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REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-19

Subject: Involvement of Women in AMA Leadership, Recognition and Research Opportunities

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

PURPOSE

American Medical Association (AMA) Policy D-65.989(3), “Advancing Gender Equity in Medicine,” directs our AMA to “to collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates (HOD), reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, councils and section governance, plenary speaker invitations, recognition awards, and grant funding. These findings will be used to provide regular reports to the HOD and make recommendations to support gender equity.” This informational report responds to this directive.

BACKGROUND

In the United States, the number of women entering medicine is steadily increasing. Women represent more than one third (35.2%) of the active physician workforce,¹ nearly half (45.6%) of all physicians-in-training² and more than half (50.7%)³ of all entering medical students in MD-granting medical schools. Despite the growing number of women in medicine, professional advancement among women physicians in the overall medical community continues to lag.

Professional advancement is associated with acknowledgment of one's work and contributions. Experiences, such as speaking engagements and participation in research teams, allow for recognition of achievements and contribute to professional growth. Various studies have indicated that female physicians generally do not receive major awards or recognitions at the same rate as their male counterparts and may even be excluded from certain professional opportunities (e.g., grand rounds).⁴ A 2017 study by Silver et al found that female physicians are underrepresented among recognition award recipients by various medical societies.⁵ Such differences in awareness and recognition of accomplishments may contribute to gender-based disparities in pay and promotion.

Accordingly, organizations that provide professional opportunities have a responsibility to ensure equitable participation. The AMA provides numerous opportunities for professional growth and leadership development for its members through committees, award programs and research opportunities. This informational report provides an overview of female AMA member involvement in enterprise-wide leadership, recognition and research opportunities.

METHODOLOGY

A qualitative analysis on the engagement of female AMA members in various leadership opportunities was conducted. In February 2019, the staff of the AMA sections, councils and

1 advisory committee was invited to participate in an electronic survey to ascertain the number of
2 women members who held leadership positions in the AMA as of year-end 2018. In addition, this
3 survey included questions on plenary speaker invitations, recognition awards, and grant funding.
4 Staff representing other units of the AMA were invited to participate in the survey so that
5 additional information on speaker invitations, recognition awards, and grants could be collected. Of
6 note, data on reference committee composition was extrapolated from the 2018 proceedings for the
7 Annual and Interim Meetings of the AMA HOD.

8
9 In addition, a review of the [Council on Long Range Planning and Development \(CLRPD\) Report](#)
10 [1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership,"](#) was
11 conducted. Delegate and alternate delegate lists, which are maintained by the AMA Office of HOD
12 Affairs and based on year-end 2018 delegation rosters provided by medical societies represented in
13 the HOD, served as a primary data source for CLRPD Report 1. Another data source included
14 rosters for the AMA councils as well as the governing councils of the AMA sections and advisory
15 committee. Data on AMA members were taken from the year-end 2018 AMA Physician Masterfile
16 after it was considered final.

17 18 RESULTS

19
20 According to CLRPD Report 1-A-19, AMA membership was 35.7 percent female as of year-end
21 2018. Thirty percent of the AMA Board of Trustees members were female. The HOD was
22 comprised of 26.4 percent female Delegates and 33.2 percent female Alternate Delegates,
23 respectively.

24
25 In 2018, more than half (51.97%) of the leadership for the AMA sections, councils and advisory
26 committee was female. Of note, the 2018 AMA Staff Survey on Inclusion of Female Members
27 included the chair, vice-chair, delegate, alternate delegate, and speaker positions under leadership
28 roles. For the AMA reference committees, the average percentage of female participants for the
29 Annual and Interim meetings was 41.5 percent and 33 percent, respectively.

30
31 Women received 79.1 percent (n = 53) of the AMA recognition awards in 2018. These awards
32 included the Principal Investigator Leadership Award (55%), Excellence in Medicine Awards
33 (40%), and Inspirational Physicians Recognition Program (now known as the Inspiration Award)
34 (88.7%). As the Inspiration Award was created by the AMA Women Physicians Section (AMA-
35 WPS) to recognize physicians who support the professional advancement of women in medicine,
36 the overall percentages of female awardees are skewed.

