

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

168th ANNUAL MEETING CHICAGO, ILLINOIS June 8–12, 2019

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 168th Annual Meeting at 2 p.m. on Saturday, June 8, in the Grand Ballroom of the Hyatt Regency Chicago, Susan R. Bailey, MD, Speaker of the House of Delegates, presiding. The Sunday, June 9, Monday, June 10, Tuesday, June 11, and Wednesday, June 12 sessions also convened in the Grand Ballroom. The meeting adjourned following the Wednesday morning session.

INVOCATION: The following invocation was delivered by Very Rev. John Kartje, PhD, STD, Rector at Mundelein Seminary and President, University of Saint Mary of the Lake in Mundelein, Illinois:

God of healing, who sees and knows the unbounded value of every person, in gratitude we ask your blessing upon all those gathered here. May they draw confidently upon the wisdom they share as a noble profession. Strengthen their spirit of cooperation and mutual encouragement. Grant their hearts freedom from any anxiety in the face of pressures in the workplace or resentment toward colleagues or rivals. May they receive and nurture an ever deeper love for the precious dignity of the lives they seek to heal in body, mind and spirit. Grant them the courage to make difficult decisions, true to their convictions and those of their profession, especially in the face of angry dissent or doubts. May they grow in empathy and compassion towards their patients and their families. Grant that they might always see your goodness in the lives before them, not only when it is evident in joy but also when hidden within suffering, pain and even death. Make them to be witnesses to your divine goodness and instruments of your love, often in the midst of a culture that yearns for such a presence. And finally may each one of them be renewed and strengthened in their life's vocation through this time they spend together here. Reconnect them with the healer's heart and mind that once set them idealistically on this life journey. Make them a source of inspiration to the young who are discerning a similar calling, and help them affirm each other in the career decisions they have elected to follow, for yours is the source of life, which they seek to enrich now and always. Amen.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by H. Tim Pearce, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, June 8, 542 out of 637 delegates (85.1%) had been accredited, thus constituting a quorum; on Sunday, June 9, delegates 590 (92.6%) were present; on Monday, June 10, 618 (97%) were present at the start of the session and 619 of 640 delegates (96.7%) were present at the end of the session; on Tuesday, June 11, 619 (96.7%) were present; and on Wednesday, June 12, 619 (96.7%) were present.

Note: During Monday's business session, the American Academy of Sleep Medicine and the American Society of Cytopathology were granted representation in the House of Delegates (see Board of Trustees Report 2), which increased the number of delegates seats to 640.

RULES REPORT - Saturday, June 8

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials recommends:

1. House Security

Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend.

2. Credentials

The registration record of the Committee on Rules and Credentials shall constitute the official roll call at each meeting of the House.

3. Order of Business

The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in her judgment, it will expedite the business of the House, subject to any objection sustained by the House.

4. Privilege of the Floor

The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.

5. Procedures of the House of Delegates

The November 2018 edition of the “House of Delegates Reference Manual: Procedures, Policies and Practices” shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates.

6. Limitation on Debate

There will be a 2-minute limitation on debate per presentation subject to waiver by the Speaker for just cause.

7. Nominations and Elections

The House will receive nominations for President-Elect, Speaker, Vice Speaker, Trustees and Council Members on Saturday afternoon, June 8. Except for the office of President-Elect, speeches will be limited to officer candidates in contested elections, with no seconding speeches permitted. The order will be selected by lottery.

The Association’s 2019 annual election balloting shall be held Tuesday, June 11, as specified in the Bylaws, and the following procedures shall be adopted:

Accredited Delegates may vote any time between 7:30 a.m. and 8:45 a.m. by reporting to the polls in Columbus K-L of the Hyatt Regency Chicago. The Committee on Rules and Credentials will certify each delegate and give him/her an “authority to vote” slip. The slip will then be handed to an election teller, who will provide the voter with a ballot and provide assistance as necessary.

The announcement and confirmation of the election results will be called for as soon as possible and appropriate.

In instances where there is only one nominee for an office, a majority vote without ballot shall elect on Saturday.

8. Conflict of Interest

Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest before testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.

9. Conduct of Business by the House of Delegates

Each member of the House of Delegates and the AMA Officers resolutely affirm a commitment to be courteous, respectful and collegial in the conduct of House of Delegates actions, characteristics which should exemplify the members of our respected and learned profession.

10. Respectful Behavior

Courteous and respectful dealings in all interactions with others, including delegates, AMA and Federation staff, and other parties, are expected of all attendees at House of Delegates meetings, including social events apart from House of Delegates meetings themselves. Hugs and embraces, while not always inappropriate, are not universally accepted. Meeting attendees are reminded of their personal responsibility, while greeting others, to consider how

the recipient of their greeting is likely to interpret it. Instances of unwelcome or inappropriate behavior should be brought to the attention of the Speakers.

SUPPLEMENTARY REPORT - Sunday, June 9

HOUSE ACTION: ADOPTED AS FOLLOWS

LATE RESOLUTIONS 1002 and 1003 ACCEPTED

EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 103, 104, 106, 108, 110, 118, 121, 128, 130, 202, 205, 209, 215, 222, 225, 230, 234, 238, 305, 306, 309, 320, 422, 506, 509, 521, 523, 701, 707, 715 and 716

(1) LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, June 8, to discuss Late Resolutions 1002 - 1003. Sponsors of the late resolutions met with the committee to consider late resolutions and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

[Note: Late Resolution 1001 was withdrawn after being considered by the committee.]

Recommended for acceptance:

Late 1002 – Sensible Appropriate Use Criteria in Medicare (247)

Late 1003 – Site of Service Differential (132)

(2) REAFFIRMATION RESOLUTIONS

The Speakers asked the Committee on Rules and Credentials to review the recommendations for placing resolutions introduced at this meeting of the House of Delegates on the Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed remain active policies within the AMA policy database and therefore are part of the body of policy that can be used in setting the AMA's agenda. It also resets the sunset clock, so such policies will remain viable for 10 years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to this report):

- Resolution 103 – Health System Improvement Standards
- Resolution 104 – Adverse Impacts of Single Specialty Independent Practice Associations
- Resolution 106 – Raising Medicare Rates for Physicians
- Resolution 108 – Congressional Healthcare Proposals
- Resolution 110 – Establishing Fair Medicare Payer Rates
- Resolution 118 – Pharmaceutical Pricing Transparency
- Resolution 121 – Maintenance Hemodialysis for Undocumented Persons
- Resolution 128 – Elimination of CMS Hospital Readmission Penalties
- Resolution 130 – Notification of Generic Drug Manufacturing Changes
- Resolution 202 – Reducing the Hassle Factor in Quality Improvement Programs
- Resolution 205 – Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary
- Resolution 209 – Mandates by ACOs Regarding Specific EMR Use
- Resolution 215 – Reimbursement for Health Information Technology
- Resolution 222 – Protecting Patients from Misleading and Potentially Harmful Bad Drug Ads
- Resolution 225 – DACA in GME
- Resolution 230 – State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes
- Resolution 234 – Improved Access to Non-Opioid Therapies

- Resolution 238 – Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis
- Resolution 305 – Lack of Support for Maintenance of Certification
- Resolution 306 – Interest Rates and Medical Education
- Resolution 309 – Promoting Addiction Medicine During a Time of Crisis
- Resolution 320 – Opioid Education in Medical Schools
- Resolution 422 – Promoting Nutrition Education Among Healthcare Providers
- Resolution 506 – Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements
- Resolution 509 – Addressing Depression to Prevent Suicide
- Resolution 521 – Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter
- Resolution 523 – Availability and Use of Low Starting Opioid Doses
- Resolution 701 – Coding for Prior Authorization Obstacles
- Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time
- Resolution 715 – Managing Patient-Physician Relations within Medicare Advantage Plan
- Resolution 716 – Health Plan Claim Auditing Programs

