US and can potentially lead to departure of many talented individuals who are current and future researchers and entrepreneurs in the US. We strongly believe the immediate and long term consequences of this EO do not serve our national interests.”

As noted in a recent article in the *New England Journal of Medicine*, “Whether we are concerned about the competence of the physicians who will care for us when we are ill, the biomedical enterprise that represents one sixth of our economy, the jobs created by academic medical centers, or our global leadership position in health and health care, immigration policy that blocks the best from coming to train and work in the United States and blocks our trainees and faculty from safely traveling to other countries is a step backward, one that will harm our patients, colleagues, and America’s position as a world leader in health care and innovation.”

INSTITUTIONAL IMPLICATIONS AND PATIENT ACCESS TO CARE

According to research generated by The Immigrant Doctors Project, physicians from Iran, Libya, Somalia, Sudan, Syria and Yemen provide 14 million doctors’ appointments each year, and almost all Americans (94%) reside in a community that hosts at least one doctor from one of the countries specified in the executive order.
As previously noted, concerns have been voiced that regardless of country of origin, qualified non-US citizen IMGs will in the future pursue training and employment in other countries.\textsuperscript{59} Yet we know that higher proportions of IMGs, compared to U.S. medical school graduates, provide care to socioeconomically disadvantaged patients,\textsuperscript{60,61,62} and health care systems and patients rely heavily on foreign-born physicians. According to a recent article in the \textit{New York Times}, “in Coudersport, Pa., a town in a mountainous region an hour’s drive from the nearest Walmart, Cole Memorial Hospital counts on two Jordanian physicians to keep its obstetrics unit open and is actively recruiting foreign specialists. In Fargo, N.D., a gastroenterologist from Lebanon — who is among hundreds of foreign physicians in the state — has risen to become vice president of the North Dakota Medical Association. In Great Falls, Mont., 60 percent of the doctors who specialize in hospital care at Benefis Health System, which serves about 230,000 people in 15 counties, are foreign doctors on work visas.”\textsuperscript{63} Findings from a recent survey from a physician recruiting agency further highlight this country’s need for foreign-born physicians, noting that just over eight percent of practicing physicians and less than three percent of trainees believe that practicing in a rural area is desirable.\textsuperscript{64}

Some specialties rely more heavily on IMGs. According to data from the 2017 NRMP Match, primary care continues to depend on foreign-born physicians. Of 7,233 positions offered in internal medicine, 2,003 were filled by non-U.S. IMGs. Of 3,356 positions offered in family medicine, 337 were filled by non-U.S. IMGs, and of 2,738 positions offered in pediatrics, 253 were filled by non-U.S. IMGs.\textsuperscript{65} Certain subspecialties also depend heavily on non-U.S. citizen graduates of international medical schools. The NRMP notes that in 2017, these individuals filled 45.1% of nephrology fellowship positions, 41.6% of vascular neurology positions, 39.3% of endocrinology/diabetes/metabolism positions, 37% of interventional pulmonology positions, and 35.3% of abdominal transplant surgery positions.\textsuperscript{66}

\textbf{RELEVANT AMA POLICY}

Policy D-255.991, “Visa Complications for IMGs in GME,” directs our AMA to work with the ECFMG to minimize delays in the visa process for international medical graduates applying for visas to enter the U.S. for GME and/or medical practice; promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for international medical graduates; and work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants and reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. It also calls on our AMA to study, in collaboration with the ECFMG and the ACGME, the frequency of such J-1 Visa reentry denials and their impact on patient care and residency training, and, with other stakeholders, to advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Policy D-255.985, “Conrad 30 - J-1 Visa Waivers,” directs our AMA to advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the U.S. in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad administrators, IMGs, US Citizenship and Immigration Services and the State Department; and continue to communicate with the Conrad 30 administrators and IMG members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
CONCLUSIONS AND AREAS FOR FURTHER STUDY

Ultimately, the real impact of the executive order will not be known until it becomes clear how the language of the revised ban is interpreted and applied at U.S. points of entry both at home and in consular offices abroad. The Supreme Court’s ruling would seem to imply that practicing physicians and resident physicians with a job offer from a U.S. institution will indeed be permitted to travel to and from the United States. However, anecdotal evidence indicates that several incoming resident trainees have either not been able to obtain a visa or have experienced significant delays, preventing them from starting residency on July 1; also, an Iranian researcher with a valid J-1 visa and job offer as a visiting scholar was prevented from entering the country on July 11.67,68

