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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

Following the failure of Congress to repeal the Affordable Care Act, the Administration has continued to take steps to undermine the law or provide coverage options outside of the ACA exchanges which could have the impact of weakening the individual market. Previously, the Administration had decided to discontinue payment of cost-sharing reduction benefits to support required premium support for low income individuals enrolled in the ACA exchanges. Other recent actions have included:

• On June 7, 2018, the Department of Justice filed a brief declining to defend the ACA in a case (Texas v. United States) brought by 20 state attorneys general. A week later, our AMA and four physician specialty associations filed an Amicus Brief urging the court to reject the effort to undermine the ACA. In announcing the filing, the AMA noted that “if the lawsuit were successful, federal policy could roll back to 2009, which would be remarkably disruptive to our nation’s health system and every single American.” It would void protections for those with pre-existing conditions, and provisions that allow children to remain on their parents’ plan until age 26. Insurers would no longer be held to the 85 percent medical loss ratio, meaning they could generate higher profits at the expense of coverage and payments for services, and 100 percent coverage for certain preventive services would cease. Furthermore, annual and lifetime dollar limits could be reinstated, leading to more bankruptcies due to health care costs.

• Following on an earlier Executive Order and proposed rulemaking, the Department of Labor on June 19 issued a final rule that would allow more small employers and individuals to form Association Health Plans (AHPs). The Congressional Budget Office has estimated that most individuals in AHPs will be healthier and have higher incomes than individuals in the ACA exchanges, potentially driving up premiums in the exchanges. In comments on the proposed rule, ourAMA noted support for increasing health plan choices for individuals and small businesses seeking coverage in the individual and small group markets, but expressed concern that the plans outlined in the proposed rule fell short of maintaining crucial state and federal patient and provider protections and could result in substandard health coverage. Our AMA also expressed concern over the preemption of state insurance laws and the potential for insolvent and fraudulent AHPs. On July 26, attorneys general of 14 states challenged the rule
in the U.S. District Court for the District of Columbia alleging that changing the definition of
employer is inconsistent with the ACA and is a violation of the Administrative Procedures Act.
• The Centers for Medicare & Medicaid Services (CMS) announced on July 7, 2018, a delay of
ACA risk adjustments for 2017. As noted in a July 16 letter opposing the decision, the risk
adjustment program protects insurers from unanticipated costs in the event their enrollees are
less healthy by transferring funds from plans with healthier enrollees. It is the only ACA
premium stabilization program that is permanent. The letter was signed by our AMA and 27
other organizations representing physicians, hospitals, and patients. Members of both parties in
Congress also expressed concern with the decision. Late on July 24, CMS announced that the
program would be reinstated following changes to the methodology that had played a part in
the decision to suspend the program.
• On July 10, CMS announced a significant cut to funding for consumer enrollment assistance
and outreach through the navigator program. Funding for the 34 states with ACA federal
market places was cut to $10 million, 80 percent less than just two years previous. Again, the
patient and provider community came together to protest this action. On July 26, 190
organizations, including the AMA, wrote HHS Secretary Alex Azar and CMS administrator
Seema Verma protesting the decision and urging the restoration of outreach funding.
• On August 1, the Administration gave the go ahead for short-term limited-duration plans of
364 days, with renewals allowed for up to 36 months. The plans would not be required to
comply with ACA protections such as coverage for pre-existing conditions or provide for
comprehensive benefits. In earlier comments urging withdrawal of the proposal, our AMA had
expressed support for the goal of increasing health plan choices but warned that the proposal
would undercut crucial state and federal patient protections, disrupt and destabilize the
individual market and result in substandard, inadequate health insurance coverage.

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

On July 12, CMS released a proposed rule for calendar year 2019 addressing both the Medicare
Physician Fee Schedule and the Quality Payment Program. In addition to the implementation of
Medicare Access and CHIP Reauthorization Act (MACRA) modifications enacted as part of the
Bipartisan Budget Act of 2018 (BBA18), discussed in a previous edition of this report, there are a
number of additional positive elements in the 2019 Proposed Rule. These include:
• Reduced documentation burden for Evaluation & Management (E&M) office visit codes,
though at this time, the degree of actual burden reduction is uncertain.
• New payments for physician services that are not part of a face-to-face visit (virtual check-ins
with patients, remote consults with patients using videos/photographs, online consults with
other physicians).
• Continuation of low volume threshold policy to exempt small practices from the Merit-based
Incentive Payment System (MIPS).
• A reduction in problematic measures in the Promoting Interoperability provisions (formerly
Meaningful Use and Advancing Care Information).

There are, however, areas of concern where the AMA will be recommending changes, including:
• E&M coding and related policies (add-on codes, multiple same day service reduction).
• AMA will urge reductions in quality measure requirements to reflect reductions in available
quality measures.
• Simplifying the MIPS scoring framework to make it more clinically relevant and
understandable for physicians.
• Keeping the cost category weight at 10 percent rather than increasing it to 15 percent.

The AMA is working closely with national, state and other physician groups to address widespread concerns with the proposed E&M coding changes. As part of our standard process to respond to major policy proposals our AMA is working with national specialty, state and other physician groups to develop recommendations that have broad support across the profession. A joint working group of CPT and RUC experts has been formed to develop recommendations for adjusting E&M coding policies. Given the complexity in this space, a coding change application may not be finalized until early November that may be voted on by the CPT Editorial Panel in early February.

While the E&M coding issues have become a major focus, there are many important issues as part of the QPP or MACRA implementation that will have a significant impact on physician practices.

On July 24, 2018, AMA Immediate Past President David O. Barbe, MD, MHA, testified before the Health Subcommittee of the U.S. House of Representatives Committee on Energy and Commerce on the topic of “MACRA and MIPS: An Update on the Merit-based Incentive Payment System.” Dr. Barbe reminded the committee members that, despite challenges in implementing the MACRA reforms, they continue to be a significant improvement over the previous SGR update system and other legacy programs that were in place prior to MACRA. While the AMA has expressed support for recent improvements to MACRA, including those implemented as part of BBA18, we recognize the need for continued improvements to move further in the direction of choice, flexibility, simplicity and feasibility. These include further simplification and harmonization of the four separate components of MIPS. The AMA will continue to work with Congress and the Administration to refine the current system.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which was to have been established under provisions of the ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for recommendations for Medicare cuts by the board was never triggered.

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

On July 11, 2018, the House Committee on Ways and Means reported 10 separate pieces of legislation to promote the use of consumer directed health care plans, including health savings accounts. After review, our AMA expressed support for eight of the proposals which were consistent with policies adopted by the House of Delegates.

On July 25, the full U.S. House of Representatives considered two bills which had been modified to substantially include the subject matter of nine of the bills previously considered by the Committee on Ways and Means.

H.R. 6199, the “Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018,” passed the House by a vote of 277-142. The underlying bill accomplished a long-supported AMA policy of restoring the ability of consumers to use HSAs, MSAs and HRAs to purchase over the counter drugs and expanded that policy to include feminine hygiene products as qualified expenses. Additionally, the bill adopted by the House allows those accounts to be used for the purchase of gym memberships and equipment, within certain limits; allows high-deductible plans to cover as much as $250 of non-preventive care before the deductible is met; and allows individuals to keep eligibility for an HSA while maintaining a direct primary care service arrangement and, within limits, use HSA funds for those arrangements. The adopted bill also
excludes some items and services from being considered as other coverage if provided at an
employer-owned or retail clinic; allows transfer of funds from an FSA or HRA to an HSA under
certain circumstances; and allows individuals to maintain eligibility for an HSA if their spouse had
coverage under an FSA as long as the FSA is limited to expenses incurred by the spouse.

H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts
Act of 2018, passed the House by a vote of 242-176. The bill would delay for another two years the
Health Insurance Tax imposed by the ACA. It would also allow anyone to purchase a catastrophic
plan, as opposed to the current limitation to those under age 30 or with specific hardship
conditions. The bill increases allowed HSA contributions to match the maximum in allowed out-of-
pocket costs and would allow bronze and catastrophic plans offered through ACA exchanges to be
used with an HSA. H.R. 6311 also allows beneficiaries enrolled only in Medicare Part A to
contribute to an HSA and allows FSA balances to be carried over to subsequent years, though any
contribution limits for the next year would be lowered by the amount over $500 that was carried
over.

At this writing, the potential for Senate consideration is not clear.

STEPS TO LOWER HEALTH CARE COSTS

Our AMA continues to engage with Congress and the Administration on a wide range of efforts
designed to lower health care costs. Ongoing efforts to address the cost of prescription drugs
remain among the highest profile of these efforts. On July 16, the AMA filed comments on the
Administration’s “Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs.” In the
comments, AMA noted that “patients are increasingly taking greater clinical risks when treatments
are cost prohibitive.” AMA comments, which are available on the AMA website, addressed a wide
range of cost drivers, including issues related to competition, transparency, the Part B drug benefit
program, value-based pricing, and the 340B discount program.

During June and July, the Senate Committee on Health, Education, Labor and Pensions held a
series of hearings on reducing health care costs focusing on rural health cost drivers, administrative
costs, the role of quality and value in reducing excess spending. The AMA remains engaged in
conversation with the committee as well as in other Congressional efforts to address the impact of
administrative and regulatory costs and improve transparency of health care costs.

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

Our AMA will remain engaged in efforts to improve the health care system through policies
outlined in D-165.938 and other directives of the House of Delegates.
EXECUTIVE SUMMARY

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared this report to fulfill this HOD directive and to provide an update on 2018 American Medical Association (AMA) advocacy activities.

The AMA was a strong and effective advocate once again for our nation’s patients and physicians this year. The AMA advanced HOD-developed policy on numerous issues. Key victories for the AMA and the Federation of Medicine include:

- Convincing Anthem to reverse course on its Modifier 25 proposal which averted cuts of $100 million in annual payments to physician practices;
- Legislative improvements to the Quality Payment Program (QPP) which will ease physicians’ QPP transition;
- Repeal of the Independent Payment Advisory Board (IPAB);
- Reauthorization of the Children’s Health Insurance Program (CHIP) for 10 years;
- Progress on key recommendations from the AMA Opioid Task Force regarding physician prescribing, physician education, use of prescription drug monitoring programs (PDMPs), and naloxone prescription availability;
- More than 60 state-level victories in collaboration with the Federation on key issues including opioids, insurer practices, and scope of practice;
- Release of the Economic Impact Statement report, which gives policymakers concrete evidence demonstrating how their local communities tangibly benefit when they support legislation that helps physician practices thrive; and
- Over 2 million grassroots engagements through social media to advance the AMA advocacy agenda.

Staff note: This report was prepared in September 2018, and may be updated prior to the Interim Meeting based on more recent advocacy developments.
Subject: 2018 AMA Advocacy Efforts

Presented by: Jack Resneck, Jr., 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 2018 American Medical Association (AMA) advocacy activities.

Once again in 2018, the AMA was a strong and effective advocate for our nation’s patients and physicians. Key wins included Anthem’s reversal of its Modifier 25 policy, Quality Payment Program (QPP) improvements, repeal of the Independent Payment Advisory Board (IPAB), and extension of the Children’s Health Insurance Program for 10 years. The AMA also conducted impactful research such as the Economic Impact Study report. AMPAC continued its strong performance and positioned the AMA to be influential in the 2018 elections (see separate report in Not for Official Business Bag). Finally, AMA grassroots networks and microsites were extremely effective with over 2 million grassroots engagements to advance our advocacy agenda through social media.