APPENDIX

- Resolution 103 – Health System Improvement Standards
 - Health System Reform Legislation H-165.838
 - Adequacy of Health Insurance Coverage Options H-165.846
 - Unfunded Mandates H-270.962
 - Out-of-Network Care H-285.904
 - Network Adequacy H-285.908
 - Collective Bargaining for Physicians H-385.946
- Resolution 104 – Adverse Impacts of Single Specialty Independent Practice Associations
 - Tiered, Narrow, or Restricted Physician Networks D-285.972
 - Access to Specialists and Subspecialists in Managed Care Plans H-285.973
 - Any Willing Provider Provisions and Laws H-285.984
 - Exclusion of Physicians by Managed Care Health Plans H-285.992
 - In addition, the AMA was party to a sign-on letter highlighting priority provisions for incorporation into the final National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act. The AMA also developed model state legislation, Physician Fair Process Protections Act.
- Resolution 106 – Raising Medicare Rates for Physicians
 - Sustainable Growth Rate Repeal D-390.953
- Resolution 108 – Congressional Healthcare Proposals
 - Health System Reform Legislation H-165.838
 - Expanding Choice in the Private Sector H-165.881
 - Opposition to Nationalized Health Care H-165.985
 - Patient Information and Choice H-373.998
- Resolution 110 – Establishing Fair Medicare Payer Rates
 - Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990
- Resolution 118 – Pharmaceutical Pricing Transparency
 - Pharmaceutical Costs H-110.987
 - Price of Medicine H-110.991
 - Private Health Insurance Formulary Transparency H-125.979
 - Pharmaceutical Benefits Management Companies H-125.986
 - In addition, to expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthinRx.org, in 2016. Nearly 350,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency.
 - PBM transparency has also been a key theme highlighted in federal advocacy efforts related to drug pricing. In a statement to the U.S. House of Representatives Energy and Commerce Committee Health Subcommittee for the hearing Lowering

Prescription Drug Prices: Deconstructing the Drug Supply Chain, Dr. Jack Resneck, Chair, AMA Board of Trustees, testified in support of increased PBM transparency. In comments in response to the proposed rule Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees in April 2019, the AMA supported applying manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale, and requiring PBMs to disclose a wide range of information, including additional information about their fee arrangements. In a statement for the record to the US House of Representatives Committee on Oversight and Reform on examining the actions of drug companies in raising prescription drug prices in January 2019, the AMA supported requiring PBMs to apply manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to ensure that patients benefit from discounts as well as eliminate some incentives for higher drug list prices; requiring increased transparency in formularies, prescription drug cost-sharing, and utilization management requirements for patients and physicians at the point-of-prescribing as well as when beneficiaries make annual enrollment elections; and prohibiting removal of drugs from a formulary or moving to a higher cost tier during the duration of the patient's plan year unless a change is made for safety reasons. These concerns were echoed in comments of the AMA submitted in response to American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint) in July 2018.

- In addition, in August 2018, the AMA submitted a letter in support of S 2554, the Patient Right to Know Drug Prices Act, which has since become law. The law prohibits health insurers and PBMs from using gag clauses that prevent pharmacists from sharing with patients the lower cost options when patients are purchasing medically necessary medication. In addition, the law will ensure that the FTC will have the necessary authorities to combat anti-competitive pay-for-delay settlement agreements between manufacturers of biological reference products and follow-on biologics.
 - In March 2019, the AMA submitted a letter that supported HR 1781, the Payment Commission Data Act of 2019. If enacted into law, the bill would provide access to essential data that the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) need to evaluate the practices of various entities within the pharmaceutical supply chain that are either not readily available or not available at all for independent analysis, including drug pricing and rebate data. In its letter, the AMA noted that the lack of independent, data driven, third-party analysis of drug pricing and rebate data continues to hamstring additional efforts needed to combat anti-competitive business practices that undermine affordability and harm patients.
 - Concerning state-level advocacy, the AMA developed model state legislation entitled, An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year (AMA Model Act), which addresses the issues of stabilized formularies and cost transparency. In particular, the AMA Model Act requires PBMs operating in the state to disclose any discounts or other financial consideration they received that affect the price and cost-sharing of covered medicines placed on a formulary.
- Resolution 121 – Maintenance Hemodialysis for Undocumented Persons
 - Health Care Payment for Undocumented Persons D-440.985
 - Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
 - Addressing Immigrant Health Disparities H-350.957
 - In addition, the AMA continues to advocate on behalf of the health care needs of undocumented persons. For example, in a December 2018 letter to the US Department of Homeland Security, the AMA expressed concerns regarding access to health care services for individuals and families who are seeking admission into the U.S., an extension of stay, or change in immigration status.
 - Resolution 128 – Elimination of CMS Hospital Readmission Penalties
 - PRO Readmission Review H-340.989
 - In addition, the AMA has recently engaged in significant advocacy regarding readmission penalties. In a February 2018 letter to CMS, the AMA recommended that CMS work in conjunction with the Agency for Healthcare Research and Quality (AHRQ) to respond to an initial set of issues to better ensure that readmission penalties are not contributing to negative patient outcomes. The AMA reiterated these concerns in two additional comment letters: (1) June 2018 comments on the Fiscal Year (FY) 2019 Proposed Rule for the Hospital Inpatient Prospective Payment System for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System, and (2) the September 2018 comments on the 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule.
 - Resolution 130 – Notification of Generic Drug Manufacturing Changes
 - Prescription Labeling H-115.974
 - Resolution 202 – Reducing the Hassle Factor in Quality Improvement Programs
 - Reducing MIPS Reporting Burden D-395.999
 - Maintenance of Certification and Osteopathic Continuous Certification D-275.954

- Resolution 205 – Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary
 - Patient Satisfaction and Quality of Care H-450.982
 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958
 - Maintenance of Certification H-275.924
- Resolution 209 – Mandates by ACOs Regarding Specific EMR Use
 - Accountable Care Organization Principles H-160.915
 - EHR Interoperability D-478.972
 - National Health Information Technology D-478.995
- Resolution 215 – Reimbursement for Health Information Technology
 - Health Information Technology Principles H-478.981
 - Information Technology Standards and Costs D-478.996
- Resolution 222 – Protecting Patients from Misleading and Potentially Harmful Bad Drug Ads
 - Attorney Ads on Drug Side Effects H-105.985
 - Privacy and Confidentiality H-315.978
 - AMA model legislation Safety in Advertising for Lawsuits against Drug and Medical Device Manufacturers Act
- Resolution 225 – DACA in GME
 - Visa Complications for IMGs in GME D-255.991
 - Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
 - AMA Principles on International Medical Graduates H-255.988
 - Strategies for Enhancing Diversity in the Physician Workforce D-200.985
 - Impact of Immigration Barriers on the Nation’s Health D-255.980
- Resolution 230 – State legislation mandating electrocardiogram (ECG) and/or echocardiogram screening of scholastic athletes
 - Government Interference in Patient Counseling H-373.995
- Resolution 234 – Improved Access to Non-Opioid Therapies
 - Workforce and Coverage for Pain Management H-185.931
 - Pain as the Fifth Vital Sign D-450.956
 - Promotion of Better Pain Care D-160.981
 - Legislative Pain Care Restrictions H-95.930
- Resolution 238 – Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis
 - Workforce and Coverage for Pain Management H-185.931
 - Pain as the Fifth Vital Sign D-450.956
 - Promotion of Better Pain Care D-160.981
 - Legislative Pain Care Restrictions H-95.930
- Resolution 305 – Lack of Support for Maintenance of Certification
 - D-275.954, Maintenance of Certification and Osteopathic Continuous Certification
 - H-275.924, Maintenance of Certification
- Resolution 306 – Interest Rates and Medical Education
 - H-305.925, Principles of and Actions to Address Medical Education Costs and Student Debt
- Resolution 309 – Promoting Addiction Medicine During a Time of Crisis
 - D-120.985, Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone
 - H-310.906, Improving Residency Training in the Treatment of Opioid Dependence
 - H-120.960, Protection for Physicians Who Prescribe Pain Medication
- Resolution 320 – Opioid Education in Medical Schools
 - D-120.985, Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone
 - H-120.960, Protection for Physicians Who Prescribe Pain Medication
- Resolution 422 – Promoting Nutrition Education Among Healthcare Providers
 - Basic Courses in Nutrition H-150.995
 - Obesity as a Major Public Health Problem H-150.953