37
38 The AMA Foundation offers financial support to medical students through various scholarship
39 programs. In 2018, the AMA Foundation awarded \$230,000 in scholarships, with 50 percent of the
40 recipients being female.

41
42 Through programs such as the Accelerating Change in Medical Education Innovation Grant
43 Program and the Joan F. Giambalvo Fund for the Advancement of Women, the AMA awarded 30
44 grants totaling \$290,000 in 2018. Seventy percent of these grant recipients were female. In
45 addition, more than seventy percent (73.7%) of the principal investigators were female. It is
46 important to note that AMA-WPS, along with the AMA Foundation, established the Joan F.
47 Giambalvo Fund for the Advancement of Women to promote the progress of women in the medical
48 profession, and to strengthen the ability to identify and address the needs of women physicians and
49 medical students.

1 The overall number of plenary speaker invitations for meetings in 2018 was not captured precisely.
2 However, survey responses indicated that 42 speaker invitations were extended to women, with
3 97.6 percent (n = 41) of those invitations being accepted.

4
5 Additional results from the 2018 AMA Staff Survey on Inclusion of Female Members can be found
6 in Appendix A of this report.

7
8 CONCLUSION

9
10 The rate of participation in AMA leadership and involvement opportunities by female members is
11 comparable to the percentage for AMA membership, with considerable representation among the
12 leadership of the AMA sections, councils and advisory committee. Although the AMA has made
13 great strides in increasing the number of women leaders, there is still work to be done. For
14 example, the current percentage of female AMA delegates is only 26.4 percent whereas AMA
15 membership is 35.7 percent female.

16
17 Also, females are well represented among scholarship and grant recipients. These study findings
18 demonstrate that female AMA members are actively involved in AMA professional activities. Of
19 note, AMA membership is not a requirement for the recipients of the Joan F. Giambalvo Award for
20 the Advancement of Women, AMA Foundation scholarships and the Inspiration Award.

21
22 As part of the AMA's commitment to advancing gender equity in medicine, trends pertaining to the
23 involvement of women in the AMA will be monitored on a routine basis. In accordance with AMA
24 Policy G-600.035, "The Demographics of the House of Delegates," successful initiatives and best
25 practices to promote diversity within state and specialty society delegations, along with statistical
26 data, will be shared through regular reports to the AMA House of Delegates. The most current
27 update on these initiatives can be found in the "Promoting Diversity Among Delegations" section
28 of CLRPD Report 1-A-19, "Demographic Characteristics of the House of Delegates and AMA
29 Leadership." This portion of the CLRPD report provides a regular overview of efforts to promote
30 diversity that have been implemented by various state and specialty societies. Examples include
31 details on initiatives such as task forces, efforts to recruit women and minorities, and minority
32 mentorship programs.

REFERENCES

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APPENDIX A: RESPONSES FROM 2018 AMA STAFF SURVEY ON INCLUSION OF FEMALE MEMBERS

Table 1: 2018 AMA Sections, Councils and Advisory Committee

Committee Name	Number of Committee Members	Percentage of Female Committee Members	Percentage of Female Members Holding Committee Leadership Positions ¹
Academic Physicians Section	9	33%	11%
Advisory Committee on LGBTQ Issues	7	28.6%	0%
Integrated Physician Practice Section	8	25%	12.5%
International Medical Graduates Section	8	25%	12.5%
Medical Student Section	8	75%	75%
Minority Affairs Section	9	66.7%	33%
Organized Medical Staff Section	7	14.3%	14.3%
Resident and Fellow Section	8	37.5%	37.5%
Senior Physicians Section	7	28.6%	28.6%
Women Physicians Section	8	100%	50%
Young Physicians Section	7	85.7%	42.9%
Council on Constitution and Bylaws	10	70%	40%
Council on Ethical and Judicial Affairs	9	33%	11%
Council on Legislation	12	50%	16.7%
Council on Long Range Planning and Development	10	20%	20%
Council on Medical Education	12	58.3%	33%
Council on Medical Service	12	58.3%	41.7%
Council on Science and Public Health	12	41.7%	8.3%
OVERALL	279	51.97%	22.58%