DISCUSSION OF 2018 ADVOCACY EFFORTS

Health system reform

In the Bipartisan Budget Act of 2018, Congress repealed the Independent Payment Advisory Board (IPAB) which was an AMA priority and came after several years of strong Federation advocacy. In the same bill, Congress extended the Children’s Health Insurance Program (CHIP) for 10 years. Further, the AMA convinced Congress to strike the House-passed language that would have extended the expiring “misvalued codes” provision for an additional year in 2019. Such a provision would have had both short term and longer term negative effects for physicians.

On June 7, 2018, the Department of Justice filed a brief declining to defend the Affordable Care Act (ACA) in a case (Texas v. United States) brought by 20 state attorneys general. A week later, the AMA and four physician specialty associations filed an amicus brief urging the court to reject the effort to undermine the patient care gains under the ACA. In announcing the filing, the AMA noted that “if the lawsuit were successful, federal policy could roll back to 2009, which would be remarkably disruptive to our nation’s health system and every single American.” It would void protections for those with pre-existing conditions, and provisions that allow children to remain on their parents’ plan until age 26. Insurers would no longer be held to the 85 percent medical loss ratio, meaning they could generate higher profits at the expense of coverage and payments for services, and 100 percent coverage for certain preventive services would cease. Furthermore,
annual and life-time dollar limits could be reinstated, leading to more bankruptcies due to health
care costs.

Also in 2018, the Administration and the Congress attempted to continue chipping away at the
infrastructure of the ACA. The major “repeal and replace” efforts from 2017 were not repeated, but
there were several efforts to modify the ACA’s impact. The AMA commented extensively in the
regulatory process on the Administration’s actions—cutting back funds for navigators, shortening
the enrollment period, eliminating the cost sharing reduction subsidies, expanding association
health plans and short-duration limited coverage plans, and reducing risk adjustment payments.
The AMA is concerned that these actions will lead to higher cost/lower quality health plan choices
for many patients. The AMA is also opposing Medicaid work requirements that are being
considered by both federal and state policymakers.

QPP implementation

The AMA continues to support physicians as they transition to the Quality Payment Program
(QPP). The AMA is also working to improve the QPP at both the regulatory and legislative levels.
The Bipartisan Budget Act of 2018 included a number of QPP refinements requested by the AMA:

• Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System
  (MIPS) payment adjustments and from the low-volume threshold determination;
• The Centers for Medicare & Medicaid Services (CMS) may reweight the MIPS cost
  performance category to not less than 10 percent for the third, fourth and fifth program years
  (rather than requiring a weight of 30 percent in the third year);
• CMS has more flexibility in setting the MIPS performance threshold for years three through
  five to ensure a gradual and incremental transition to the threshold being set at the mean or
  median performance level in the sixth year; and
• The Physician Focused Payment Model Technical Advisory Committee may provide initial
  feedback regarding the extent to which alternative payment model proposals meet criteria and
  an explanation of the basis for the feedback.

On July 12, CMS released a proposed rule covering Medicare physician fee schedule and QPP
changes for 2019. Positive elements of the proposal included:

• Reduced documentation burden for evaluation and management (E/M) office visit services;
• New payments for services that are not part of a face-to-face visit (e.g., virtual check-ins with
  patients, remote patient consults using videos/photographs, online consults with other
  physicians);
• Continuation of the low volume threshold policy to exempt practices from MIPS; and
• A reduction in problematic measures in the Promoting Interoperability component of MIPS
  (formerly Meaningful Use and Advancing Care Information).

However, there were also several areas of concern for which the AMA will be recommending
changes in its comments to CMS, which are due on September 10. These include:

• A proposed collapse of E/M payments for physician office visit codes;
• Reduced payments for office visits and procedures performed on the same day; and
• The need for a simplified MIPS scoring framework and reduced quality measure requirements.

The AMA has been working with Federation groups to further identify positive and problematic
aspects of the proposed regulations, as well as potential constructive solutions.
Regulatory relief

The AMA is focused on regulatory relief and administrative simplification issues beyond what is included in the QPP. For example, in 2017 the AMA convinced CMS to retroactively align legacy pay-for-reporting programs with the current MIPS program for the 2016 reporting period, reducing penalties for physicians by $22 million in 2018. This year, major regulatory wins include:

- The Veterans Administration agreed to exempt only employed physicians from multistate licensure requirements when delivering telehealth services;
- CMS created a new beneficiary look-up tool and launched an education campaign to assist physicians as beneficiaries’ social security numbers are removed from their Medicare cards;
- CMS delayed implementation of appropriate-use criteria;
- Office of the National Coordinator promoted AMA STEPS Forward™ modules with the Federal Health IT Playbook;
- Medicare administrative contractors now must use targeted modeling for audits that emphasizes education to prevent billing errors before they are referred to recovery audit contractors (RACs);
- CMS auditors must use predictive analytics to focus audits on claims that are at high risk for improper payments; and
- RAC auditors now must reimburse physicians for medical records as part of the audit process.

The AMA also sponsored an online discussion board with practice managers and two focus groups with physicians in Chattanooga, TN, and Iselin, NJ, to further explore physicians’ regulatory burdens in order to refine and prioritize its advocacy agenda. Topics covered during the discussions included electronic health record requirements, prior authorization, carrier audits, documentation burdens, prescription drug monitoring programs, and patient translators, among others.

The AMA also commented both to Congress and the Administration on the impact that current Stark self-referral and the anti-kickback statutes are having on physician development and adoption of alternative payment models.

Further, the AMA, through the Professional Satisfaction and Practice Sustainability focus area, has created a Debunking Regulatory Myths website to clarify common regulatory compliance questions for physicians as part of the broader effort to reduce administrative burdens.

Prior authorization (PA)

Prior Authorization (PA) has grown into a major concern among physicians due to patient care delays and practice burdens. The AMA conducted a survey of 1,000 practicing physicians at the end of 2017 which was released this year. Among surveyed physicians, 64 percent reported waiting at least one day for PA decisions from health plans, while 30 percent reported waiting at least three business days. Not surprisingly, 92 percent of physicians said that PA can delay access to necessary care. These delays may have serious implications for patients, as 78 percent of physicians reported that PA can lead to treatment abandonment, and 92 percent indicated that PA can have a negative impact on patient clinical outcomes. Moreover, PA hassles have been growing over time, with 86 percent of physicians reporting that PA burdens have increased over the past five years. Physicians and practice managers also placed PA at the top of their list of administrative frustrations in focus groups and online research conducted by the AMA.

To address these issues, the AMA has undertaken a major campaign to urge health plans to “right-size” PA programs. In January 2017, the AMA established a coalition of 16 other organizations and
released a set of 21 Prior Authorization and Utilization Management Reform Principles. Over 100 additional provider and patient groups have signed on to the principles as formal supporters. The principles spurred conversations with health plans about the need for significant reform in PA programs. One result of these discussions was the January 2018 release of the Consensus Statement on Improving the Prior Authorization Process by the AMA, American Hospital Association, America’s Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. This document reflects an agreement between provider and health plan organizations to pursue PA reform in several key areas.

State legislative efforts are also critical in the AMA’s campaign to improve PA processes, and the AMA is working with state and specialty societies to enact PA and utilization management legislation. The AMA offers model legislation that continues to serve as the basis for many of the state bills and provides resources and support for these efforts. This year alone, more than 20 states are addressing utilization management reform in their legislatures with significant enactments in Indiana, New Mexico, and West Virginia. Physicians struggle with PA in the Medicare Advantage (MA) and Medicare Part D drug plans, so the AMA is addressing PA issues at the federal level too. These efforts include a recent AMA letter to CMS disputing the findings of a Government Accountability Office report that recommended increased use of PA for Medicare-covered services.

The AMA has also launched a grassroots advocacy website dedicated to PA (www.FixPriorAuth.org). The website includes both patient- and physician-oriented online experiences that end with a “share your story” call to action. Compelling stories gathered thus far are featured in the site’s story gallery, and additional physician and patient PA accounts will be added over time and used to guide and support the AMA’s advocacy efforts. FixPriorAuth.org also contains a resource library of PA-related news stories and AMA PA advocacy and educational tools, including the three-part video series on electronic prior authorization that has been approved for 0.25 credits of AMA PRA Category 1 Credit™.

Telemedicine

After concerted AMA advocacy coupled with the efforts of the Digital Medicine Payment Advisory Group (DMPAG), beginning January 1, 2018, Medicare expanded coverage of remote patient chronic care management. This represents a historic expansion of coverage that extends throughout the country without geographic limitations and includes services delivered virtually in a patient’s home. In addition, CMS has proposed to cover additional remote patient management services including a range of technical and professional components that accurately reflect the costs of delivering such services beginning January 1, 2019. Furthermore, the AMA’s coalition building and strong support for the Medicare telehealth provisions of the Bipartisan Budget Act of 2018 which passed earlier this year paves the way for expanded Medicare coverage for telestroke and telehealth services for patients with end stage renal disease, chronically ill patients in Medicare Advantage, as well as coverage of telehealth for beneficiaries in certain accountable care organizations (two-sided risk models only).

The AMA has also worked at the state level to ensure coverage of telemedicine and modernization of medical practice acts. In the 2018 legislative session, 44 states introduced over 160 telehealth-related pieces of legislation. Many bills addressed different aspects of payment regarding both private payers and Medicaid, with some bills making changes to existing payment laws. Many states also proposed legislation directing licensure boards to establish standards for the practice of telehealth within their given profession. The AMA was pleased to see that many of these bills were either based on the AMA Telemedicine Act, or were amended to incorporate language from this model bill. In addition, the AMA supported several state efforts to join the Interstate Medical
Licensure Compact, with now 24 states, DC, and Guam participating in the Compact’s expedited licensure process.

**Diabetes Prevention Program (DPP)**

CMS approved coverage of the Medicare Diabetes Prevention Program (MDPP) effective April 2018. This was a very positive development in the effort to prevent diabetes on a national scale. To further advance these efforts, the AMA has been urging CMS to approve coverage of virtual or digital MDPP programs participation to improve access in rural and underserved areas. The AMA also has ongoing discussions with staff at the Center for Medicare & Medicaid Innovation (CMMI) about the MDPP and has been working to disseminate information about it to potential suppliers. For example, the AMA convened a webinar for health systems interested in the DPP with a CMMI presenter and developed a question-and-answer document for them following the webinar.

**Mergers**

The AMA was instrumental in last year’s action to block the Anthem/Cigna and Aetna/Humana mergers. The Anthem/Cigna merger alone would have cost physicians $500 million in payments annually. In 2018, the AMA had to evaluate several new potential mergers that were not just a health insurer merging with a health insurer but more complicated mergers such as CVS/Aetna which involves a health insurer merging with a pharmacy chain/pharmacy benefits manager (PBM).

In February, the AMA submitted a statement to the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law for a hearing on this merger. The statement expressed the AMA’s concerns that the proposed merger has the potential to worsen competition (or reduce hopes for amelioration) in three poorly performing markets: PBM services; local health insurance markets; and many local retail pharmacy markets.