- Resolution 506 – Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements
 - H-150.954, Dietary Supplements and Herbal Remedies
 - H-150.946, Advertising for Herbal Supplements
 - H-115.988, Qualitative Labeling of All Drugs
 - D-150.991, Herbal Products and Drug Interactions
- Resolution 509 – Addressing Depression to Prevent Suicide
 - H-345.984, Awareness, Diagnosis, and Treatment of Depression and other Mental Illnesses
- Resolution 521 – Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter
 - H-115.972, Over-the-Counter Inhalers in Asthma
- Resolution 523 – Availability and Use of Low Starting Opioid Doses
 - D-160.981, Promotion of Better Pain Care
 - D-120.947, More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief
 - D-120.976, Pain Management
 - D-120.971, Promoting Pain Relief and Preventing Abuse of Controlled Substances
- Resolution 701 – Coding for Prior Authorization Obstacles
 - Prior Authorization and Utilization Management Reform H-320.939
 - Approaches to Increase Payer Accountability H-320.968
 - Managed Care H-285.998
 - In addition, the House considered a resolution on this same topic at the 2018 Interim Meeting, Resolution 812, resulting in the modification of Policy H-320.939. The AMA has been extremely active in supporting efforts to illuminate the patient impacts of prior authorization. This work includes the 2018 AMA physician survey, which featured questions focused on assessing patient impact of prior authorization, the AMA Grassroots website (www.fixpriorauth.org), which captures first-hand patient stories about the hardships they have endured due to prior authorization, and state advocacy efforts requiring health plans to publicly report data on the results of prior authorization, including patient impact statistics.
- Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time
 - Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849
 - Administrative Simplification in the Physician Practice D-190.974
 - Health Insurance Affordability H-165.828
 - In addition, at Interim 2016, Resolution 805 was referred for decision. Resolution 805-I-16 similarly requested that health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient. As a result of Resolution 805-I-16, the AMA Board of Trustees agreed to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. The AMA continues to hold such meetings with insurers to address this issue as well as other issues relating to physician burden and practice sustainability.
 - Moreover, the AMA has developed a comprehensive point-of-care pricing toolkit to help practices with patient collections (ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/managing-patient-payments.page). The toolkit recognizes the issue of uncollected patient financial responsibility that can result in physician practices taking on debt and contains varied resources to help mitigate the problem.
 - Importantly, Council on Medical Service Report 9-A-19 responds to referred Resolution 707-A-18 that asked that our AMA urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance, and deductibles. This Council report makes recommendations directly related to the issue of physician resources expended collecting patient deductibles.
- Resolution 715 – Managing Patient-Physician Relations within Medicare Advantage Plans
 - Retroactive Assignment of Patients by Managed Care Entities H-285.947
 - Physician Payment Reform H-390.849
 - Work of the Task Force on the Release of Physician Data H-406.991
- Resolution 716 - Health Plan Claim Auditing Programs
 - Uses and Abuses of CPT Modifier -25 D-70.971
 - Managed Care H-285.998
 - Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
 - Prior Authorization and Utilization Management Reform H-320.939
 - Medicare Prepayment and Postpayment Audits H-330.921

CLOSING REPORT

HOUSE ACTION: ADOPTED

Madam Speaker, Members of the House of Delegates:

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Bailey, and the Vice Speaker, Doctor Scott, for the outstanding manner in which they have assisted our deliberations by their fair and impartial conduct of the House of Delegates and to commend the members of the House for their cooperation in expediting the business before us.

Your Committee wishes at this time to offer the following resolution:

Whereas, The Annual Meeting of the House of Delegates of the American Medical Association has been convened in Chicago, Illinois during the period of June 8-12; and

Whereas, This Annual Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowship; and

Whereas, The City of Chicago has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Hyatt Regency Chicago, to the City of Chicago, to the members of the Alliance, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Annual Meeting of the House of Delegates.

Madam Speaker, This concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption.

APPROVAL OF MINUTES: The Proceedings of the 72nd Interim Meeting of the House of Delegates, held in National Harbor, Maryland, Nov. 10–13, 2018, were approved.

ADDRESS OF THE PRESIDENT: AMA President Barbara L. McAneny, MD, delivered the following address to the House of Delegates on Saturday, June 8.

Physician Leadership and the Hard Choices in Health

Madam Speaker, Members of the Board, delegates, friends, and the amazing people who work for the AMA, thank you for the second most remarkable year of my life. Second, because of course the most remarkable year was when I met and fell in love with my husband, Steve Kanig.

It's been my honor to travel the country as AMA president this past year, talking to physicians from all walks of life, all specialties, all age groups and practice types. Representing the AMA to the World Medical Association gave me the opportunity to hear first-hand how medicine is practiced around the globe. One thing I've learned is that professional burnout is pervasive and that physicians across the U.S. and internationally are feeling its effects. But its root causes are different in other countries. Abroad it seems to stem from insufficient resources to get people the quality care they need and deserve. One comment I heard again and again from our international colleagues was, well, at least their health system isn't as bad as ours. Or as Walter Cronkite—the iconic network anchor who was once most trusted man in America—famously said, “America's health care system is neither healthy, caring, nor a system.”

It saddens me to say I agree that we don't operate in a healthy delivering system. And we physicians do care, we are immensely frustrated. I'm afraid for the future of health care in our nation unless policymakers, with physician guidance, make necessary changes. I'm particularly afraid that without changes, Medicare will not be there for our seniors. Our current situation simply is unsustainable. We spend about three-and-a-half trillion dollars a year on health

care, and unless we make some dramatic changes, we're on pace to exceed five trillion dollars by 2026. That leaves insufficient funding for schools, firefighters, public parks or responding to natural disasters. Obviously, we can't allow that to happen.

We need to make some difficult decisions. So, the question is whom do we trust to make those decisions? Everyone in this room knows the answer.

In America, the entry ticket for our health system is an insurance policy, which is why I'm proud the AMA continues to fight on the side of patients, fighting to ensure people have the coverage they need, at a cost they can afford, and pushing back on efforts in Congress to take insurance away.

We all know that delaying care until it becomes an emergency is not the best way to manage the chronic diseases that account for nearly 90 percent of our health care spending. By that point it's too late, and too expensive. The average American doesn't have \$500 saved for an emergency, and insurance companies routinely issue them policies with \$5,000 deductibles. No wonder two-thirds of bankruptcies are triggered by a health event and two-thirds of those bankruptcies happen to people with insurance. How many months could any of us manage our health care expenses if we had to stop working because of a serious illness?

We've learned that high co-pays often dissuade people from getting necessary care, so perhaps we should rethink whether co-pays are the useful management tool they were thought to be. Or are they just cost shifting? Our nation's largest health insurance plans made billions last year. Do we want a health system that simply fills insurer's pockets or one that allows us to deliver our best care to patients?

I'm proud that the AMA is taking on insurance companies to reform prior authorization, helping a dozen states remove prior authorization for medication-assisted therapy to get timely treatment for a substance use disorder. I'm proud that one of the ways the AMA is working to lower health care costs is by confronting the rise in chronic disease with evidence-based diabetes prevention programs, and a strategy to leverage community networks dedicated to early detection and intervention. I'm proud of how we're a leading voice for common sense gun violence prevention policies. And I've never been more proud of the AMA than I was this spring when we joined forces to sue the federal government to protect millions of women who receive reproductive care through Title X, fighting to preserve our ability to have open conversations with our patients about all their health care options.

Since becoming law 50 years ago, Title X has been responsible for helping millions of women avoid unplanned or unwanted pregnancies, bringing abortion rates to an all-time low, and giving women access to potentially life-saving cancer screenings. We were astounded by the administration's decision to reduce access to Title X clinics and to impose gag rules on physicians, limiting our ability to give our patients a full range of treatment options.