Table 2: AMA Reference Committees

2018 Annual Meeting Reference Committees	Female Members
Reference Committee on Amendments to Constitution and Bylaws	16.6%
Reference Committee A (Medical Service)	57.1%
Reference Committee B (Legislation)	14.3%
Reference Committee C (Medical Education)	57.1%
Reference Committee D (Public Health)	66.7%
Reference Committee E (Science and Technology)	33.3%
Reference Committee F (AMA Governance and Finance)	57.1%
Reference Committee G (Medical Practice)	28.6%

2018 Interim Meeting Reference Committees	Female Members
Reference Committee on Amendments to Constitution and Bylaws	28.6%
Reference Committee B (Legislation)	14.3%
Reference Committee C (Medical Education)	42.9%
Reference Committee F (AMA Governance and Finance)	57.1%
Reference Committee J (Advocacy related to medical service, medical practice, insurance and related topics)	28.6%
Reference Committee K (Advocacy related to science and public health)	28.6%

¹ For the purposes of this report, leadership positions within the AMA Sections, Councils and Advisory Committee are defined as Chair, Vice-Chair/Chair-elect, Delegate, Alternate Delegate, and Speaker.

Table 3: 2018 Recognition Awards

Award Name	Awards Granted	Female Awardees
Principal Investigator Leadership Award	11	55%
Excellence in Medicine	5	40%
Inspiration Award	51	88.7%
Total	67	79.1%

Table 4: 2018 Scholarship Funding

Scholarship Name	Number of Grants Awarded	Percentage of Female Recipients	Monetary Value
AMA Alliance Grassroots (Physicians of Tomorrow Scholarship Program)	3	100%	\$30,000
Cady/ New York Medical Society (Physicians of Tomorrow Scholarship Program)	2	100%	\$20,000
Chicago (Physicians of Tomorrow Scholarship Program)	4	25%	\$10,000
Dr. Richard Allen Williams and Genita Evangelista Johnson/Association of Black Cardiologists	1	0%	\$0
Herman E. Diskin Memorial Scholarship (Physicians of Tomorrow Scholarship Program)	1	0%	\$0
Ohio (Physicians of Tomorrow Scholarship Program)	2	100%	\$20,000
Underrepresented in Medicine Scholarship Program	15	40%	\$150,000
Total	28	50%	\$230,000

Table 5: 2018 Grant Funding

Grant Name	Number of Grants Awarded	Female Principal Investigators	Monetary Value
Accelerating Change in Medical Education Innovation Grant Program	13	61.5%	\$270,000
Joan F. Giambalvo Fund for the Advancement of Women	2	100%	\$20,000
Total	15	73.7%	\$290,000

APPENDIX B: Excerpt from CLRPD Report 1-A-19, Demographic Characteristics of the House of Delegates and AMA Leadership

Table 1. Basic Demographic Characteristics of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	594	401	20	170	250,253	1,341,682
Mean Age (Years)	56.4	51.1	57.0	50.4	46.0	51.0
Age distribution						
Under Age 40	14.1%	22.7%	10.0%	32.9%↑	51.5%↑	29.7%
40-49 Years	10.4%	18.7%↑	15.0%	11.2%	9.7%	18.5%
50-59 Years	22.2%	23.9%	15.0%	15.3%	9.9%	17.4%
60-69 Years	34.5%	26.2%	55.0%	24.7%↓	10.8%	16.9%
70 or More	18.7%	8.5%	5.0%	15.9%	18.1%	17.5%
Gender						
Male	73.6%	66.8%↓	70.0%	53.5%↓	64.3%	64.8%
Female	26.4%	33.2%↑	30.0%	46.5%↑	35.7%	34.7%
Unknown	0.0%	0.0%	0.0%	0.0%	0.1%	0.5%
Race/ethnicity						
White, Non-Hispanic	70.2%↓	66.6%	70.0%	59.4%	52.7%↓	51.0%
Black, Non-Hispanic	5.1%	4.0%	15.0%	7.1%	4.6%	4.2%
Hispanic	2.9%	4.7%	0.0%	6.5%	5.5%	5.5%
Asian/Asian	9.1%	13.5%	5.0%	15.3%	14.6%	15.3%
Native American	0.2%	0.0%	0.0%	0.0%	0.3%	0.3%
Other	1.5%	1.0%	0.0%	1.2%	1.4%	1.4%
Unknown	11.1%	10.2%	10.0%	10.6%	20.8%↑	22.3%
Education						
US or Canada	93.3%	90.8%	95.0%	90.0%	82.6%	77.1%
IMG	6.7%	9.2%	5.0%	10.0%	17.4%	22.9%