On June 19, the AMA moved to oppose the CVS/Aetna merger. This was announced in California at a Department of Insurance (DOI) hearing. AMA President Barbara L. McAneny, MD, presented testimony urging regulators to block the proposed CVS/Aetna merger because it is likely to substantially lessen competition in many health care markets, to the detriment of patients. A CVS/Aetna deal would allow the combined corporate entity to fortify dominant positions in health insurance, pharmaceutical benefit management, retail and specialty markets that already lack competition. The AMA’s filing for the hearing also outlined further the merger’s potential negative consequences for health care access, quality and affordability, including:

- An expected increase in premiums due to a substantial increase in market concentration in 30 of 34 Medicare Part D regional markets;
- An anticipated increase in drug spending and out-of-pocket costs for patients as Aetna and CVS fortify their dominant positions in the health insurance, pharmaceutical benefit management, retail and specialty pharmacy markets that already lack competition;
- Reduced competition in health insurance markets that will adversely affect patients with higher premiums and contribute to a decline in the quality of insurance; and
- A foreseeable failure to realize proposed efficiencies and benefits because the merger faces enormous implementation challenges, and those efficiencies have a questionable evidence base.

On August 1, 2018, the California DOI agreed with our arguments and those of the experts that testified, urging the U.S. Department of Justice (DOJ) to block the proposed merger. The AMA
also submitted extensive comments to the DOJ on the proposed merger on August 8. At the time of
this report, the outcome of the proposed merger had yet to be decided, so AMA advocacy
continues.

**Insurer coverage issues**

In 2018, the AMA continued to collaborate with state and specialty medical societies to ensure that
patients have appropriate coverage for unanticipated out-of-network care. The AMA continues to
promote coverage policies that are based on reasonable physician charges, to financially protect
patients and promote fair contracting between physicians and insurers. AMA model legislation
serves as the basis for many of these proactive efforts. Similarly, problematic state bills have been
regularly defeated as the AMA and medical societies communicate to legislators about their impact
on patient access to care and physician practice stability. The AMA has worked closely with state
medical associations and the American College of Emergency Physicians (ACEP) to combat
Anthem/BCBS policies that deny coverage for emergency care when the final diagnosis is
determined to be non-emergent. Legislative restrictions were adopted in Missouri.

**Modifier 25**

At the 2017 Interim Meeting, the House of Delegates established new policy to advocate against
payment reductions for evaluation and management (E/M) codes appropriately reported with a
have been raised by many state medical associations and national medical specialty societies, most
recently in regard to health insurer Anthem’s proposed policy to reduce payments by 50 percent for
E/M services billed with CPT modifier 25 when reported with a minor surgical procedure code
beginning in the first quarter of 2018. Several other insurers have followed suit with similar
proposals.

Starting in November 2017, the AMA advocated directly to Anthem to halt this proposed move.
The AMA sent a letter to Anthem expressing our concerns and hosted two meetings with AMA and
Anthem senior leadership. During these discussions, the AMA voiced strong objections to this
unwarranted reduction in physician payment and presented evidence showing that the
recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC)
do not include duplicative physician work or practice expense for procedures typically billed with
an E/M service on the same date. Many state medical associations and national medical specialty
societies also strongly advocated for Anthem to rescind this policy, which would impede the
 provision of unscheduled, medically necessary care. Following these combined efforts, Anthem
withdrew its modifier 25 payment reduction. The AMA welcomed this news, as this policy would
have had resulted in a $100 million cut in physician payments nationwide.

The AMA has continued advocacy on this issue, to include provision of supporting documentation
to assist medical societies in successfully fighting implementation of modifier 25 payment
reductions by Blue Cross Blue Shield of Michigan and Health Net in California. This will be an
ongoing campaign, and the AMA will engage national commercial insurers and governmental
entities considering similar policies involving modifier 25 or other CPT modifiers. The Centers for
Medicaid & Medicaid Services proposed a new application of the Modifier 25 policy as part of the
evaluation and Management coding proposals. In comments on the proposed rule, the AMA
stressed that these reductions were inappropriate and if advanced would necessitate an extensive
review of related codes to assure that services were accurately valued.
**Opioid epidemic**

The opioid epidemic continues to have a devastating effect on our nation; however, there are signs of progress in physicians’ actions to help end this public health epidemic. The AMA Opioid Task Force issued a report in June 2018 highlighting some of this progress:

- Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million—or 22.2 percent;
- Use of prescription drug monitoring programs (PDMPs) is growing—more than 300 million queries were made in 2017;
- Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000 dispensed per week;
- More than 549,000 physicians and other health care professionals completed continuing medical education (CME) trainings and other Federation education resources in 2017; and
- Finally, the number of physicians trained/certified to provide buprenorphine in-office continues to rise—more than 50,000 physicians are now certified—a 42 percent increase in the past 12 months.

Attention to the need for increased access to Medication Assisted Therapy (MAT) resources is a top priority in 2018—as is calling on health insurers to eliminate PA requirements and other barriers to MAT as well as enhancing access to comprehensive, multidisciplinary treatments for pain, including non-opioid alternatives. AMA model state legislation can help address these and other related areas.

At the federal level, Congress enacted the Consolidated Appropriations Act of 2018 which includes nearly $4 billion for prevention, treatment, and law enforcement efforts targeted at addressing the opioid epidemic. The AMA has been calling for increased federal funding for several years.

In 2018, the AMA offered background, analysis, and technical support to at least 25 states as they addressed the opioid epidemic. This includes support for bills aligned with AMA policy, and efforts to amend or defeat bills with negative provisions. The AMA also continues to maintain and update the AMA opioid microsite, www.end-opioid-epidemic.org, with more than 400 education and training resources specific to state and specialty societies.

**Pharmaceutical cost transparency**

In 2018, the AMA is encouraging patients and physicians to share their stories about the impact of drug pricing and is urging state medical associations to advance AMA model legislation to increase transparency requirements on payers, pharmacy benefit managers and pharmaceutical manufacturers. The AMA also updated the Truthinrx.org website and continues to issue regular updates through the Patients Action Network (PAN) and the Physicians Grassroots Network (PGN) social media channels. The campaign is well-positioned to engage grassroots pressure in favor of positive reform-minded legislation once it materializes.

In May of 2018, the Trump Administration issued a Blueprint for addressing the problem, which is a high priority for the Secretary of HHS, Alex Azar. While the Blueprint lacks detail on key issues, it appears the focus will be on limited regulatory actions that the Administration can take without action by Congress.

The AMA commented on the Blueprint, and expressed strong support for a select number of provisions: (1) requiring pharmaceutical supply chain transparency; (2) accelerating and expanding
regulatory action to increase pharmaceutical market competition and combat anti-competitive practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing information as part of their workflow, including in the electronic health record (EHR); and (4) ensuring federal programs and commercial practices billed as lowering prescription medication prices do so for patients directly. The AMA identified and expressed concern about Blueprint proposals that would increase patient costs and erect barriers, including onerous insurer paperwork requirements that impede timely patient access to affordable and medically necessary medications and treatments. Further, the AMA opposes policies that would financially penalize physicians and pharmacists for high cost prescription medication.

The AMA also sent a letter of support to the Hill for S. 2554, which would prohibit the use of gag clauses in a manner the AMA strongly supports and would provide the Federal Trade Commission with clear authority to combat pay for delay agreements entered into between biological/biosimilar companies.

The AMA has also been working to influence legislative efforts at the state level to address drug costs, often by questioning the business practices and value equation that pharmacy benefit managers (PBMs) add to the system. The AMA has been engaged in the development of model bills by both the National Association of Insurance Commissioners (NAIC) and the National Conference of Insurance Legislators (NCOIL) to better regulate PBM practices. Additionally, nearly 20 states have now enacted legislation to allow pharmacists to discuss drug costs and payment options with patients (gag clause legislation)—policies supported by the AMA and outlined in AMA model legislation.

Gun violence

After another series of tragic mass shootings, the AMA renewed the call for the U.S. Centers for Disease Control and Prevention (CDC) to investigate the root causes of gun violence. There is concern that the CDC is prohibited from conducting this research, but the Dickey Amendment only prohibits the CDC from using appropriated funds “to advocate or promote gun control.” The AMA urged Congress to earmark appropriations specifically for gun violence research efforts. It also commented on proposed regulations issued by the Department of Justice on so-called “bump stocks.”

As the push for federal funding continues, the AMA recently partnered with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit organization that aims to counter the lack of federal funding for gun violence research by sponsoring gun violence research with privately-raised funds. AMA Trustee, Albert Osbahr, III, MD, is on AFFIRM’s steering committee; other physician group partners include the American College of Surgeons, American College of Emergency Physicians, and the Massachusetts Medical Society. More information about the group can be found at www.affirmresearch.org.

In 2018, nine states (Kansas, Louisiana, Maryland, New York, Ohio, Oregon, Utah, Vermont and Washington) enacted laws restricting access to firearms for individuals convicted of domestic violence or subject to a restraining order due to domestic violence. Delaware, Florida, Illinois, Maryland, Massachusetts, New Jersey, Rhode Island and Vermont passed laws establishing gun violence restraining orders. Nine states (Connecticut, Delaware, Florida, Hawaii, Maryland, New Jersey, Rhode Island, Vermont, and Washington) banned bump stocks. Finally, Florida, Louisiana, New Jersey, Oregon, Tennessee and Vermont strengthened background check requirements.
The AMA adopted several policies on gun violence at its 2018 Annual Meeting and will continue to seek opportunities at the federal and state levels to advance new and existing AMA policy on this topic:

- Advocating for schools as gun-free zones;
- Calling for a ban on the sale of assault-type weapons, high-capacity magazines;
- Expanding domestic violence restraining orders to include dating partners;
- Removing firearms from high-risk individuals;
- Supporting an increase in legal age of purchasing ammunition and firearms from 18 to 21;
- Opposing federal legislation permitting “concealed carry reciprocity” across state lines; and
- Supporting gun buyback programs in order to reduce the number of circulating, unwanted firearms.

Scope of Practice

Policy adopted at the 2017 Interim Meeting called on the AMA to convene a meeting of relevant physician stakeholders to create a consistent national strategy to effectively oppose efforts to grant independent practice to non-physician practitioners. To implement this directive, the AMA hosted a summit at AMA headquarters in March 2018. The Scope of Practice Partnership (SOPP) provided funding to support the summit. Eighty-one physicians, executive staff, and government affairs staff from 32 state medical associations, 16 national medical specialty societies, and the American Osteopathic Association joined AMA leadership and staff at the summit. The strategy resulting from this meeting was discussed in detail at the A-18 SOPP meeting and will guide our ongoing advocacy efforts.

In 2018, there was a great deal of concern about the Advanced Practice Registered Nurse (APRN) Compact, a multistate licensure compact developed by the National Council of State Boards of Nursing (NCSBN). It establishes a process by which an APRN with certain credentials can receive a multistate license that allows the APRN to practice in any APRN Compact member state. APRNs practicing under this multistate license can practice and prescribe independently, despite any state law to the contrary. Idaho, North Dakota, and Wyoming have joined the APRN Compact, which will go into effect if 10 states join. Due to AMA and Federation efforts, bills were defeated in Iowa, Minnesota, Nebraska, and no further APRN Compact bills were enacted in 2018.