Let me be clear. Any law or regulation that prevents us from fulfilling our ethical duty to give our patients complete and honest information is unacceptable and will be challenged by the AMA. Any law or regulation that criminalizes medically sound health care is unacceptable and will be challenged by the AMA. And any law or regulation that interferes with the patient-physician relationship or that undermines that trust is unacceptable and will be challenged by the AMA.

As a country, our health care priorities are out of whack. In my frequent visits with medical associations, I was often invited to tour a brand-new building or new hospital wing, usually prominently decorated with the name of a major donor. Is erecting new brick-and-mortar buildings for tertiary services really the best use for our precious health care dollars? Wouldn't it be more cost effective to lessen the need for such services by prioritizing early intervention for those with a chronic disease and keeping them healthy enough to avoid a hospital stay? How many health clinics could we imbed in high-risk communities or small towns with that much money? How many primary care doctors could work rent free in those clinics to handle diabetes and heart disease cases for the enormous cost of a new hospital wing? That would truly change the economic model for primary care and improve health outcomes.

Health care is now the largest employer in the U.S. economy, driven largely by new hires focused on administrative tasks instead of clinical care. We've all heard the AMA studies saying that our most highly trained health professionals, physicians, spend about two hours entering data for every hour with a patient. How many of you really enjoy spending part of your nights recording patient data to improve your hospital's star rating for higher payments, a task that does nothing to improve patient care?

The AMA is focused on reducing this ever-increasing bureaucracy. Prior authorization drives us all crazy and the AMA has engaged some of the largest players to right-size that process, easing physician frustration and ensuring that patients receive the care they need in a timely manner.

We all look forward to the day when electronic health records are a useful tool instead of a glorified billing machine, but the EHR market is very concentrated and powerful. Anti-competitive markets limit choices and raise costs, which is why AMA policy strongly supports choice for patients and doctors.

Our AMA has fought the mergers and acquisitions of health insurance companies and won! Now we're challenging the CVS-Aetna merger. How many of you think patients will benefit or out-of-pocket drug costs will go down if this acquisition occurs?

We're seeing the same anti-competitive consolidations across health care, including in the hospital market where they seem to think the only way to combat consolidation in the insurance market is to consolidate themselves and acquire physician practices. The promise is that efficiencies of scale will lower prices for patients, but the facts don't bear that out. Instead, choices go down, costs go up and staff input on hospital operations is diminished, adding to physician frustrations.

I hear these frustrations all the time. There's little doubt in my mind, and clear evidence, that burnout for employed physicians stem from a lack of control. It's a lack of control in their day-to-day work environment, but also when they identify a clinical need but can't convince their employer to invest to try and solve it. Like when physicians want more addiction medicine specialists but the hospital system's resources are being put toward that new wing. For physicians in private practice, the frustrations are generally fewer resources to confront growing administrative requirements. We cannot afford to provide social workers or dietary consultations because the physician fee schedule doesn't cover it. Independent physicians are working longer hours but are seeing their compensation from Medicare and Medicaid dropping below the cost of keeping the office open.

The AMA is working on several fronts to reduce administrative burdens on physicians and we are thankful we have an ally at the Centers for Medicare and Medicaid Services. Physicians aren't the only one who've noticed that the cost of providing care has increased about 30 percent since 2002 while physician payments have risen just six percent and hospital payments about 50 percent. This means that if I sold my practice to a hospital tomorrow and I provided the same services to the same patient in the same exam room, Medicare would be charged double and the commercial plans would be charged triple.

The AMA tried to fix this when we led the charge to get rid of the Medicare Sustainable Growth Rate formula in favor of MACRA. Unfortunately, budget politics led to a policy where MIPS participants will have five years of zero percent updates. We cannot keep up with practice expenses without an increase, which is what I told the Senate Finance Committee last month, urging Congress to provide funding for positive updates and other improvements in the MACRA/QPP program. We're also advocating for more opportunities for Alternative Payment Models while we continually remind CMS and commercial payers that innovation costs money!

No wonder so many of us are burned out. Resilience training might help you get through a bad day, but to cure this disease we actually have to fix short-sighted policies and truly pay for value. A few insurance companies are recognizing that creating new payment structures require collaboration with doctors. We know our patients and what they need and where money is wasted. Innovative insurance companies can work with doctors to align redesigned payment systems with redesigned care processes and to create quality measures that actually help us improve. I know this can be done because I'm working on just such a project with a major payer in New Mexico.

But far too many insurance companies are still using prior authorization as a blunt object administered by people who don't know the patients or understand their needs. Too many insurance companies are still working as adversaries to physicians, trying to maximize profit by paying below what it costs to do business. They're still creating narrow networks that trap patients by omitting essential specialties and creating gaps in their health coverage.

We have to rethink high-deductible health plans. Too many people see the lower premiums and think they're getting a great deal, only to find out that the deductible makes their insurance unusable. Our country cannot continue to pay almost 20 percent of its of GDP for health care, and we all need to stop acting like this will go on forever even if that means lower profit margins for the insurance industry.

Pharmacy Benefit Managers are my favorite example of middlemen whose profit far exceeds their value, making money off high drug prices and the backs of sick people whose very lives may depend on that medication. They cannot continue to milk the system until it collapses under its own weight. As physicians speaking up for our patients, we cannot allow that. We must be the agents of change—the voices that speak truth to power and that demand a system that delivers for patients what they need, when they need it.

Surely the richest country on earth can figure this out. Physicians and patients are increasingly aware of the critical need for health policy reform. This is a heavy lift, and we will only be successful through organizations like the AMA working in concert with one another.

My friends and colleagues, the people I trust—whom our patients trust—to fix our system are in this room today. Look around. We are the ones called to fight regressive policies and needless bureaucracy at this most critical time. There is no greater service to humanity than to help people live longer and healthier. And we are bound by our oath and by our honor as physicians to always fight for what we believe is right.

The AMA is the strongest organization that has both the ability and the will to take on the crisis our health system faces. We advocate for sustainable physician-practice economics, enabling us to implement delivery reforms that we know will improve care and lower costs. The clock is ticking. We don't have time to waste. The AMA, our House of Delegates, our Councils and our Sections bring experience and expertise that no one else can match. We have a powerful voice through the AMA and the view of our system no one else has: from inside the exam room.

I began my term as AMA president warning that our health system didn't respect physicians or patients or the values of medicine we're committed to uphold. And after a year in office, I depart with a greater understanding of the depth of our country's challenges and the forces—political and otherwise—that threaten to derail our progress. But I'm also as confident as I've ever been in the collective will of physicians and the House of Medicine to continue this fight. To come together on the issues that truly matter.

And as I stand here as your president, I'm reminded of the immense power in our collective hands. Together we are not just stronger, when we join hands and speak up for our patients we are unstoppable.

Thank you.

REPORT OF THE EXECUTIVE VICE PRESIDENT: James L. Madara, MD, executive vice president of the Association, delivered the following address to the House of Delegates on Saturday, June 8.

Advancing Health Care Through the Lens of History, Equity

Madam Speaker, Madam President, members of the Board, delegates, and guests:

Welcome to Chicago, a city known for its architecture, museums, restaurants and rich music scene. Chicago is a place where anything is possible, even time travel. Here in downtown Chicago, it's 2019, and life expectancy for those living here is 82 years. But if we hop on the train and ride just 20 minutes south to Fuller Park, life expectancy is only 65 years. That's less by 17 years. That's right; just a few miles south, a person loses 17 years of life.

How far back in time would we have to travel for the average American to lose this much life expectancy, to expect to die at age 65? The answer is from the 1930s to the 1940s, a period overlapping with the Great Depression, Prohibition, the infamous Chicago Stockyards. All it takes to revisit that distant era—from a health standpoint—is a short trip south. Or a short drive west for that matter, as life expectancy in a number of Chicago neighborhoods is far below the national average.

How can that be? How, in a country and in a city as dynamic, rich in educational assets, and affluent as ours, can there be such an enormous difference in life expectancy from one neighborhood to the next? A difference akin to time-traveling back the major part of a century?