APPENDIX C: RELEVANT AMA POLICY

[Advancing Gender Equity in Medicine D-65.989](#)

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement. 2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits. 3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity. 4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

[The Demographics of the House of Delegates G-600.035](#)

1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. 2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. 3. Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.

[Women in Organized Medicine H-525.998](#)

Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession; (2) supports the concept of increased tax benefits for working parents; (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; and (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-19

Subject: Restrictive Covenants of Large Health Care Systems

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

1 INTRODUCTION

2
3 At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD) adopted Policy D-383.978, “Restrictive Covenants of Large Health Care Systems,”
5 introduced by the Organized Medical Staff Section, which asked:

6
7 1. Our AMA, through its Organized Medical Staff Section will educate medical
8 students, physicians-in-training, and physicians entering into employment contracts
9 with large health care system employers on the dangers of aggressive restrictive
10 covenants, including but not limited to the impact on patient choice and access to
11 care.

12
13 2. Our AMA study the impact that restrictive covenants have across all practice
14 settings, including but not limited to the effect on patient access to health care, the
15 patient-physician relationship, and physician autonomy, with report back at the 2019
16 Interim Meeting.

17
18 Testimony noted that this is a significant issue that is rarely looked at, that physicians often are not
19 given a choice but to sign a covenant, and that students are rarely educated on the practice before
20 entering the workforce. Speakers also testified that the practice has negative ramifications for rural
21 medicine, and that physicians can be limited from even volunteering to practice in retirement due
22 to restrictive covenants.

23
24 It should be noted that during the 2019 Annual Meeting, the HOD referred Resolution 010
25 “Covenants not to Compete” to the AMA Board of Trustees. Resolution 010 asked our AMA to
26 consider as the basis for model legislation the New Mexico statute allowing a requirement that
27 liquidated damages be paid when a physician partner who is a part owner in practice is lured away
28 by a competing hospital system. Resolution 010 also asked our AMA to ask our Council on Ethical
29 and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case
30 of a physician partner who is a part owner of a practice, in light of the protection that liquidated
31 damages can confer to independent physician owned partnerships, and because a requirement to
32 pay liquidated damages does not preclude a physician from continuing to practice in his or her
33 community. The AMA Board of Trustees will present the HOD with a report concerning
34 Resolution 010 at the 2020 Annual Meeting.

35 36 DISCUSSION

37
38 Restrictive covenants, which often are included as part of a physician employment contract,
39 typically prohibit physicians from practicing medicine within a specific geographic area and time
40 after employment. For example, a restrictive covenant may prohibit the physician from practicing

1 medicine within 10 miles of the location where he or she treated patients for two years after
2 employment has ended. With respect to geographic restrictions, physicians should be mindful that
3 the geographic scope of a restrictive covenant can be greatly expanded if the covenant is tied to
4 multiple locations where the employer furnishes health care services. For example, a restrictive
5 covenant may prohibit the physician from practicing within 10 miles from *any* location where a
6 large health care system provides patient care, regardless of whether the physician actually treated
7 patients at a given location. If a large health care system furnishes health care services in multiple
8 locations, the covenant could force the physician to move out of a city or even a state if he or she
9 wanted to keep practicing medicine, which, in turn, may make the physician inaccessible to former
10 patients.