Immigration

Based on policy adopted at A-18, the AMA wrote to the Administration to withdraw its “zero tolerance” immigration policy and to stop separating children from their families. The fear is that Administration’s policy will do great harm to children and their parents or caregivers. The AMA sent the letter to the secretaries of the Homeland Security and Health and Human Services departments, as well as the U.S. Attorney General. The letter pointed out that childhood trauma and adverse childhood experiences created by inhumane treatment often create negative health impacts that can last an individual’s entire lifespan. The president subsequently issued an executive order reversing the Administration’s position on separating children. The AMA is closely monitoring the reunification of parents and children.

The AMA also voiced concerns in a letter to the Director of the U.S. Citizenship and Immigration Services about delays in H-1B visa processing due to increased inspection of prevailing wage data for incoming non-U.S. international medical graduates (IMGs) who have accepted positions in U.S. Graduate Medical Education (GME) programs.
Cybersecurity

The AMA has been raising awareness of cybersecurity threats to physician practices. Last year, an AMA/Accenture survey of 1300 physicians found that phishing and viruses are the most common types of cyberattacks encountered by small practices. Viruses often appear as a result of software that is not regularly updated or “patched.” To assist physicians, the HHS Office for Civil Rights (OCR) issued a monthly newsletter devoted to cybersecurity issues. In addition to encouraging the federal government to issue additional guidance like this to physicians, the AMA continues to urge stakeholders—including health information technology vendors—to pay special attention to the needs of small and mid-sized practices, which often lack the resources that larger practices and health systems enjoy.

Protecting the patient-physician relationship

In response to the Administration’s plan to withhold federal family planning funding from Planned Parenthood and other entities, the AMA issued a statement and submitted comments strongly objecting to the policy change, asserting that it interferes with patient-physician relationships and negatively affects quality of care. The HHS announcement specifically noted that the regulation update “would prohibit referral for abortion as a method of family planning.” The proposal would also endanger access to care that the Title X program has helped to facilitate. Title X has helped to expand access to basic reproductive health care like birth control, cancer screenings, STI testing and treatment, and exams. The program serves roughly 4 million people every year, many of whom would otherwise be unable to access care. The AMA’s stance on this issue is in keeping with its longstanding position on maintaining patient choice and physician freedom to practice in the setting they choose, and reflects a broader commitment to protecting free communication between patients and physicians.

Physician conscience rights

In 2018, HHS issued a Notice of Proposed Rulemaking on “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority.” In response, the AMA sent a letter to Secretary Azar to express opposition to the measure, citing concern for vulnerable patient populations and asserting that conscience rights for physicians are not unlimited. The proposed rule would dramatically expand the discretion that religious or moral objectors have to refuse care without meaningful safeguards to ensure that the rights of those receiving care are protected. The rule is part of a broader Administration effort to protect religious rights and follows the announcement in late January of the creation of a new office within the Office of Civil Rights (OCR), the Conscience and Religious Freedom Division. The AMA is alarmed because if implemented, the rule would function as a shield for people asserting objections on religious or moral grounds and could permit them to withhold care from already vulnerable groups and create confusion in health care institutions. While the AMA is committed to conscience protections for physicians and other health professional personnel, the exercise of those rights must be balanced against the fundamental obligations of the medical profession and physicians’ paramount responsibility and commitment to serving the needs of their patients.

Equality issues

Five states (Delaware, Hawaii, Maryland, New Hampshire, and Washington) enacted laws opposing “conversion therapy.” AMA policy strongly opposes conversion therapy, and the AMA stands ready to work with state medical associations interested in pursuing a ban on this harmful practice.
In addition, the AMA advocated before the U.S. Department of Veterans Affairs and the Department of Defense on coverage for transgender-related health care services.

Tobacco

The AMA along with more than a dozen other physician groups sent a letter to ranking members of the Senate and House appropriations committees urging them to oppose any provisions that weaken or delay the U.S. Food and Drug Administration’s (FDA) ability to regulate any and all tobacco products. Responding to provisions passed by the House in recent years that exempt thousands of tobacco products—including many candy- and fruit-flavored products now favored by teens—from the scientific review process mandated by the Family Smoking and Prevention Tobacco Control Act is cause for concern as 11.3 percent of high school students in 2016 reported using e-cigarettes during the last 30 days. Under these House provisions, many tobacco products that the FDA had only just begun to regulate, such as e-cigarettes and cigars, would be exempted from a product review if they were on the market prior to Aug. 8, 2016. The oft-cited reason for these provisions is the ability of e-cigarettes to help smokers quit traditional cigarettes; however, the efficacy of this is not yet proven by the research.

At the state level, Maine and Oregon raised the tobacco purchase age to 21. Five states now have this requirement. California, Hawaii, and New Jersey enacted laws in previous sessions.

Economic Impact Study

At the beginning of 2018, the AMA released its updated Economic Impact Study. The report gives policymakers concrete evidence demonstrating how their local communities tangibly benefit when they support legislation that helps physician practices thrive. The 2018 study found that nationally:

- Physicians support nearly 12.6 million jobs. On average, each physician supports more than 17 jobs;
- Physicians create a total of $2.3 trillion in economic output, comprising about 13 percent of the total U.S. economy. On average, each physician supports $3.2 million in economic output;
- Physicians contribute more than $1 trillion in wages and benefits for all supported jobs. On average, physicians support $1.4 million in total wages and benefits per physician; and
- Physicians support $92.9 billion in state and local tax revenues—approximately $126 thousand per physician on average.

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 Congress. A report summarizing AMPAC activities will be distributed at the Interim Meeting in National Harbor.

CONCLUSION

Once again, the AMA has delivered some significant advocacy victories in a challenging political environment. The outcome of the 2018 elections is unknown at the time this report was prepared, but the AMA is poised to work with both sides of the aisle in 2019 to advance the interests of patients and physicians on the most critical health care issues. The AMA thanks its Federation partners for their collaboration and support and looks forward to tackling medicine’s biggest issues when newly elected state and federal officials take office in January.
Subject: Update on TruthinRx Grassroots Campaign

Presented by: Jack Resneck, Jr., MD, Chair

INTRODUCTION

At the 2017 Interim Meeting, the House of Delegates adopted Policy D-110.988[2] “Prescription Drug Price and Cost Transparency,” which asked for a report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. This report, which is presented for the information of the House, summarizes the creation of the TruthinRx grassroots campaign, its evolution, and its progress and impact. The report also summarizes relevant American Medical Association (AMA) policy and advocacy, which is reflected in the TruthinRx grassroots campaign.

BACKGROUND

In 2015, Policy H-110.987, “Pharmaceutical Costs,” directed the AMA to 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. Accordingly, the AMA convened a Task Force on Pharmaceutical Costs, which met four times in the first six months of 2016 to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency among pharmaceutical companies, health plans, and pharmacy benefit managers (PBMs) should be the initial focus of the campaign, which led to the launch of a grassroots campaign in the third quarter of 2016, and the launch of the TruthinRx website, TruthinRx.org, on November 1, 2016.

EVOLUTION OF THE TRUTHINRX GRASSROOTS CAMPAIGN

The goal of the TruthinRx campaign has been to mobilize the AMA Physician Grassroots Network (PGN), the AMA Patient Action Network (PAN), the public, and thought leaders around the challenges posed by the lack of transparency surrounding prescription drug pricing and costs. TruthinRx.org engages physicians, patients/consumers, and health care policy influencers by: (a) providing critical information about prescription drug price and cost challenges, as well as the lack of drug price and cost transparency, and (b) facilitating grassroots action in support of improving prescription drug price and cost transparency. Since its launch in November 2016, TruthinRx.org has evolved through two key stages. In its first stage, the TruthinRx.org landing page focused on informing visitors about how drug price negotiations happen behind closed doors and how pharmaceutical companies, PBMs, and health insurance companies participate in these negotiations. The page concludes that “when patients are left out, health care suffers.” This landing page directs visitors to four main website subsections:

- “Your Stories” – invites visitors to read and contribute their own stories about how the lack of transparency in drug pricing impacts our health care system.
• “Behind the Label” – illustrates how the lack of transparency in prescription drug pricing and costs – involving opaque price agreements between PBMs, health plans, and pharmaceutical manufacturers – contributes to adverse patient effects such as increased costs and unpredictable price swings for patients, and ultimately adversely affects patients and physicians.

• “Get Involved” – facilitates grassroots advocacy by providing visitors with a customizable message that can be personalized to US Senators and Representatives, calling on legislators to support increased transparency in prescription drug prices. Additionally, visitors have an opportunity to subscribe to future legislative updates and alerts from the AMA.

• “Get Informed” – provides visitors with a myriad of timely articles to help them understand the seemingly arbitrary costs of prescription medication. The articles are categorized according to the following thought-provoking questions:
  o “What influences the price of drugs?”
  o “How does drug pricing affect patients like you?”
  o “What’s being done to help?”

At the time that this report was written, the second stage of TruthinRx.org was scheduled to be launched in fall of 2018 to further mobilize voters around the issue of prescription drug price transparency. TruthinRx.org will include an interactive data visualization that highlights various reasons why drug prices fluctuate. The data visualization will explore the roles of four key themes behind drug price fluctuation: (1) generics – despite the assumption that generic drugs will be affordable, over time, the prices of generic drugs can rise significantly; (2) competition – despite the expectation that competition in the marketplace would lead to lower prices, competitors’ prices can seemingly increase simultaneously; (3) acquisition – the price of drugs produced by a given company can rise significantly after the company is acquired; and (4) supply chain dynamics – PBMs cast themselves as saving money, but with the lack of supply chain transparency, it is unclear how these middlemen negotiate drug prices. The data visualization will lead to a call to action for improved transparency. This interactive subsection of TruthinRx.org can be used both on mobile and desktop devices, and is designed so that it can be shared on social media.

PROGRESS AND IMPACT OF THE TRUTHINRX GRASSROOTS CAMPAIGN

The TruthinRx grassroots campaign has significantly impacted public awareness of, and grassroots action in response to, the opaque process that pharmaceutical companies, PBMs, and health plans engage in when pricing prescription drugs. Between the website’s launch in November 2016 and August 2018, the TruthinRx campaign has achieved the following milestones:

• The TruthinRx campaign generated 827,759 messages sent to Congress demanding price transparency.

• As part of the TruthinRx grassroots campaign, the PAN launched a petition calling for increased prescription drug price and cost transparency, and this petition has been signed by 275,590 individuals.

• TruthinRx.org has been visited 117,474 times, by 95,873 unique internet users.

• The AMA has published 656 posts on Twitter and Facebook focused on the TruthinRx campaign. Combined, these posts were displayed 10,859,853 times (“impressions”). This led to 514,118 people interacting with the posts (“engagements”).