One answer is found in what we now refer to as the social determinants of health. Food insecurity, housing insecurity, income inequality, limited access to health care and transportation, and other circumstances all conspire to erode a

person's prospects for a healthy life. They're determinants of health and life. Here in Chicago and, indeed, in much of the country, including rural America, these inequities are barriers to optimal health. That's to say, there is an absence of health equity.

I'm sure all of you can recite the three arcs of our long-range strategic plan. A plan that rests upon the policy portfolio created by this House. The first strategic arc is reimagining medical education and lifelong learning. This began with our consortium of medical schools, now numbering 37 and has produced a number of innovations such as the creation of the third medical science—health system science—as well as a shift to measured competencies.

Our second arc is confronting the challenge of chronic disease. This includes our focused work on pre-diabetes and better control of hypertension; with the latter, for example, now targeting 22 million hypertensive Americans in our program by the end of 2021. It also includes our work to end the opioid epidemic. Ambitious aspirations.

And the third strategic arc is attacking the dysfunction in health care by improving the environment of the patient-physician setting. Work here includes our web-based StepsForward® practice improvement modules, our work to right-size prior authorization and work which promises to improve the flow of clinical data, using the product of the first company spun out of Health2047 in Silicon Valley. That new company is Akiri (A-K-I-R-I) whose product is a clinical data liquidity solution. Check it out at Akiri.com.

As indicated by those examples, we've gained considerable traction in each of our strategic arcs, garnering national attention and expanding the AMA's reputation in leadership and innovation. But what has become clear is that the inequities that persist throughout health care are obstacles to achieving our goals in each of our strategic areas. That is to say, while we can be proud of our progress in the three arcs over the last seven years, we now have yet another call to action.

As a nation, and as an association, we need to ensure that when solutions to improve health care are identified, that positive impacts are recognized by all, that one shared characteristic of such solutions is that they also bend toward health equity. Addressing inequities will require an enormous cooperative effort by our nation. The AMA will be a leader, positioned at the tip of this effort.

Not surprisingly, this House has recognized the importance of work toward health equity. So, let me briefly touch on our emerging work in this area. First, we're in the early launch phase of the AMA Center for Health Equity. Our founding Chief Health Equity Officer is now on board. Dr. Aletha Maybank, a prominent national figure in health equity, has joined us from the New York City Department of Health. Aletha's first task is to lead the planning phase for our work on health equity, which will critically impact the breadth of our work at the AMA.

A springboard for this effort was our Health Equity Task Force chaired by Dr. Willarda Edwards, a long-standing member of this House and a current AMA Board member. Thanks, Willarda, and thanks to all members of that Task Force.

Improving health equity will take time; it will take patience; and it will take perseverance. It will also require new technological tools to facilitate rigorous analyses of underlying factors. For example, currently there is a lack of a structured hierarchy to capture social determinants in a normalized and exacting fashion. Lacking such tools impedes progress in understanding how social determinants impact health, and thus without these tools our ability to study, modify, and improve health equity is compromised.

In previous presentations, I have discussed a tool and approach that will aid the work of our three strategic arcs by improving the organization of, and extracting better meaning from, clinical data. That tool—the Integrated Health Model Initiative, or IHMI—fills gaps in the current health data models to create better and more useful clinical data objects. This is an effort that was birthed in AMA Health Solutions and has now been launched as a unit led by Dr. Tom Giannulli, whom I briefly introduced last fall. Tom is a physician, an engineer, and a seasoned entrepreneur in the health data space.

Let me give an example of recent work of IHMI and you will see how it can carry over to work on social determinants. Over the past year, the IHMI team created a software-based approach allowing a previous gap to be filled—in this instance it's the ability to capture accurate remote blood pressure measurements and to both incorporate and organize

those measurements in the medical record without paper shuffling by physicians. Remotely monitored blood pressures captured and coded in an organized electronic fashion, filling a critical gap in our work on chronic disease.

Similarly, and related to today's theme, this approach also provides a blueprint to more precisely capture, define and code for social determinants of health. In collaboration with others, our IHMI team has begun work toward filling this need in social determinants another example of how health equity penetrates all of our work, including cutting-edge innovation and technology.

At the Interim Meeting, I'll provide a more thorough update on our strategic arcs, and there's lots to say. I am compelled to at least provide you a taste. Earlier this week we announced the eight medical schools, residency programs and health systems that will launch our \$15 million "Reimagining Residency" initiative. Three of these eight institutions have innovative projects that relate to health equity or social determinants of health, better training our physicians of tomorrow to deliver more effective and equitable health care. This initiative will bridge our work of reinventing medical school to the residency programs. The goal is to make a more seamless handoff from med school to residency while also placing GME on a 21st century footing.

Another taste: in coordination with our work on pre-diabetes, Health2047 has spun out a second company. FirstMileCare creates a new path to the prevention of chronic disease by taking a personal care approach and harnessing the gig economy. Check it out [FirstMileCare.com](https://www.FirstMileCare.com).

There're so many exciting things happening across the three arcs that I find myself verging on a tangent. So, let me return to where we began—time travel. This nation can't afford to travel backward when it comes to health care and life expectancy. We need to work creatively, and collaboratively, to move forward; to create a health care system that deserves a place in the 21st century.

But how can we accomplish this considering the current contentious national health care debate? How do we improve conditions for patients and physicians today, while also working to create the health system for the mid-21st century? Our approach, as discussed in a prior address, is to focus on what I call pre-competitive needs, needs that are vast and unmet but have to be filled for any health system to function optimally, regardless of its structure.

For example, any future health system will have these needs: the need for better organized clinical data, true interoperability as a physician would define it, clinical data liquidity, and data technology that, overall, takes less time and expense, not more. Also needed, physicians trained for the 21st century, not the 20th; for team-based care, analytics, population health, defined competencies including cultural competencies, and the need to define new solutions to handle the tsunami of chronic disease.

Collectively, these are the needs addressed by our strategic arcs, and related to each of them are the challenges that come from system inequities related to social determinants of health. To reach our ambitious goals, we need a mixed portfolio of activity, a balance between the needs of today, and the long-term pre-competitive needs that will make health care much better in the future.

Until then, let's focus on time-travel, but time-travel that is forward-looking. Is a future with a well-sculpted health system an aspiration that seems too distant? As was once said about time-travel: "Nothing is as far away as one minute ago." Our future can, and should be, more accessible than our past.

Thank you.

REMARKS FROM THE CHAIR OF THE AMPAC BOARD: The following remarks were presented to the House of Delegates on Saturday, June 8 by Lyle Thorstenson, MD, Chair of the AMPAC board.

Good afternoon! For those of you that don't know me, my name is Lyle Thorstenson. I'm an Ophthalmologist from Nacogdoches, Texas, and I'm the Chair of the AMPAC Board of Directors.

As Chair, it's my responsibility to remind each of you of the critical role that AMPAC and the AMA plays in ensuring that the policies that those of you in this room work so hard to create can be put into action on the federal level. The

success of AMPAC and the AMA advocating for that work depends on the personal financial support of its members. Without adequate funding, AMPAC and the AMA can't be successful in taking your ideas to Capitol Hill.

Right now, AMPAC participation in the House stands at 49% and we ended 2018 at 80% participation. That's why your support is so important and I'm asking you to step up and join AMPAC today.

I join AMPAC every year at the Capitol Club Platinum level, and I hope you'll consider making that investment in our profession as well. If you join the Capitol Club at any level you'll be invited to take part in our annual luncheon on Tuesday, June 11th from 12:00 to 1:30 pm. Our special guest is noted author and presidential historian Doris Kearns Goodwin; a tremendous speaker who really brings history to life.

I hope you will take advantage of this opportunity and join us. We make it very easy to contribute. All you need to do is text the word AMPAC to 202-831-8785 and follow the prompts to contribute.

Now I would like to take a moment to thank a very special member of the House of Delegates, Dr Marilyn Heine (HI-nah) of the Pennsylvania delegation. She is the inaugural winner of AMPAC's Award for Political Participation! This award recognizes an AMPAC member for outstanding political work on behalf of medicine during the last election cycle.