11
12 State law governs covenants, and states can vary widely in how they address them. Some states
13 have statutes that regulate restrictive covenants, and some of those statutes prohibit restrictive
14 covenant enforcement against employed physicians. California, Delaware, Massachusetts, New
15 Hampshire, North Dakota, Oklahoma and Rhode Island, for example, have enacted laws that would
16 prohibit restrictive covenant enforcement against employed physicians.¹ Other states may deal with
17 restrictive covenant issues solely through court cases. Absent a specific statute prohibiting the
18 enforcement of a restrictive covenant, courts in most states will generally allow an employer to
19 enforce a reasonable restrictive covenant against an employed physician, notwithstanding the
20 concerns raised by Policy D-383.978.

21
22 *Application to all care settings where restrictive covenants are concerned*

23
24 Policy D-383.978 asks our AMA to “study the impact that restrictive covenants have across all
25 practice settings....” This report primarily addresses restrictive covenant use in the large health
26 care system environment. However, this report’s discussion about concerns associated with
27 aggressive restrictive covenant enforcement will be applicable across all care settings, since those
28 concerns may arise whenever an employer utilizes restrictive covenants, regardless of practice
29 setting.

30
31 *Restrictive covenants to protect legitimate business interests*

32
33 A court will enforce a reasonable restrictive covenant in a physician employment agreement when
34 it determines that the covenant is necessary to protect an employer’s legitimate business interest.
35 With respect to physician employment, the legitimate business interest typically is the investment
36 the employer has made in helping the physician establish his or her practice. A physician employer,
37 e.g., a large health system, may spend thousands of dollars recruiting the physician, covering the
38 physician’s relocation costs, training, providing administrative support and marketing the
39 physician. The employer may also give the physician access to community referral sources, patient
40 lists and propriety information. This investment will likely be more significant if the employer is
41 recruiting the physician right out of residency. Given this resource commitment, the employer may
42 think it necessary to protect its investment in the physician through a restrictive covenant that will
43 prevent the physician from leaving and joining a rival health system, or otherwise competing with
44 the former employer. Although aggressive enforcement of restrictive covenants can raise the issues
45 identified in Policy D-383.978, restrictive covenants can benefit employed physicians. For
46 example, a potential employer may be much less willing to make the time and resource
47 commitments that are needed to help physicians succeed in medical practice without a restrictive
48 covenant in place.

1 *Concerns that Policy D-383.978 identifies*

2
3 As Policy D-383.978 notes, aggressive enforcement of restrictive covenants in physician
4 employment contracts can trigger issues regarding the patient-physician relationship, access to
5 health care, physician autonomy and patient choice. A restrictive covenant's application could, for
6 example, negatively impact patient access to care by severing a long-standing patient-physician
7 relationship, particularly in cases where the physician has been regularly and actively involved in
8 helping the patient manage an ongoing mental or physical condition. If a restrictive covenant
9 requires the physician to leave the area in order to continue practicing medicine, for example, the
10 patient may not as a practical matter be able to continue seeing the physician. The result here
11 would be an end to the patient-physician relationship and further, this could potentially hinder the
12 patient's ability to manage his or her condition. Even assuming a smooth care transition to another
13 physician, a significant amount of time might pass before this new patient-physician relationship
14 enjoys the same level of trust and candor as the first.

15
16 Aggressive enforcement of a restrictive covenant could also have negative consequences on patient
17 care outside of a long-term patient-physician relationship. For example, depending on the
18 geographic area, there may be just a few physicians, general practitioners or specialists, available to
19 serve the needs of the patient population. This may be particularly true in rural parts of the country.
20 Even if several physicians practice in the community, requiring a physician to leave the area may
21 reduce the number of available physicians. Although a replacement physician may ultimately be
22 brought to the area, recruitment can be a lengthy process. In fact, it may be quite a while before the
23 replacement physician can start seeing the community's patients. In the meantime, the absence of
24 the physician subject to the restrictive covenant could hinder patient access by increasing patient
25 wait times—assuming the community's remaining physicians have the capacity to take on new
26 patients. The situation could be compounded if the community has only one general practitioner or
27 physician of a needed specialty. In that case, obligating a physician to leave the area could deny the
28 community those medical services until a new physician could commence practice. In the interim,
29 patients may have to decide whether they can travel to other communities to obtain those services,
30 which may not always be practically feasible, or do without for the time being.