• Evidencing the TruthinRx campaign’s continued impact on public discussion, since July 2017, the hashtag “#TruthinRx” has been mentioned on Twitter and/or Facebook 1,617 times.
AMA POLICY AND ACTIVITY

It is important to recognize that the TruthinRx grassroots campaign is one key component of a much broader, ongoing AMA focus on prescription drug affordability. Recent AMA policy and activity aimed at improving prescription drug price and cost transparency include:

- The AMA developed and disseminated model state legislation entitled, “An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year.”
- The AMA submitted comments in July 2018 in response to the HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs. Patient and other stakeholder experiences with affordability and lack of access that were obtained through the TruthinRx campaign were incorporated as vignettes in this comment letter. The AMA has received positive feedback on these vignettes.
- In April 2018, Jack Resneck, Jr., MD, testified at the US House of Representatives Democratic Steering and Policy Committee Briefing on Prescription Medication Pricing and Access Challenges and Solutions. Dr. Resneck’s testimony focused on how the lack of prescription drug pricing transparency impacts his patients.
- In December 2017, Gerald e. Harmon, MD, testified before the Health Subcommittee of the US House of Representatives Committee on Energy and Commerce on the topic of “Examining the Pharmaceutical Supply Chain.” Dr. Harmon’s testimony focused on what the escalating cost and complexity of obtaining medically necessary prescriptions or physician-administered drug treatments mean for patient adherence, timely access, and health outcomes.
- Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs, and health insurance companies and establishes extensive AMA policy aimed at improving access to affordable prescription drugs, including: promoting legislation that authorizes the Attorney General and/or the Federal Trade Commission (FTC) to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients, and encouraging FTC actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers.
- Policy H-110.987, also directs the AMA to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
- Policy H-125.979, which supports legislation or regulation that secures private health insurance formulary transparency.
- Policy H-110.991, which advocates for greater prescription drug price transparency at the pharmacy point-of-sale.
- Policy H-110.991, also supports physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale.

Moreover, the AMA is continuing to develop evolving policy in support of improved prescription drug affordability. Ongoing AMA initiatives include:

- At this Interim Meeting, the Council on Medical Service is presenting Report 1-I-18 that addresses prescription drug importation for personal use.
- At the 2019 Annual Meeting, the Council on Medical Service will present a report that addresses the impact of PBMs on patients.
- At the 2019 Annual Meeting, the Board of Trustees will present a report that addresses three related referred resolutions that address reforming the Orphan Drug Act, legislation related to an optional national prescription drug formulary, and modifications to the Hatch-Waxman Act and Biologics Price Competition and Innovation Act (i.e., Biosimilars Act).
CONCLUSION

In the approximately two years since the TruthinRx grassroots campaign was launched, the initiative has demonstrated significant success in engaging physicians, patients/consumers, and health care policy influencers in discussion of and advocacy to improve prescription drug price and cost transparency. As described above, the TruthinRx campaign is a key component of a broader, ongoing AMA focus on prescription drug affordability, and TruthinRx.org will continue to evolve as relevant AMA policy evolves. The objective metrics outlined above indicate that the TruthinRx grassroots campaign is succeeding in stimulating public discourse, and TruthinRx.org will continue to be updated to capture public attention and mobilize action.
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 areas: Improving Health Outcomes, Accelerating Change in Medical Education, and Shaping Care Delivery and Payment for Professional Satisfaction and Practice Sustainability. These areas have evolved to more encompassing strategic arcs: 1) improving the health of the nation by confronting the chronic disease burden, 2) reimagining medical education, training, and lifelong learning, and 3) attacking the dysfunction in health care by removing the obstacles and burdens that interfere with patient care. They 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 these areas in 2019 and highlights other work to modernize the means through which physicians can engage in advancement of the mission.

ATTACKING THE DYSFUNCTION IN HEALTH CARE

With the continued dramatic shifts in the health care landscape putting more pressure on physicians and their practices, our work continues to focus on addressing the organizational and system level dysfunction that hinders physicians’ ability to provide high quality patient care. Through our ongoing work, we are committed to making the patient-physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. The goal is to create a future pathway for physicians to choose from a broad array of payment and health care delivery models, including viable fee-for-service options, which can provide a sustainable and satisfying physician practice. We are focused on improving—and setting a positive future path for—the operational, financial and technological aspects of a physician’s practice.

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 2019 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.

• Build on the foundation of prior years’ work in the area of physician burnout and professional satisfaction by expanding our empirical research in and understanding of the organizational, system, and environmental factors that contribute to burnout with the aim of developing efficacious methods to defeat the problem at its source.

• Discover and promote the physician perspective across health technology sectors, directing development for improved usability, productive access to data, and respect for the patient-physician relationship.

In addition based on new AMA policy (Policy H-480.940, “Augmented Intelligence in Health Care”) passed at A-18 we will build on our research and development capacity to further our understanding of how best to incorporate the emerging field of artificial intelligence into medical practice to preserve and enhance the patient physician relationship.

IMPROVING THE HEALTH OF THE NATION

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. We have fixed on two ambitious long term goals:

• To have a nation where there is no incidence of preventable type 2 diabetes.

• To have a nation where all adults are meeting their blood pressure goals.

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 widespread 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 began coverage in 2018)
and self-measured blood pressure monitoring devices. Looking forward in 2019, we intend to
blend the “best of” our prediabetes and hypertension work and add programming on cholesterol
management to assist physicians and care teams more comprehensively with cardiovascular risk
reduction for their patients.

REIMAGINE MEDICAL EDUCATION, TRAINING, AND LIFE LONG LEARNING

We are committed to a comprehensive approach to physician professional education and learning.
In 2019, the AMA will have mature and substantial effort in undergraduate medical education, be
expanding to graduate medical education and have a growing presence in physician lifelong
learning. These programs are designed to respond to the on the ground needs of physicians in the
evolving environment in which practice by utilizing modern adult education knowledge and digital
technology.

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 are the consortium’s health system science textbook that is being adopted by
more and more medical schools and the successful application of the chronic care curriculum based
on work done in our Improving Health Outcomes area. The latter is an example of the application
of work emanating from one strategic area to another critical arena.

The initial grant period of the Consortium ends in 2018, but due to the success of this collaboration
the schools have committed to continue to work together with AMA programmatic support to
sustain and grow this community of innovation, but without further grant funds. This is an example
of our efforts to cost effectively catalyze change through partnerships and collaborations. In 2019,
based on the experience and learning from the work in undergraduate medical education, we will
initiate a multi-year program to smooth the transition from medical school to residency through a
number of demonstration programs that include medical schools, residency programs, and
associated health systems.

In 2018, we continued to build education delivery capabilities with the development and launch of
the new AMA Ed Hub™ platform. The platform blends innovations in content, technology, and
user experience to deliver increasingly more personalized and compelling virtual learning
experiences to meet individual needs and preferences. AMA Ed Hub brings together the AMA’s
diverse educational offerings under one unified umbrella. Included are Learning™, STEPS
Forward™, GME Competency Education Program (GCEP), e-learning modules that support the
AMA’s Health Systems Science textbook, interactive micro-learning modules based on the AMA’s
modernized Code of Medical Ethics, curricula related to pain management, firearm safety and other
topics. As we look to 2019 and beyond, we will continue to build and enhance the platform as a set
of digital solutions that optimizes discovery of educational content for individual users, facilitates
delivery of an educational curriculum at an organization level, explores innovations in learning
experiences more closely connected to physicians’ daily practice, and expands automatic reporting
capabilities to support licensure and certification. We also will be exploring collaborations with
other organizations to advance both educational content and platform offerings.
ENGAGING PHYSICIANS AND ADVANCING THE MISSION

Our ambitions are high and we must utilize all available tools and assets to reach them. To this end we wish to highlight three areas of leverage.

First, beginning in 2016 we have been building an innovation ecosystem that connects AMA experience, knowledge, and mission priorities with technology and private sector groups. Our wholly owned Silicon Valley situated subsidiary Health 2047 is a centerpiece of this effort. Accessing world class technology, product development, and venture expertise it focuses on the commercial complements of the AMA’s strategic arcs. It has already founded a data interoperability company and we anticipate several new ventures in 2019 that will address other important areas that advance our mission.

Second, the goal of health equity is infused in all our strategic work. Each of the mission areas have components directed toward the health equity goal. Based on guidance from the House and with the support of the Board of Trustees in 2019 AMA management will establish a functional hub that further facilitates and enhances concentration on this area. The unit’s objective will be to ensure optimal coordination, collaboration, and program development across the AMA’s mission areas in support of our commitment to national health equity.

Third, as evidence of AMA mission impact continues to grow, there is an opportunity for AMA to deepen its engagement and strengthen its brand identity among physicians, students, residents and other stakeholders. By leveraging more sophisticated approaches to identifying interests and needs of the physician population, we can continuously improve our services and offerings to retain and grow our membership base. We will create new connections, drive awareness and increase opportunities to interact with the AMA using traditional and interactive/social/digital media, building off our experience in 2018.

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.
REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

Ceja Opinion 1-I-18

Subject: Medical Tourism

Presented by: James E. Sabin, MD, Chair

INTRODUCTION

At the 2018 Annual meeting, the American Medical Association (AMA) House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-A-18, “Medical Tourism.” 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-1.2.13 – Medical Tourism

Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, high quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient’s decision to seek health care abroad. (IV, V, VI)

* 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.
Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.

(b) Advocate for education for health care professionals about medical tourism.

(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.

(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual’s concerns and wishes about care.

(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.

(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.

(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.

(i) Offer their best professional guidance about a patient’s decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patient’s best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.

(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician’s prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:

(i) the nature and duration of the patient-physician relationship;

(ii) the likely impact on the individual patient’s well-being;

(iii) the burden declining to provide follow-up care may impose on fellow professionals;

(iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services. (IV, V, VI)
REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS1*

CEJA Opinion 2-I-18

Subject: Expanded Access to Investigational Therapies

Presented by: James E. Sabin, MD, Chair

INTRODUCTION


E-7.3.10 – Expanded Access to Investigational Therapies

Physicians who care for patients with serious, life-threatening illness for whom standard therapies have failed, are unlikely to be effective, or do not exist should determine whether questions about access to investigational therapy through the U.S. Food and Drug Administration’s “expanded access” program are likely to arise in their clinical practice. If so, physicians should familiarize themselves with the program to be better able to engage in shared decision making with patients.

When a patient requests expanded access to an investigational therapy, physicians should:

(a) Assess the patient’s individual clinical situation to determine whether an investigational therapy would be appropriate, including:

   (i) whether there is a satisfactory alternative therapy available to diagnose, monitor, or treat the patient’s disease or condition;

   (ii) the nature of potential risks of the investigational therapy and whether those risks are not unreasonable in the context of the patient’s disease or condition;

   (iii) whether the potential benefit to the patient justifies the risks of the investigational therapy;

   (iv) whether the patient meets inclusion criteria for an existing clinical trial of the investigational therapy.

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(b) As part of the informed consent process, advise the patient (or parent/guardian if the
patient is a minor) that the investigational therapy has not yet been demonstrated to be
effective in treating the patient’s condition and may pose as yet unknown risks.
Physicians should explain the importance of clinical trials, encourage patients who meet
inclusion criteria to participate in an existing trial rather than seek access to
investigational therapy through the FDA expanded access program, and direct patients
who wish to participate in research to appropriate resources.

(c) Decline to support an application for expanded access to an investigational therapy
when:

(i) the physician judges the treatment with the investigational therapy not to be in the
patient’s best interest, and explain why; or

(ii) the physician does not have appropriate resources and ability to safely supervise
the patient’s care under expanded access.