We received eight incredible nominees from across the country and while it was almost impossible to choose, Dr Heine's (HI-nah) dedication to supporting the issues that are important to medicine through political activism was truly inspiring. Dr Heine (HI-nah) will be receiving her award at Tuesday's AMPAC Capitol Club luncheon, but please stand now and join me in giving her a round of applause. Thank you, Dr Heine (HI-nah).

In closing, thank you to everyone who has given to AMPAC this year, and I hope to see all of you at Tuesday's Capitol Club luncheon!

Thank you!

DISTINGUISHED SERVICE AWARD: Otis Webb Brawley, MD, Atlanta, Georgia, was nominated by the Board of Trustees and confirmed by the House of Delegates to receive the 2019 Distinguished Service Award at the 2019 Interim Meeting. Jack Resneck, Jr., MD, Chair of the Board of Trustees presented the following report.

Throughout his career, Dr. Otis Webb Brawley has made substantial contributions to the care of cancer patients and is considered a global leader in the field of cancer health disparities. At the National Cancer Institute, Dr. Brawley was appointed to direct the office of healthcare disparities and went on to a leadership position at the Emory University Cancer Center. In 2007 he assumed the role of Chief Medical and Scientific Officer at the American Cancer Society where he was heavily involved in cancer prevention, early detection and quality treatment through cancer research and education. He continues to champion efforts to decrease smoking, improve diet, detect cancer at the earliest stage, and provide the critical support cancer patients need.

Dr. Brawley's 2012 book, "How We Do Harm: A Doctor Breaks Ranks About Being Sick in America," describes the challenges some ordinary Americans experience while trying to get quality health care. The book has become a classic in the field of evidence-based practice.

Dr. Brawley is currently Bloomberg Distinguished Professor at Johns Hopkins University Schools of Medicine and Public Health. He is a Fellow of the American Society of Clinical Oncology, a Fellow of the American College of Epidemiology, and a Master of the American College of Physicians. He is also an elected member of the National Academy of Medicine.

The Distinguished Service Award may be made to a member of the Association for meritorious service in the science and art of medicine, and your Board believes that Dr. Brawley's career-long dedication to the science and art of medicine for the benefit of patients and the practice of medicine exemplifies what it means to be distinguished in our profession.

PRESENTATION FROM SEEMA VERMA, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES: The following presentation was delivered to the House of Delegates on Monday, June 10.

Thank you for that kind introduction...it's an honor to be here today. And I would like to start by recognizing the leadership of the AMA, Dr. Sue Bailey, Dr. Barbara MAC-Nainy, Dr. Jack Resneck, and Dr. Jim Madara. I would also like to acknowledge my HHS colleague, the Surgeon General of the United States, Dr. Jerome Adams, who is here today. Thank you all for your service and leadership.

Being in a room full of doctors is like coming home for me. Last year three generations of doctors were seated at our Thanksgiving table, and I can tell you that my husband's multi-specialty poker group has given me a lot of insight over the years on the day to day challenges of doctors.

On my way here, I was reminded of a famous speech Teddy Roosevelt gave in Chicago. It was 50 pages long...and he had it folded in half in his breast pocket. On his way to the event, someone took a shot at him and he was wounded. The doctors later determined that the speech had significantly slowed the bullet—and essentially saved his life. That must be the first and only time in history that a patient's life was actually saved by paperwork.

The United States health care system is in many ways the best in the world – we have centers of excellence that attract patients from around the globe, and we are the leading hub of private sector biomedical innovation.

And because of that, we stand at the cusp of a new era in medicine that is opening exciting windows on prevention and new doors to treatment. Robotic surgeries, telehealth, and artificial intelligence are leveraging technology to help us improve outcomes and expand access. Treatments are being designed for a patient's unique genetic profile—and for the first time, we can even cure certain conditions by modifying a patient's genetic code.

But, while we have one of the best health systems in the world, we pay more than any other country. CMS actuaries predict that by 2026, we will spend one in every five dollars on health care.

But despite our ever-increasing spending, we have more avoidable hospital admissions than any other developed country, and our quality outcomes are inconsistent.

New challenges continue to emerge and others remain, from our higher rates of maternal mortality, and chronic disease, to rural hospital closures. And 29 million Americans remain uninsured and there are growing numbers of underinsured individuals that are unable to afford rising deductibles and out of pocket costs.

Much of what ails our system can be attributed to the underlying flaws in government policy that have contributed to rising costs. Many government policies intended to solve our nation's health care problems are contributing to and in some cases exacerbating them. In fact, the last decade has seen a historic intrusion of government into the delivery and care and the practice of medicine. As physicians on the front lines, you are stuck in the middle of all of this. You witness firsthand the limitations and unintended consequences of well-intentioned government policies.

A great example of this is that the paperwork required to comply with government regulations often pulls you away from the important work of patient care, driving administrative costs even higher. A study found that for every hour providers spend seeing patients, they spend nearly two additional hours on paperwork.

It should come as little surprise that physician burnout, or moral injury is at an all-time high, and it is having reverberating effects throughout our entire health care system. It's getting harder for physicians to finish their training, hang their shingle, and deliver care to their communities. Faced with the growing complexity of government regulations, independent physicians are increasingly selling their practices to hospital systems, and new physicians are more often beginning their careers as employees of larger health systems. This consolidation has unfortunate implications for American health care. We have seen many examples of anti-competitive behavior by large systems, including efforts to thwart price transparency and use monopoly status to drive up prices. This is why CMS has been working toward site neutral payments and other policies, like 340b to level the playing field for independent practices.

Everything we do at CMS is aimed at ensuring that all Americans have access to high quality, affordable health care. We are using our role as the nation's largest insurer to address the underlying drivers of health care costs to ensure that we have a sustainable safety net for our most vulnerable and to promote a competitive market that delivers choice, quality and accessibility to all Americans.

CMS has over 16 initiatives driving toward this vision, from strengthening Medicaid, protecting Medicare, to tackling the high costs of prescription drugs, ensuring choice and affordability in the individual market, and developing innovative payment models to drive our system away from fee for service to a value-based one. Now I won't go into all of them today, but I do want to specifically address a few that directly impact physicians.

In 2017, following the leadership of President Trump's "Cut the Red Tape" effort, we created the Patients over Paperwork initiative. It's a historic effort that began with a nationwide listening tour and resulted in over 1,300 providers identifying outdated and unnecessary regulations that cause undue burden and lead to higher health care costs.

CMS is working to untangle government regulations, and this effort that has already delivered results. Patients over Paperwork has yielded savings to all providers at an estimated 5.7 billion dollars—with a reduction of 40 million burden hours through 2021. We are not done and we're working to develop new ways for your voice to be heard. As part of Patients over Paperwork, we are focusing on three government programs that have created major pain points for doctors, MACRA, E&M codes, and interoperability.

Let's start with MACRA. It was a good thing that Congress finally repealed the SGR, but I wonder if the cure was worse than the disease. The program has laudable goals. When providers have responsibility for managing a budget and their reimbursement is tied to outcomes, they are incentivized to find innovative ways to keep people healthy and lower costs. But our progress toward a more value-based health care system has been too slow, and it's left many providers on the sidelines. Today, only 10 percent of clinicians in Medicare are taking on significant levels of risk. To this end, CMS has spent the last year developing a new cadre of payment models and a strategy to increase provider participation.

Recognizing that not every provider is comfortable taking full risk, we are offering new opportunities that ease providers into value-based agreements and deliver options that work for them. We are also providing a new level of regulatory flexibility, allowing more telehealth and reducing program integrity requirements as providers take on additional accountability. The new direct primary care models, we just announced are an example of this. These models test making payments to practices through a simplified total monthly payment plus flat per visit fees. This allows clinicians to focus on caring for patients rather than tracking their revenue cycle.

As we design models, we are deploying learning networks to help physicians succeed in a world of value-based payment and providing more data to clinicians about their patients and we're working with other payers to align our models, because, ideally, providers that are participating in models are doing so not only for their Medicare patients, but for all of their patients.

And while we continue our work on developing value based models, we recognize that the MIPS program is the only option for many doctors. And to be frank, I myself have found MIPS to be very complex and difficult to understand, and we have been listening to your recommendations.