As noted previously, even the specter of immigration limitations can have an effect on individuals seeking to enter the United States. As a recent article observes, “Even with the travel restrictions on hold, admissions from the six nations fell dramatically in March and April, government data show. Compared with a year earlier, the number of people admitted from Iran, Libya, Somalia, Sudan, Syria and Yemen was down by about half year over year. It was unclear whether that was primarily due to fewer people seeking to travel to the U.S. or to the administration rejecting more applications.”69

Although not the focus of this report, what is less clear at this time is how the ruling will apply to foreign students seeking to apply to U.S. medical schools. As a parallel, we might look to the immigration environment immediately following the 2001 terrorist attacks. As one recent article notes, “Student visa applications dropped by 25 percent between 2001 and 2002, and the number of rejections rose from 25 to 34 percent between 2001 and 2003; and perhaps as a result of those post-9/11 policies, the number of international students enrolled at universities dropped for several years, says the 2009 report by the Council on Foreign Relations. ‘Overall, the number of foreign students attending American universities would have been about 25 percent higher if the pre-9/11 growth rates had continued,’ the report says. During that same time period, the report continues, international enrollment in the United Kingdom, France, Australia, Japan, and Germany surged as students went elsewhere.”70 The effects of the executive order on medical school enrollment bear monitoring, as a diverse body of medical students is critical to the creation and retention of a diverse physician workforce.

If there is a bright side to the executive orders, it is this: extensive and very public discussions are taking place in multiple venues, all of which provide an excellent opportunity to educate the American people regarding the crucial, life-saving role played in this country by foreign-born physicians. Additional dialogue regarding the importance of collaborative, international research is also valuable and necessary. The Council on Medical Education therefore will continue to follow this issue and report back to the House of Delegates as necessary.
REFERENCES


29. Ibid.

30. Ibid.


33. Personal Communication from Sarah Brotherton, Director, Data Acquisition Services, American Medical Association.

34. Personal Communication from William Pinsky, President and CEO, Educational Commission for Foreign Medical Graduates.

35. Ibid.

36. Ibid.


58 Ibid.


Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, Speaker
               Bruce A. Scott, MD, Vice Speaker

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 changes will delete references to reports that have been completed but otherwise do
not affect existing policy.

1. Policy D-405.988, “The Preservation of the Private Practice of Medicine,” includes a reference
to a report that was considered by the House at the 2015 Annual Meeting as Board of Trustees
Report 16. That reference will be stricken, but the remainder of the policy unchanged.

Policy D-405.988, “The Preservation of the Private Practice of Medicine”
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit
to patients; (2) will utilize its resources to protect and support the continued existence of solo
and small group medical practice, and to protect and support the ability of these practices to
provide quality care; (3) will advocate in Congress to ensure adequate payment for services
rendered by private practicing physicians; (4) will work through the appropriate channels to
preserve choices and opportunities, including the private practice of medicine, for new
physicians whose choices and opportunities may be limited due to their significant medical
education debt; (5) will work through the appropriate channels to ensure that medical students
and residents during their training are educated in all of medicine's career choices, including
the private practice of medicine; (6) will create, maintain, and make accessible to medical
students, residents and fellows, and physicians, resources to enhance satisfaction and practice
sustainability for physicians in private practice, with a progress report at the 2015 Annual
Meeting; and (7) will create and maintain a reference document establishing principles for
entering into and sustaining a private practice, and encourage medical schools and residency

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programs to present physicians in training with information regarding private practice as a viable option.

2. 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.

3. H-110.987, “Pharmaceutical Cost,” calls for a progress report on a “drug pricing advocacy campaign at the 2016 Interim Meeting.” That report was delivered in Board of Trustees Report 10, AMA Initiatives on Pharmaceutical Costs. Hence the specific call for the report will be removed from policy.

H-110.987, “Pharmaceutical Cost”
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting.
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.

4. 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.

5. 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.

be rescinded as it has been superseded by the new procedure to apportion specialty society
delegates that will be implemented in 2018.

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.

7. 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.

8. 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.

9. 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.

10. 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.

Fiscal note: $250 to edit policy database.