In such cases, physicians should refer the patient to another physician with whom to discuss
possible application for expanded access.

(d) Discuss the implications of expanded access for the patient and family and help them
form realistic expectations about what it will mean to be treated with the investigational
therapy outside a clinical trial. Physicians should alert patients:

(i) to the possibility of financial or other responsibilities associated with receiving an
investigational therapy through expanded access;

(ii) to the lack of infrastructure to systematically monitor and evaluate the effects of
the investigational therapy outside a clinical trial;

(iii) that they need information about how to contact the manufacturer for guidance if
they seek emergency care from a health care professional who is not affiliated with
a clinical trial of the investigational therapy;

(iv) that the physician has a responsibility to collect and share clinical information
about the patient’s course of treatment with the investigational therapy, as well as
to report any adverse events that may occur over the course of treatment;

(v) to the conditions under which the physician would recommend stopping treatment
with the investigational therapy. (V,VI)
Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: James E. Sabin, MD, Chair

INTRODUCTION


The merger of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity. Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.

Physician-leaders within institutions that have or are contemplating a merger of secular and faith-based institutions should:

(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the same breadth of services and care previously offered will continue to be available to the community.

(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

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(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same breadth of services and care remain available to the community.

(d) Recognize that physicians’ primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

Individual physicians associated with secular and faith-based institutions that have or propose to consolidate should:

(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.

(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care. (VII, VIII, IX)
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-1-18

Subject: Review of AMA Educational Offerings

Presented by: Carol Berkowitz, MD, Chair

INTRODUCTION

The Council on Medical Education has been gratified to observe our American Medical Association’s (AMA) committed investment in and focus on the development and provision of high-quality educational resources and initiatives for physicians and physicians in training, and is pleased to be able to highlight these to members of the House of Delegates (HOD).

THE EARLY YEARS: THE AMA’S COUNCIL ON MEDICAL EDUCATION

Our AMA’s commitment to medical education dates to the founding of the Association in 1847, when one of its first acts was to appoint a body known as the Committee on Medical Education. The Committee on Medical Education was transformed into the Council on Medical Education in 1904; an addition to AMA bylaws in that year noted that:

The functions of the Council on Medical Education shall be:

- To make an annual report to the House of Delegates on the existing conditions of medical education in the United States.
- To make suggestions as to the means and methods by which the American Medical Association may best influence favorably medical education.
- To act as the agent of the American Medical Association (under instructions from the House of Delegates) in its efforts to elevate medical education.¹

In 1905, the Council published its first set of educational standards for medical schools, recommending (1) that medical schools require preliminary education sufficient to enable the candidate to enter a recognized university; (2) a 5-year medical course; and (3) a sixth year as an intern in the hospital.²

In 1906, the Council, tasked with rating U.S. medical schools, surveyed 160 schools regarding the performance of graduates on state licensure examinations. Schools were graded as acceptable, doubtful, or non-acceptable based on a set of ten defined qualifications. Only 82 schools received an “acceptable” rating. This led to the Council’s 1909 partnership with the Carnegie Foundation on a new study of medical schools; the results of this study were published in 1910 in the Flexner Report.³

In the intervening years, our AMA, through the Council on Medical Education and other groups, has been involved in the establishment of many of the leading U.S. medical education organizations that exist today and with the development of multiple educational innovations. These organizations and innovations are summarized in Appendix A.
EXPANDING OUR AMA’S EDUCATION DEVELOPMENT AND DELIVERY
CAPABILITIES

Our AMA has recently dedicated additional resources and staff to its educational initiatives, and as a result, numerous innovations are being developed.

Content

In-house instructional design capabilities have been enhanced, and measures have been taken to ensure educational content incorporates learning trends that engage adult learners. Additionally, our AMA has developed a library of templated eLearning interactions, which can be leveraged across the organization in content development efforts. A robust quality rubric has been implemented to guide the planning, development, and evaluation of education. The rubric helps to ensure that education is well-designed and likely to result in achieving the desired learning outcomes. Finally, the assessment creation process has been improved to better evaluate mastery of learning objectives.

Platform

Our AMA plans to launch a unified education delivery platform known as the AMA Ed Hub™. The AMA Ed Hub™ will bring together our AMA’s diverse educational offerings under a unified umbrella, including JN Learning™; the GME Competency Education Program (GCEP); e-learning modules that support our AMA’s Health Systems Science (HSS) textbook; interactive micro-learning modules based on our AMA’s modernized Code of Medical Ethics; the STEPS Forward™ practice transformation series; and curricula related to pain management, firearm safety, and other topics. The platform will blend innovations in content, technology, and user experience to deliver increasingly more personalized and compelling virtual learning experiences to meet individual needs and preferences. Additionally, it will feature trusted education in engaging and multi-dimensional formats to satisfy a variety of preferences (audio, interactive, journal, and video). The platform is designed to facilitate easy discovery of relevant education. All content is standardized, tagged, and enriched in a way that allows our AMA to actively engage learners by offering content across many channels, sites, apps, and products.

OUR AMA’S EDUCATIONAL INITIATIVES AND RESOURCES

Our AMA is also proactively seeking cooperation between business units to mine additional educational content, more effectively leverage subject matter expertise across products, and expand target audiences. For example, authors of the HSS textbook have extended their contributions beyond medical school to residency by contributing to the development of GME Competency Education Program educational modules. Also, education regarding physician burnout has been repackaged to focus on burnout at the resident physician level.

Accelerating Change in Medical Education Consortium innovations

Our AMA’s Accelerating Change in Medical Education initiative, launched in 2013, has fostered a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and
communication of groundbreaking ideas and projects. The AMA awarded grants to an additional 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools are represented in the 32-member consortium, which is delivering revolutionary educational experiences to approximately 19,000 medical students—students who one day will provide care to a potential 33 million patients annually.

A summary of innovations resulting from the Consortium can be found in Appendix B. Additionally, a comprehensive, annotated bibliography of publications based on the work of the Consortium has been published and is available for review.

Innovative Educational Formats in the JAMA Network

The JN Listen™ app provides learners with convenient access to engaging podcasts based on peer-reviewed articles published in JAMA. Learners can listen to content they select and earn CME, all via the mobile app.

STEPS Forward™

The AMA STEPS Forward™ practice transformation series is an online educational product designed to offer innovative strategies that assist physicians in the new health care environment. Leveraging findings from an AMA-RAND study, the online modules provide clinicians and practice managers with the data, tools, education, and certification needed to be successful in a value-based payment environment. Learners can take courses about patient care, workflow and process, and professional well-being, among other topics. All STEPS Forward™ modules are Centers for Medicare & Medicaid Services-approved Clinical Practice Improvement Activities; by completing these modules, physicians can demonstrate compliance with Merit-Based Incentive Payment System requirements.

Recently, each of the 48 available modules’ learning objectives and assessments were revised to ensure that learner expectations and outcomes are aligned. Content is currently being converted to a standardized format for multichannel publication.

GME Competency Education Program

The AMA GME Competency Education Program (GCEP) comprises a series of online educational modules designed to complement teaching in patient settings and didactic curricula in residency and fellowship programs. The program helps residents and their institutions meet core competency requirements. In 2018, GCEP was selected as a Gold winner in the 2018 Digital Health Awards, which recognizes high-quality digital health resources for health professionals.

Over the past year, the 33-module GCEP library has been upgraded to add animation, case vignettes, and mock simulations to help residents visualize how the content is applicable to their daily practice. The final eight modules are currently being enhanced, including content on quality improvement practices, promoting medication adherence, navigating a lawsuit, and creating an effective and respectful learning environment, among other topics. Personalized instruction has been incorporated, as well as guided learning using relatable mentor characters.

Health Systems Science

In addition to basic and clinical sciences, recognition is growing that physicians also need to know HSS, understanding how care is delivered, how patients receive that care, and how systems...
function to improve health. By the end of 2018, the AMA plans to have completed six e-learning modules for medical students that complement the HSS textbook, with the goal of providing a cohesive introduction to HSS. While the initial target audience is medical students, faculty development components will be included. Eventually, a parallel learning strategy for faculty and residents is also envisioned. Current modules in development include systems thinking, patient safety, and population health.

Ethics

In 2017, our AMA adopted the modernized Code of Medical Ethics, and new, interactive micro-learning modules have been created around key Code opinions. In 2018, the AMA has been developing new modules on privacy and confidentiality, surrogates, and physicians as leaders.

Health Equity

To support the work stemming from our AMA’s newly adopted policy related to health equity, a new module has been launched titled Collecting Patient Data: Improving Health Equity in Your Practice.

The AMA Physician’s Recognition Award and Credit System

The AMA Physician’s Recognition Award (PRA), established by the HOD in December 1968 and celebrating its 50th anniversary in 2018, recognizes physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The AMA PRA credit system was developed to describe CME activities with sufficient educational value that could be counted towards the requirements to obtain the PRA. AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations.

The AMA PRA credit system has continued to respond to the needs of physicians and to changes in the practice of medicine. Recognizing that physicians learn in different ways and that a variety of educational formats should be recognized for credit, the Council on Medical Education has approved new educational formats for AMA PRA Category 1 Credit™ over the years in addition to the original formats of live certified activities and enduring materials. Subsequently approved formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003), Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017, the Council on Medical Education approved a format of “Other” for those activities that meet core requirements but do not fall within one of the already existing formats.

The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a Council on Medical Education report to establish a process for qualified international conferences to offer AMA PRA Category 1 Credit™ to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn AMA PRA Category 1 Credit™ have expanded to include activities covered by agreements between the AMA and the credit systems of other regions and nations. Three agreements currently exist, with the European Union of Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar Council for Healthcare Practitioners.
Section/Council Educational Sessions

Since 2014, AMA sections and/or councils have produced approximately 120 educational sessions at the Annual and Interim meetings (15 sessions per meeting, on average), in addition to various other activities provided throughout the years. Nationally renowned experts, including many AMA members, have educated on important and timely topics, such as physician burnout, the opioid epidemic, firearm safety, value-based care, physician leadership, and innovation.

Collaboration with External Organizations

Our AMA continues to work to lessen the administrative burden for physicians by simplifying and streamlining the automatic tracking and reporting of credit to support certification and licensure needs. Currently, our AMA partners with the ACCME and ABIM to report completed JAMA Network CME activities on behalf of physicians certified by the ABIM. The AMA will extend these reporting capabilities to include all AMA educational activities and additional ABMS member boards in 2019. Finally, a pilot is being planned with the ACCME and Board of Medical Examiners in Tennessee to report completed activities on behalf of physicians licensed in Tennessee.

Our AMA has also been approved as an ABMS Multi-Specialty Portfolio Program sponsor and has developed CME programs that are eligible for continuing certification (MOC Part IV) credit.

Future Innovations

Additional planned innovations will focus on educational features and apps that offer innovation in the education space. Currently, our AMA is:

• Leveraging augmented intelligence to power learning experiences;
• Taking new approaches to documenting meaningful involvement in performance improvement; and
• Considering different types of assessment, which could expand the content for which credit can be offered.

Finally, our AMA is also exploring the potential of the AMA Ed Hub™ platform to be of service to other educational providers.