We are working toward a new vision for MIPS, a more practical, simpler, and cohesive program for every clinician—regardless of specialty or practice size. We want to create a program that allows physicians to pick a set of measures that clearly relates to your specialty or the type of patients that you see. We're cutting measures that aren't relevant or are difficult to report, and we're focusing on measures that assess outcomes, not meaningless process measures. To make measures easier to report, we're exploring new solutions that use Artificial Intelligence to pull clinical data directly from EHRs for quality measurement. In an ideal world, doctors wouldn't have to do much more than press a button, and the system would generate quality data.

We also recognize that underlying government policy flaws that affect physician billing have had a negative impact on our health care system, which brings me to our work on E&M codes. Recognizing their importance and influence, we tackled E&M reform to reduce administrative burden and ensure that payments reflect the critical thinking involved in managing the care of complex patients.

Last year, for the first time in 20 years, the Trump Administration undertook truly historic changes by proposing to simplify how doctors must document E&M visits for the purpose of billing Medicare. We received extensive feedback—over 10,000 comments on our proposed rule. We heard you loud and clear, and we realize that not everyone agreed with our approach. But our proposal was never intended to be the end of the discussion, but a beginning and a

demonstration of our sincere commitment to reducing burden for physicians. AMA's recent work to simplify the CPT code set has a major impact on the CMS changes that are scheduled to go into effect in 2021, and so we are working with the AMA and others on how we may further update and improve our policies to incorporate the CPT improvements into the overall E&M changes.

But our work on E&M reform doesn't end with reducing burden. The practice of medicine has greatly changed over time. Physicians must now spend time managing patients with multiple co-morbidities while assessing genetic information, evaluating the social determinants of health, and coordinating care. But as more procedural codes have been added, I'm concerned that the value placed on E&M has actually decreased, even though the complexity of managing patient care has increased. We need to be sure that we strike the right balance in how we pay physicians to ensure that we are rewarding doctors appropriately for the services they provide. E&M code values should reward the time all doctors are spending caring for complex patients. By considering the revaluation of E&M codes, we are investing in the critical thinking required during patient visits and our reform efforts will impact how current and future doctors practice medicine. We appreciate the efforts of the AMA and the RUC to revalue these codes, by surveying over 50 physician specialties. We're reviewing all of the data, and I'm hopeful that our collaboration will get us across the finish line.

We're also focusing on the issue of electronic health records and data sharing, or interoperability within the health system. Here, government programs have created huge problems again. We've spent over \$36 billion, forcing doctors to use systems that just weren't built to facilitate high-quality patient-centered care. And now you have to spend too much of your day looking at a screen, with your hands on a keyboard, instead of using that time and energy engaging with patients.

Again, government policies are well intentioned. Electronic health data could have the power to transform health care, contributing to greater efficiency, and providing data to spawn more evidence based treatment guidelines, research and new cures. Instead of just throwing money at the problem or trying to centrally plan the solution, our job is to make sure we have a free market, where records and health data follow a patient wherever they go and are theirs to share with providers across the health system.

As a physician, your systems should allow you to track a patient's medical history from birth throughout their life, bringing together information from each visit, as well as claims data and information created through wearable technology. This information should be readily available to you at the point of care—ensuring that you're not repeating tests or treatments and you have the information you need to ensure safety and to use your clinical judgement as effectively as possible. Achieving true interoperability is critical to promoting greater efficiency, competition and innovation. And this administration is doubling down on efforts to make this a reality with our new interoperability rules.

Our administration is laser-focused on supporting and partnering with physicians, to create programs and policies that will help you lower costs, improve quality and outcomes for your patients. But let's look at the larger picture. Government policies have long set the standard in America's health care system. Outdated government payment policies and central planning have stifled the competitive forces that bring down cost and improve quality.

We all know our current system is not sustainable and because of it, many American's can't afford care and our existing safety net programs are already on shaky financial ground. Recent projections indicate that the Medicare's Hospital Trust Fund is set to run out of money by 2026 and the Medicaid program is one of the largest budget items for every state, competing with roads and schools. Simply said, we can barely afford the programs we have.

We all know that the approach we have taken for generations to fix what ails our health care system is to regulate its every sector, and that has failed. That's why, as the head of the Medicare program, I'm deeply concerned about proposals for Medicare for All. Medicare for All would enlarge our existing program, threatening its promise of health and hope for America's seniors, who have paid into it their entire lives. This is neither fair nor compassionate.

Medicare for All would strip private health insurance from 180 million people, take away choices and force them into a one-size fits-all government program—with innumerable rules, regulations, and rubrics. You have all experienced the harmful impact of well-meaning government policies on the practice of medicine. The impact of Medicare for All on physicians would be particularly impactful. I know our system isn't perfect, but it does afford you some ability to

choose which payers you want to do business with, and what payment terms you're willing to accept. Medicare for All would take away that choice.

Further, we all know that Medicare payment rates are already much lower than private payer rates. And analyses of Medicare for All indicate it would lead to lower physician reimbursement rates, some showing reductions on the order of 40 percent. This could lead to major access problems for all Americans, as some doctors may choose not to participate.

The cost of Medicare for All would be enormous, increasing taxes for all Americans. This cost growth could lead to rationing, as it has in other countries and would prevent physicians from accessing the therapies their patients need, because we all know government systems are slow to recognize and pay for new innovations in care, and that government bureaucracy leads to longer wait times.

Others are proposing a "public plan" option, but this concept is also troublesome. A public plan is a government plan and it would rely on the same cost control levers as Medicare or Medicaid—cutting provider payment rates.

By now, it should be clear that this Administration is not in favor of preserving the status quo in our health care system. But our solution is to address the underlying drivers of health care costs, so that all Americans have access to high quality care. We need a health care system that provides Americans with security and peace of mind; choice and control; affordability and convenience. And, let me be clear we are deeply committed to helping those who need it. But, while doing that, we must put the patient and their doctors in the driver's seat to make decisions about their care, not the government. This administration stands committed to addressing these issues, including by ensuring that people with pre-existing conditions have the protections they need and all Americans have access to affordable, high quality care.

We believe market forces can most effectively address the underlying cost drivers in our health care system. Simply having the government take over health care and pay for everything won't do that. We can only transform our health care system through a competitive free market—one that fosters and nurtures innovation, that promotes an environment where providers compete on the basis of cost and quality and patients have choices and make decisions about their care

We absolutely need fundamental reforms. But doubling down on failing government interventions to enact a complete takeover of the health care system is not a solution and will threaten all that makes the American system the best in the world. Instead, I hope that you will work with us to improve our health care system to make it more efficient, competitive and innovative.

I can think of few causes as worthy as what all of you do, each and every day, to help your patients enjoy longer lives...and better lives. And to those of you in the room, that go above and beyond your day-to-day responsibilities to help policy makers with your ideas and your thoughts, thank you. Doctors have a unique vantage point, and your participation in the public policy debate is crucial, policy makers need to hear from you and your colleagues.

CMS is committed to reducing provider burden to make the programs we have work more effectively and efficiently and to do everything we can to help you and future generations of doctors be able to practice medicine the way you intended when you started down this noble path.

Thank you.

RETIRING AMA OFFICERS, DELEGATES AND MEDICAL EXECUTIVES

American Academy of Neurology

Skip Davison, MD

**American College of Occupational and
Environmental Medicine**

Robert Orford, MD

Texas Medical Association

Louis J. Goodman, PhD, CAE

AMA Officers

David Barbe, MD

Albert Osbahr, MD

Ryan Ribiera, MD

Karthik Sarma

Georgia Tuttle, MD

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 Bassam H. Nasr, MD, Michigan
 Jill M. Owens, MD, Pennsylvania
 Scott Pasichow, MD, American College of Emergency Physicians, Sectional Resident
 Abdul Rehman, MD, New York*
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 Rohan Rastogi, Massachusetts, Regional Medical Student*
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 Nicole Dundial, MD, New Jersey*
 Jean Elizabeth Forsberg, MD, College of American Pathologists*
 Steven R. Hays, MD, Texas*
 Paul O'Leary, MD, American Psychiatric Association*
 Alan Schwartzstein, MD, American Academy of Family Physicians*
 Sergio B. Seoane, MD, Florida*

Election Tellers

Jerry P. Abraham, MD, American Academy of Family Physicians*
 T. Jann Caison-Sorey, MD, Michigan*
 Marygrace Elson, MD, Iowa*
 Heidi Hullinger, MD, Texas
 Vikram B. Patel, MD, Illinois*
 Steven Thornquist, MD, Connecticut*

* Alternate delegate

INAUGURAL ADDRESS: Patrice Harris, MD, MA, was inaugurated as the 174th President of the American Medical Association on Tuesday, June 11. Following is her inaugural address.