31
32 As Policy D-383.978 notes, aggressive enforcement of restrictive covenants may also detrimentally
33 impact a patient's choice of physician. Obviously, application of a restrictive covenant can
34 negatively affect patient choice if the covenant obligates the patient's preferred physician to
35 relocate to an area that is beyond the patient's practical reach. But patient choice could still be
36 affected if his or her preferred physician moves to an area that the patient does not regard as
37 geographically inaccessible, e.g., the patient places such a value on continuing the patient-
38 physician relationship that he or she is willing and able to accept inconveniences that the
39 physician's relocation may have created, such as increased travel distance. However,
40 notwithstanding the patient's willingness, relocation may affect the physician's network status with
41 respect to the patient's health insurance coverage or employee benefits plan. If the physician had
42 been out-of-network previously, continued out-of-network status may have little impact on patient
43 choice. But if the physician had been in-network, the increase in the patient's financial obligation
44 to stay with the physician may compel the patient to select another, in-network, physician.

45
46 Policy D-383.978 also identifies physician autonomy as a concern raised by aggressive restrictive
47 covenants. AMA policy recognizes the importance of physician autonomy. For example, Policy
48 H-225.950, "AMA Principles for Physician Employment," states in part that "[e]mployed
49 physicians should be free to exercise their personal and professional judgment in voting, speaking,
50 and advocating on any matter regarding patient care interests, the profession, health care in the
51 community, and the independent exercise of medical judgment." Further, according to

H-225.950, employed physicians should not be considered to have violated their employment agreements or suffer retaliation for exercising their personal and professional judgment. Notwithstanding H-225-950, if a physician knows that the culture of his or her employer is one of aggressive restrictive covenant enforcement, that knowledge may dampen the physician's willingness to freely and fully exercise his or her autonomy in patients' best interests. For example, typically a physician employment agreement will contain a "without cause" termination provision. This provision allows an employer to end the employment agreement so long as the employer gives the physician prior notice, e.g., 90 days. The physician need not have violated his or her agreement to be subject to "without cause" termination.² If the physician is concerned that his or her employer may end their employment under a "without cause" provision in retaliation for strong patient advocacy, for example, the physician may be reluctant to serve as a strong advocate. This may be especially true if the "without cause" termination also triggers the application of a restrictive covenant that may require the physician to move out of the community if the physician wanted to continue practicing medicine.

Potential difference between restrictive covenants in large health systems and independent physician practices

Although Resolution 26 addresses aggressive restrictive covenant enforcement by large health system employers, independent physician practices also use restrictive covenants. The concerns identified in Resolution 26 can apply equally across the board regardless of employer. There may, however, be cases where concerns about restrictive covenants may be greater when the employer is a large health system vis-à-vis a physician practice. One difference could be the extent to which a potential physician employee may be able to negotiate the scope and duration of a restrictive covenant. A large health system may be less inclined than, say, a small physician practice to negotiate the terms of a restrictive covenant or other conditions of employment, e.g., due to institutional policies. However, a physician should never be reluctant to voice his or her concerns about the impact that restrictive covenant language may have on physician autonomy or simply assume that a large health system will not negotiate restrictive covenant language to address those concerns. A large health system may, in fact, be amenable to negotiations depending on the circumstances, which may be highly fact-specific.