SUMMARY

For 150 years, our AMA has demonstrated a commitment to developing and supporting advancements in medical education, both autonomously and in partnership with others. From the Council on Medical Education’s contributions to the Flexner Report, to the groundbreaking Accelerating Change in Medical Education Consortium, to newly enhanced e-learning content design and delivery, our AMA is well positioned to lead medical education innovations into the next century.
APPENDIX A: THE AMA’S INFLUENCE IN ESTABLISHING MANY LEADING U.S. MEDICAL EDUCATION ORGANIZATIONS AND DEVELOPING EDUCATIONAL INNOVATIONS

1847 The American Medical Association is organized and the Committee on Medical Education is formed.

1904 The AMA transforms the Committee on Medical Education into the Council on Medical Education (Council).

1905 The Council publishes its first set of educational standards for medical schools.

1906 The Council performs its first inspection of medical schools.

1910 The Council’s partnership with the Carnegie Foundation leads to the publication of the Flexner Report.

1912 The Council fields its first survey of hospitals for the training of interns.

1919 The Council establishes the “Essentials” for approved Internships.

1920 The Council organizes 15 committees to study and “recommend what preparation was deemed essential to secure expertness in each of the specialties”; these committees represent the forerunners of today’s boards.

1927 The Council begins approval of residency programs in hospitals.

1928 The Council establishes “Essentials” for registered hospitals and for approved residencies and fellowships.

1934 The Council approves examining boards for the certification of specialists and establishes standards for the formation of American boards in the specialties.

1939 The Council, with the American Board of Internal Medicine (ABIM) and American College of Physicians (ACP), forms the Conference Committee on Graduate Training in Internal Medicine, later to become the Residency Review Committee for Internal Medicine; other specialty boards soon request their own committees.

1942 At the request of the Council, the AMA Board of Trustees and the Association of American Medical Colleges (AAMC) form the Liaison Committee on Medical Education (LCME).

1948 The Council and the Advisory Board for Medical Specialties establish the Liaison Committee for Specialty Boards.

1950 The Council establishes the Conference Committee on Graduate Training in Surgery.

1954 With representation from the Council, the AAMC, the American Hospital Association (AHA), and the Federation of State Medical Boards (FSMB), an Internship Review Committee is established to review the reports of surveys of intern training programs made by members of the Council’s field staff.
1955 Based on work performed by the Council, the “Publication of Postgraduate Medical Education in the United States: A Report of the Survey of Postgraduate Medical Education Carried Out by the Council on Medical Education and Hospitals” is published.

1957 A guide on postgraduate medical education (continuing medical education) is issued.

1957 With the AHA, AAMC, and FSMB, the Council sponsors the organization of the Educational Commission for Foreign Medical Graduates (ECFMG).

1962 The AMA completes the first accreditation survey of continuing medical education (CME) sponsors; the lists of accredited sponsors are published in *JAMA*.

1967 The Advisory Committee on Continuing Medical Education, of the AMA House of Delegates, develops a nationwide accreditation system for CME providers.

1968 The AMA establishes the AMA Physician’s Recognition Award (PRA) to recognize physicians who earn at least an average of 50 credits per year from educational activities that meet AMA standards and the AMA PRA CME credit system.

1970 The Advisory Board for Medical Specialties is reorganized as the American Board of Medical Specialties (ABMS).

1971 The Council establishes the Liaison Committee on Graduate Medical Education, which later becomes the Accreditation Council for Graduate Medical Education (ACGME).

1977 The Council establishes the Liaison Committee on Continuing Medical Education (LCCME).

1981 The AMA, with the AAMC, AHA, FSMB, ABMS, Association for Hospital Medical Education, and Council of Medical Specialty Societies, creates the Accreditation Council for Continuing Medical Education (ACCME) as successor to the LCCME for the accreditation of CME sponsors.


1991 The AMA’s Fellowship and Residency Electronic Interactive Data Access (FREIDA) System is established.

1996 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for reading journal articles.

1996 AMA FREIDA becomes AMA FREIDA Online®.
2000 The Council approves its first international agreement for the conversion of CME credits, providing physicians the opportunity to receive *AMA PRA Category 1 Credit™* for attending European Union of Medical Specialists educational activities certified for credit. Other agreements would follow.


2003 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for test item writing and manuscript review learning formats.

2004 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for Performance Improvement CME (PI CME) learning format.

2005 The Council on Medical Education approves *AMA PRA Category 1 Credit™* for Internet Point of Care learning format.

2005 The AMA embarks on its Initiative to Transform Medical Education (ITME).

2006 The Alliance for CME awards the AMA the Frances M. Maitland PACME Award for “significant contribution to the field of CME and the future of the profession.”

2006 The AMA trademarks the phrase *AMA PRA Category 1 Credit™*.

2006 Phase 2 of ITME begins, resulting in recommendations for change across the continuum to address identified gaps in medical education.

2007 Phase 3 of ITME begins with a working conference on Optimizing the Medical Education Learning Environment.

2008 Phase 3 of ITME continues with a conference in collaboration with the American Academy of Pediatrics on Physician Reentry into Practice.

2009 The AMA and Association of American Medical Colleges hold ITME Conference on Increasing Attention to Behavioral Competencies in the Admissions Process.

2010 The AMA and AAMC co-sponsor an invitational conference, “New Horizons in Medical Education: A Second Century of Achievement.”

2011 The AMA Innovative Strategies for Transforming the Education of Physicians (ISTEP) research collaborative begins the second stage of its study of the medical education learning environment.

2012 The AMA announces a new strategic plan to focus on Accelerating Change in Medical Education as one of its three main focus areas.

2012 The AMA and AAMC sign a formal agreement that outlines their joint, ongoing commitment to supporting the medical education accreditation process.
2013 The AMA announces grant funding for medical school innovations and awards $11 million to 11 medical schools nationwide as part of its Accelerating Change in Medical Education initiative.

2013 The AMA PRA recognizes teaching students and residents as an *AMA PRA Category 1 Credit™* activity.

2013 The AMA launches its Save GME grassroots campaign (saveGME.org) to urge Congress to preserve GME funding and lift the federal cap on residency slots.

2014 The AMA is among the four signers of a formal agreement between the LCME and the Committee on Accreditation of Canadian Medical Schools (CACMS) to ensure medical school graduates in both the United States and Canada meet their respective countries’ standards and are prepared for the next phase of their medical training.

2014 The Council on Medical Education convenes a conference with the ABMS and its member boards to discuss ways to improve Maintenance of Certification and make the process more meaningful for physicians.

2015 The AMA awards grants to an additional 21 medical schools as a part of the Accelerating Change in Medical Education Consortium, further expanding this community of learning.

2018 The Council on Medical Education co-convenes a second conference with the ABMS and its member boards to discuss the future of continuing certification.
### APPENDIX B: SUMMARY OF CONSORTIUM INNOVATIONS IN MEDICAL EDUCATION

<table>
<thead>
<tr>
<th>INNOVATION FOCUS</th>
<th>SUMMARY</th>
<th>PUBLICATIONS AND OUTCOMES</th>
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<td>Developing flexible, competency-based pathways</td>
<td>Medical education at all levels is shifting away from emphasizing time spent in lectures and classrooms and toward establishing that the necessary knowledge and skills have been acquired. Medical schools are incorporating milestones and entrustable professional activities (EPAs) into the curriculum to determine the best path for students to follow in order to move to the next level of training. These flexible, competency-based pathways create physicians who are comfortable assessing their abilities and addressing any deficiencies throughout their careers.</td>
<td>Generalizing Competency Assessment Scores Across and Within Clerkships⁹</td>
</tr>
<tr>
<td>Teaching new content in Health Systems Science</td>
<td>To fully serve patients, physicians must know more than biomedical and clinical sciences. The new discipline of health systems science includes understanding how to improve health care quality, increase value, enhance patient safety, deliver population-based care, and work collaboratively in teams. Physicians need to learn how to advocate for their patients and communities and understand the socio-ecological determinants of health, health care policy, and health care economics.</td>
<td>Health Systems Science¹²</td>
</tr>
<tr>
<td>Working with health care delivery systems in novel ways</td>
<td>Consortium schools are creating new learning experiences embedded within health care systems. Training students to be patient navigators, to plan and execute quality improvement projects, and to perform important functions that benefit patient-centered teams serve dual purposes. Students learn about health care delivery by working in authentic settings and are able to contribute to</td>
<td>How Can Medical Students Add Value? Identifying Roles, Barriers, and Strategies to Advance the Value of Undergraduate Medical Education to Patient Care and the Health System.¹⁵</td>
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<tr>
<td>Making technology work for learning</td>
<td>Consortium schools are adapting technology in new ways to solve key problems and advance physician training. They are teaching the use of EHRs, management of patient panels to improve health outcomes, and interpretation of big data. In addition, schools are applying learning technology to manage individualized, flexible progress by assessing student competencies along their medical education journey. New tools are being used to compile assessment data that will allow for easier self-assessment by students and review with faculty coaches.</td>
<td>Regenstrief EHR Clinical Learning Platform(^\text{18})</td>
</tr>
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<td>Envisioning the master adaptive learner</td>
<td>Physicians need to rapidly access and interpret continuously evolving information and to understand how the use of new data supports the delivery of the best patient care. One of the aims of the consortium is to assist physicians in becoming master adaptive learners—expert, self-directed, self-regulated and lifelong workplace learners.</td>
<td>Fostering the Development of Master Adaptive Learners: A Conceptual Model to Guide Skill Acquisition in Medical Education.(^\text{21}) Mission Control: The Gamification of Medical Learning(^\text{22})</td>
</tr>
<tr>
<td>Shaping tomorrow’s leaders</td>
<td>Future physicians will need to do more than deliver high-quality care. To be effective in the health care system of tomorrow, they will need to possess the ability to lead teams and participate in positive change. Consortium schools are integrating leadership and teamwork training into curricula that will prepare today’s medical students to become future leaders.</td>
<td>Shifting the Curve: Fostering Academic Success in a Diverse Student Body(^\text{23}) Medical Student Perceptions of the Learning Environment: Learning Communities Are Associated With a More Positive Learning Environment in a Multi-Institutional Medical School Study(^\text{24})</td>
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<td>Universal outcomes</td>
<td>Coaching Handbook&lt;sup&gt;25&lt;/sup&gt;</td>
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<td>Curricular Transformation: The Case Against Global Change&lt;sup&gt;26&lt;/sup&gt;</td>
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INTRODUCTION

The American Medical Association (AMA) is celebrating the 50th anniversary of the AMA Physician’s Recognition Award (PRA) this year. This report regarding the AMA PRA, and the credit system that was developed to support this award, is submitted to the House of Delegates (HOD) for informational purposes.

The AMA has played a central role in the development of continuing medical education (CME) in the United States by developing the AMA PRA credit system, which codified the requirements and standards for earning AMA PRA Category 1 Credit™ and AMA PRA Category 2 Credit™. The AMA PRA was established by the HOD in December 1968 to recognize physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The 1968 report adopted by the HOD that established the AMA PRA included the following goals:

1. To provide recognition for the many thousands of physicians who regularly participate in CME.

2. To encourage each physician to keep up-to-date and to improve knowledge and judgment by CME.

3. To provide reassurance to the public that America’s physicians are maintaining their competence by regular participation in CME.