Working Together to ‘Transform One Million Realities’

Good evening. Tonight is very special for me and I am honored that each of you is here to share it.

The poet, Maya Angelou, once said, “If one is lucky, a solitary fantasy” ... and I would add, dream ... “can totally transform one million realities.” You didn’t think you’d sit through an address from a psychiatrist and not hear something about fantasies and dreams, did you? But the great thing about psychiatrists is we can talk about dreams and fantasies as well as the hippocampus and the cytochrome P450 system. It’s truly a dream come true to stand before you tonight.

A dream my ancestors, parents, my extended family, and my friends supported before it even entered my imagination. A dream my West Virginia, Georgia, psychiatry and AMA families helped me achieve. And, I know in my heart that tonight, “I am my ancestors’ wildest dreams!”

Tonight, I would like to thank

My parents,
Anthony,
Harris/Smith family,
Barron/Singley and Williams family,
Clark/Broddie family,
My sorority sisters from Alpha Kappa Alpha,
My WVU and West Virginia friends,
My Atlantans and Georgians who are here tonight.
And AMA management and staff

I’d also like to recognize two others who broke barriers in our organization. Dr. Lonnie Bristow, the first African American to lead the AMA, and Dr. Nancy Dickey, the first woman to lead the AMA. Please join me in thanking them for their contributions to the growth of our profession.

I have chosen as the theme of my inauguration “From Many Families: One.” Each of our families, whether composed of relatives, friends or colleagues, has something to teach us, and mine is no different. A common thread of my lessons learned is the importance of standing together:

From my Aunt Betty who when confronted with a challenging situation, would remind me, “We Harrisese stick together.”
From my Georgia family, who taught me that physicians are at our best in advocacy when we work together.
And you, my AMA family, remind me daily that there is strength in our collective voice.

My personal journey has also taught me many valuable lessons:

First, medicine involves a community. I learned this from Marcus Welby, MD, a fictional television doctor from the 1970s who actually inspired me to become a physician. Dr. Welby not only cared for his patients inside the exam room, but he cared about their lives, their families and their communities.

Medicine relies on teamwork. I learned this as a medical student in the emergency department, holding a woman’s heart in my hand as a member of the on-call trauma team who worked to keep her heart beating after a motor vehicle accident.

Medicine needs a broad perspective. From my work with patients who’ve been abused, neglected, diagnosed with a mental illness, subjected to childhood trauma, who are homeless or unemployed, I learned that often overlooked health determinants have an effect on one’s health over a lifetime.

Medicine needs allies. I have learned the critical importance of creating partnerships with legislators, community-based organizations, and the business community, and the impact of those partnerships on patient health.

And finally, medicine's future needs leadership. It needs us, the AMA, to lead the way.

Last month, I gave the commencement address at the Morehouse School of Medicine. There I saw the future. I saw our brilliant and highly-motivated future colleagues, who cannot wait to stand where we are, and who are counting on us to lead before we pass the baton.

Our personal journeys inform the people we become. Just as I am the sum of my parts. An African American woman, a psychiatrist, and a child from the heart of coal country, so each of you is the sum of your parts, where you came from, your specialty, and your experiences.

Our diversity is the source of our strength as we face medicine's most daunting challenges. From geography, to specialty to age and gender, our uniquely lived experiences shape who we are as people and as physicians. While we have many differences, at the AMA, we have this common goal: Through this great organization, we believe we can uplift our entire profession, improve care for all of our 300-plus million fellow Americans and stand as leaders in health care across the globe. And lead we must and we will.

But, our core values:

- access to health care for all;
- diversity and inclusion;
- the primacy of the patient-physician relationship;
- the advancement of science and public health

will not be part of the health care landscape unless we ensure that they are.

Over our 172-year history as an organization, we have faced many challenges. We are all too well aware of what we face today:

- While the Affordable Care Act brought coverage to millions of Americans, millions still lack coverage, and there are those who want to roll back the gains we have made;
- Far too many people—one in two adults—struggle with chronic conditions like diabetes and heart disease;
- Though we've made progress, the face of medicine still fails to match the faces of our patients;
- People living in rural areas too often have to drive hundreds of miles to the nearest physician, or hospital;
- Overdoses continue to outpace other causes of premature death and wreak havoc on our communities;
- Our young people are subject to the dangers of e-cigarette use at epidemic levels;
- And pharmaceutical prices continue to soar.

I see these not as intractable problems but as intractable opportunities, opportunities that we as physicians fully embrace. We don't run away from problems; physicians run towards them! That is our role, our responsibility, our AMA mission. We can make a difference and we do make a difference. Our formula for success: community, teamwork, a broad perspective, professional allies and a willingness to lead.

While a year is not a long time, like all who came before me, I, too, hope to leave a mark on the AMA, both as a child and adolescent psychiatrist, and as the first African American woman to hold this position. When I look back on my time as President, I hope to say:

- We turned the promise of parity for mental health into reality.
- We moved the needle on health equity.
- We reformed prior authorization so that more patients could get the right care at the right time.
- We saw the end to the opioid epidemic on the horizon, and furthered alliances in Washington and across every state to remove barriers to treatment for those diagnosed with substance use disorders.

One of my favorite poems about leadership was written by Mary Lou Anderson. She wrote, "Leaders are called to stand in that lonely place between the no longer and the not yet and intentionally make decisions that will bind, forge, move and create history."

When it comes to health equity, to mental health, and to many other issues, medicine is in that lonely place between the "no longer" and the "not yet," and we must act intentionally to move forward. We are no longer at a place where those with mental illness and addiction are hidden and ignored, but we are not yet at a place where mental disorders are viewed without stigma, and truly integrated into health care. We are no longer at a place where we can tolerate the disparities that plague communities of color, women, and the LGBTQ community. But we are not yet at a place where

health equity is achieved in those communities. And not yet at a place where women can live with confidence that we are firmly in charge of our own medical decisions.

We are no longer at a place where underrepresented groups are unwelcomed in medicine; but we are not yet at a place where African American men are entering, or graduating, from medical schools at the rates of their peers. We are no longer at a place where we can tolerate bureaucratic government and payor requirements that add to the cost of care without increasing value but not yet at a place where we have eliminated unnecessary regulations and can truly focus on care. We are no longer at a place where we can turn a blind eye to the chronic conditions that plague half of American adults, but not yet at a place where everyone has access to affordable health care.

Colleagues, as medicine's leaders, we all need to stand in those sometimes lonely places, and make decisions now that will move us forward to a future we help create. So I ask you to join me in taking the next step of leadership and "intentionally make decisions that will bind, forge, move and create history."

The AMA has led the way on innumerable public health advances throughout its history. Let us commit tonight to move medicine forward again this year, as we state emphatically that health, in all its dimensions, is a basic human right.

We can do this! Because when we all join together, bringing our differing perspectives, backgrounds, experiences and resources to bear that's when we can truly move medicine forward for the good of our patients, the profession, the nation and the world.

I'll close with one more quote from Maya Angelou, who said, "Life is not measured by the number of breaths we take but by the moments that take our breath away." For me, tonight is one of those moments. I am honored that each of you is here to share it with me, and by the trust you have placed in me. I can promise you that the legacy of the AMA will be in good hands as we work together "to transform one million realities."

Good night, Mom. Good night, Dad.