4. To emphasize the AMA’s position as a leader in CME.

5. To emphasize the importance of developing more meaningful continuing education opportunities for physicians.

STATUS OF THE AMA PRA AND CREDIT SYSTEM

AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations. A total of 50 U.S. jurisdictions, including 45 states, four territories, and Washington, DC, currently have CME requirements for licensure of physicians; all recognize AMA PRA credit to fulfill these requirements. Many jurisdictions accept the AMA PRA certificate or an approved AMA PRA application as documentation of meeting their CME requirements.
The AMA PRA credit system has continued to respond to the needs of physicians and to changes in the practice of medicine. Recognizing that physicians learn in different ways and that a variety of educational formats should be recognized for credit, the AMA Council on Medical Education has approved new educational formats for AMA PRA Category 1 Credit™ over the years, in addition to the original formats of live certified activities and enduring materials. Subsequently approved formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003), Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017, the Council on Medical Education approved a format of “Other” for those activities that meet core requirements but do not fall within one of the already existing formats.

Previous domestic credit system innovations include the following:

1. Permitting physicians to self-claim AMA PRA Category 2 Credit™ for educational experiences (not designated for AMA PRA Category 1 Credit™) that comply with the AMA definition of CME and pertinent Council on Ethical and Judicial Affairs opinions; and

2. Allowing physicians to apply directly to the AMA for AMA PRA Category 1 Credit™ for defined activities that have been recognized as worthwhile learning experiences but are not certified for credit through an accredited CME provider. These include teaching at live CME activities that are designated for AMA PRA Category 1 Credit™; publishing articles in MEDLINE indexed journals; presenting a poster that is included in the published abstracts for a conference certified for AMA PRA Category 1 Credit™; earning medically-related advanced degrees; completing an American Board of Medical Specialties (ABMS) member board certification process (a primary ABMS member board certification/recertification or a subspecialty board certification/ recertification); or successfully completing an Accreditation Council for Graduate Medical Education-accredited residency or fellowship.

The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a Council on Medical Education report to establish a process for qualified international conferences to offer AMA PRA Category 1 Credit™ to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn AMA PRA Category 1 Credit™ have expanded to include activities covered by agreements between the AMA and credit systems of other regions and nations. Three agreements currently exist, with the European Union of Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar Council for Healthcare Practitioners.

Finally, the AMA has embarked upon an ongoing process with the Accreditation Council for Continuing Medical Education (ACCME) with the intent of aligning the credit and accreditation systems and simplifying the process for both physicians and CME providers. Organizations that are accredited by either the ACCME or an ACCME-recognized state medical society are given the privilege, by the AMA, of certifying activities for AMA PRA Category 1 Credit™ and awarding that credit to physicians. That privilege may be withdrawn by the AMA if the accredited CME provider fails to bring the program and activities into compliance with AMA PRA policies, regardless of accreditation status. Recently, the AMA developed a process with the ACCME to revise requirements for accredited CME providers. That process led to development of aligned and simplified requirements that became effective September 29, 2017. The AMA and the ACCME will continue to work together to modernize and evolve CME activities while maintaining educational quality.
CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY

The past 50 years have seen many changes in CME, and the AMA has led many of these changes by adapting the AMA PRA and the credit system to include new concepts, introduce new ideas, and recognize the multiple ways in which physicians learn and improve. The AMA PRA credit system must continue to be responsive to the needs of physicians to ensure they are adequately recognized for their participation in certified CME activities. To achieve this goal, the Council on Medical Education recognizes the importance of its continued stewardship of this valuable process.

As the AMA celebrates the 50th anniversary of this award, the Council on Medical Education would like to draw attention to Policy H-300.959, “Physician Participation in the AMA Physician’s Recognition Award,” which states that: “(1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician’s Recognition Award; and (2) that all physicians participate in the AMA Physician’s Recognition Award as a visible demonstration of their commitment to continuing medical education.” (CME Rep. 1, I-93; Reaffirmed with change in title: CME Rep. 2, A-05; Reaffirmed: CME Rep. 1, A-15)
APPENDIX: RELEVANT AMA POLICY

H-275.917, “An Update on Maintenance of Licensure”

3. Our AMA will: A. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the United States, including the Performance Improvement CME (PICME) format, and continue 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 as part of the process for MOL.

H-275.924, “Maintenance of Certification”

AMA Principles on Maintenance of Certification (MOC): 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 United States, 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.

H-295.926, “Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings”

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for AMA PRA Category 1 Credit™; and (3) encourages that teaching continue to be accepted for AMA PRA Category 2 Credit™ when not designated for AMA PRA Category 1 Credit™.

H-300.955, “Restructuring of Continuing Medical Education Credits”

The AMA encourages state licensing boards with CME reporting requirements to allow AMA PRA Category 1 Credit™ and AMA PRA Category 2 Credit™ toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician’s Recognition Award as evidence of completion of these requirements.

H-300.959, “Physician Participation in the AMA Physician’s Recognition Award”

It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician’s Recognition Award; and (2) that all physicians participate in the AMA Physician’s Recognition Award as a visible demonstration of their commitment to continuing medical education.

H-300.974, “Unification of Continuing Education Credits”

Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to AMA PRA Category 1 Credit™.
H-300.977, “Revisions to the Physician’s Recognition Award”

Our AMA has adopted the following changes in the Physician’s Recognition Award: (1) to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate; (2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and (3) to allow credit for teaching to be reported for AMA PRA Category 2 Credit™ toward the award.

D-300.999, “Registration of Accredited CME Sponsors”

1. Our AMA will 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. 2. Our AMA will 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.

H-480.974, “Evolving Impact of Telemedicine”

Our AMA: (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician’s Recognition Award, for educational consultations using telemedicine…
American Medical Association (AMA) Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” states:

That our American Medical Association determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action.

This policy resulted from Resolution 019-A-18, which called for our AMA to conduct a study to accurately quantify the actual incidence of medical student, resident, and physician suicide. Testimony on this item was unanimously supportive during the hearing of the Reference Committee on Amendments to Constitution and Bylaws at the 2018 AMA Annual Meeting. In its report, the reference committee noted the severity of the issue of physician suicide and the significant need for attention to this problem. However, our AMA does not generally conduct independent empirical research. Therefore, the Reference Committee suggested amending Resolution 19-A-18 so that the AMA could determine the most efficient and accurate mechanism to accurately quantify the actual incidence of medical student, resident, and physician suicide. Your Reference Committee consequently recommended adoption with this amendment and a directive to report back findings at the 2018 Interim Meeting of the House of Delegates (HOD).

The AMA Council on Medical Education recognizes the salience and timeliness of this topic and agrees that appropriate resources should be dedicated to identify these mechanisms for study. However, meaningful and constructive review of this issue, and of the work done to date by other organizations, will require additional time. The Council therefore will present a report on this issue at the 2019 Annual Meeting of the HOD.
REPORT OF THE SPEAKERS

Subject: Recommendations for Policy Reconciliation

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

Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” calls on your Speakers to “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 to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at the recent Annual Meeting. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to language will be made, additions are shown with underscore and deletions are shown with strikethrough.

RECOMMENDED RECONCILIATIONS

Obsolete references to be deleted from policies

Policy G-600.031 characterizes the roles and responsibilities of delegates and alternate delegates. The policy dates from 1999 and was most recently reaffirmed at the 2012 Annual Meeting. Your Speakers regard it as an important policy, but it includes a reference to a program that no longer exists. That clause will be deleted and a minor editorial change made.

G-600.031 Roles and Responsibilities of AMA Delegates and Alternate Delegates

(1) Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and email addresses so that the AMA can make the information accessible to individual members through the AMA Web site and through other communication mechanisms.

(2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA; (b) relate constituent views and
suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff; (c) advocate constituent views within the House of Delegates or other governance unit, including the executive staff; (d) attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings; (e) serve as an advocate for patients to improve the health of the public and the health care system; (f) cultivate promising leaders for all levels of organized medicine and help them gain leadership positions; and (g) actively recruit new AMA members and help retain current members; and (h) participate in the AMA Membership Outreach Program.

Directives to be rescinded in full

The following directives will be rescinded in full, as the requested studies have been completed and presented to the House of Delegates.

At the 2017 Annual Meeting, the House adopted Policy D-215.987, “Studying Healthcare Institutions that Provide Child Care Services,” directing our AMA to work with relevant entities to study healthcare institutions to determine whether they provide childcare services and report on those findings at the 2018 Annual Meeting. Board of Trustees Report 32-A-18, “Studying Healthcare Institutions that Provide Child Care Services,” was presented to the House as an informational report and was filed. Consequently, the policy will be rescinded.

D-215.987, “Studying Healthcare Institutions that Provide Child Care Services”

1. Our AMA will work with relevant entities to study healthcare institutions to determine whether they provide childcare services. Survey elements should include the size of the institutions in terms of the number of physicians, physicians-in-training, and medical students, how these services are organized, and the various funding mechanisms.

2. Our AMA will report back to the House of Delegates at the 2018 Annual Meeting the results of its study on models used to provide childcare services, how these services are organized, and the various funding mechanisms. This report, which is presented for the information of the House, provides background on child care services in health care and the implications of access to child care for physicians, as well as results of a study conducted by the AMA and other relevant research.

Policy D-315.976, “Ownership of Patient Data,” calling for a study on the use of patient information by hospitals, was adopted at the 2017 Annual Meeting. The requested study was fulfilled by Board of Trustees Report 21-A-18, “Ownership of Patient Data,” an informational report that noted our AMA’s active engagement with the Department of Health and Human Services, the Office of the Inspector General and the Office of the National Coordinator based on policies covering all aspects of patient record maintenance, access and control. The policy will be rescinded.

D-315.976, “Ownership of Patient Data”

Our AMA will undertake a study of the use and misuse of patient information by hospitals, corporations, insurance companies, or big pharma, including the impact on patient safety, quality of care, and access to care when a patient’s data is withheld from his or her physician, with report back at the 2018 Annual Meeting.

Also adopted at the 2017 Annual Meeting was Policy D-405.982, “Management of Physician and Medical Student Stress,” which requested a report on various regulatory burdens placed on physicians. Your Board of Trustees presented an informational report, BOT Report 36-A-18,
“Management of Physician and Medical Student Stress” that fulfilled the request. Therefore the directive will be rescinded.

D-405.982, “Management of Physician and Medical Student Stress

Our AMA will produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens.

CHANGES IN TERMINOLOGY

The following policy statements were updated to comport with AMA style and usage in references to continuing medical education credit for the AMA Physician’s Recognition Award. PolicyFinder now employs an italic typeface and the trademark (TM) symbol in references to AMA PRA Category 1 Credit™ or AMA PRA Category 2 Credit™. The prior version of PolicyFinder did not allow these features. We point this out primarily to alert members of the House to the correct usage. It also happens that this year is the 50th Anniversary of the AMA Physician’s Recognition Award and Credit System.

The affected policies are:

• H-275.924, “Maintenance of Certification”
• H-295.926, “Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings”
• H-300.955, “Restructuring of Continuing Medical Education Credits”
• H-300.974, “Unification of Continuing Education Credits”
• H-300.977, “Revisions to the Physician's Recognition Award”

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