Further, the culture of restrictive covenant structure and enforcement may differ between a large health system employer and an independent physician practice. Physicians frequently own and control independent practices, and thus decide how restrictive covenants will be drafted and enforced. Since physicians are in control, the structure and enforcement of restrictive covenants may be sensitive to the concerns raised by Policy D-383.978. In contrast, in large health systems, non-physicians may dictate how restrictive covenants are structured and enforced and may not be as cognizant of the issues identified in Policy D-383.978. It must, however, be emphasized that simply because a restrictive covenant is used within the context of a small physician practice does not mean that the scope and enforcement of the covenant does not exceed what is reasonable and does not implicate the concerns raised in Policy D-383.978. Furthermore, use of restrictive covenants by large health system employers may not always negatively impact patient access, choice and/or physician autonomy.

Finally, a large health care system's aggressive enforcement of a restrictive covenant may have adverse consequences on network participation which do not often arise when an independent physician practice is involved. For example, in contrast to most independent physician practices, large health care systems may sponsor clinically integrated networks or accountable care organizations (ACOs). Some have also created affiliated health insurers. The system's aggressive enforcement of a restrictive covenant may trigger issues that Policy D-383.978 identifies if the

covenant would force the physician out of the system's clinically integrated network or ACO, or prohibit the physician from participating in the system's health insurance provider network. In some cases, the prospect of adverse network consequences may, in fact, concern the physician as much as the restrictive covenant itself.

AMA POLICY

Our AMA has several policies that address restrictive covenants. For example, CEJA Ethical Opinion 11.2.3.1, entitled "Restrictive Covenants" states that, "[c]ompetition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms." That Opinion also states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care, and that physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. The Opinion further adds that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

In addition to the CEJA Opinion, Policy H-310.929, "Principles for Graduate Medical Education," states that restrictive covenants must not be required of residents or applicants for residency education; Policy H-295.910, "Restrictive Covenants During Training," strongly urges residency and fellowship training programs that utilize restrictive covenants to provide written intent to impose such restrictions in advance of the interview process; Policy H-295.901, "Restrictive Covenants in Residency and Fellowship Training Programs," states that physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program; Policy H-225.950, "AMA Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment; and Policy H-383.987, "Restrictive Covenants in Physician Contracts," states that "[o]ur AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies."

SOME KEY POINTS AND AMA RESOURCES ON RESTRICTIVE COVENANTS

As the prior discussion shows, physicians should very carefully scrutinize any restrictive covenant language in employment contract offers they receive. Obtaining the assistance of an attorney who has experience representing physicians in employment matters can be very helpful in determining whether proposed restrictive covenant language is reasonable and appropriate. Physicians should proactively bring any concerns they have about restrictive covenant language to the potential employer and should not be afraid to ask for changes.

The following are some key points that can help physicians evaluate the reasonableness of restrictive covenant language:

- what triggers the restrictive covenant, e.g., the employer's terminating the agreement for *any* reason as opposed to termination because the physician failed to live up to his or her contract obligations;
- the duration of the covenant, e.g., one year versus three years;

- 1 • the covenant's geographic scope, e.g., is it greater than what is necessary to protect the
2 employer:
 - 3 ○ for example, 10 miles might be reasonable in a rural area but may not be in an urban
4 setting;
 - 5 ○ for example, is geographic scope tied to an appropriate site of service, e.g., where the
6 physician actually treated his or her patients or does the scope extend to *any* location where
7 the employer has facilities;
- 8 • does the covenant apply only to the services that the physician furnished, or does it prohibit the
9 physician from practicing medicine entirely or from providing administrative services; and
- 10 • does the covenant contain a reasonable "buy-out" provision that, if satisfied, would free the
11 employed physician from time and geographic restrictions.

12
13 Finally, it ought to be noted that the AMA has many resources that educate medical students,
14 physicians-in-training, and physicians about restrictive covenants. For example:

- 15
16 • The AMA Career Planning Resource webpage has a wealth of information discussing
17 physician employment issues, which includes information and tips regarding
18 restrictive covenants. The AMA Career Planning Resource webpage may be accessed
19 at [https://www.ama-assn.org/residents-students/career-planning-](https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts)
20 [resource/understanding-employment-contracts](https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts).
- 21 • The AMA also has two model employment agreements that discuss restrictive
22 covenants, the Annotated Model Physician-Hospital Employment Agreement, 2011
23 edition: E-Book, free for AMA members at [https://commerce.ama-](https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod1240028&sku_id=sku1240037)
24 [assn.org/store/ui/catalog/productDetail?product_id=prod1240028&sku_id=sku12400](https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod1240028&sku_id=sku1240037)
25 [37](https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod1240028&sku_id=sku1240037), and the Annotated Model Physician-Group Practice Employment Agreement: E-
26 Book, free for members at [https://commerce.ama-](https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku2530104)
27 [assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku25301](https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku2530104)
28 [04](https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku2530104). These agreements contain model restrictive covenant language for potential
29 physician employees to consider, which may prove useful in the employment
30 negotiation process.
- 31 • Finally, staff at the AMA Advocacy Resource Center, the state advocacy unit of the AMA,
32 work extensively on physician employment issues. AMA members are encouraged to contact
33 the Advocacy Resource Center at arc@ama-assn.org, if they would like to obtain more
34 information and resources concerning restrictive covenants.

REFERENCES

¹ See Cal Bus & Prof Code § 16600; 6 Del. C. § 2707 (allows liquidated damages); ALM GL Ch. 112, § 12X; RSA 329:31-a; N.D. Cent. Code, § 9-08-06; 15 Okl. St. § 219A (so long as the employee does not solicit the former employer's customers); R.I. Gen. Laws § 5-37-33.

² Frequently the agreement will (and should) contain a reciprocal "without cause" provision, meaning that the physician can also terminate the agreement if he or she gives the employer the same prior notice as the employer is obligated to provide the physician.

REPORT 7 OF THE BOARD OF TRUSTEES
2019 AMA Advocacy Efforts

EXECUTIVE SUMMARY

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: It was prepared in early August based on approval deadlines and may be updated if warranted based on legislative, regulatory, or judicial developments.)

The AMA continues to be a powerful ally for physicians as it shapes the health of the nation by working to reduce dysfunction in the health care system, achieve health equity, train the next generation of physicians, and improve public health. The AMA produced strong results again in 2019 by advancing key policy objectives on physician payment, drug pricing, ill-conceived health insurer policies, the opioid epidemic, and consolidation in the health sector. The AMA’s stellar advocacy work is recognized by industry watchers including APCO Worldwide which ranked the AMA as a “top-rated association” in four of 15 categories in its TradeMarks report (coalition building, industry reputation steward, local impact, and bipartisanship) when compared to 50 other associations representing various industries. The AMA was the top-rated association in 11 of 15 categories when compared only to other health care stakeholders.

Key AMA advocacy wins in 2019 include:

- The Centers for Medicare & Medicaid Services (CMS) is recommending adoption of recommendations from the RUC and CPT regarding coding changes and relative work values for office-based E/M services (further work is needed on the E/M component for global surgical services).
- CMS also approved several new Alternative Payment Models (APMs) and is moving towards a new approach for the Merit-based Incentive Payment System (MIPS) based on recommendations from an AMA-led Federation work group.
- AMA research and advocacy led a federal judge to conduct a rigorous review of the proposed CVS-Aetna merger—decision pending.
- CMS limited step therapy in Medicare Advantage plans and nine states, such as Colorado and Kentucky, enacted state legislation to limit prior authorization across the board.
- Eleven states and Washington, DC enacted laws or implemented policies to limit prior authorization for medication-assisted treatment (MAT) for substance use disorder (SUD).
- Congress is considering drug pricing legislation and the AMA is actively engaged on this issue with over 1 million physician/patient messages sent to Congress through AMA grassroots efforts since the campaign’s inception.
- The House of Representatives has passed a universal firearm background check bill, and the AMA is advocating for similar legislation in the Senate.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-19

Subject: 2019 AMA Advocacy Efforts

Presented by: Jesse M. Ehrenfeld, MD, MPH, 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 American Medical Association (AMA) advocacy activities for the year. (Note: It was prepared in early August based on approval deadlines and may be updated if warranted based on legislative, regulatory, or judicial developments.)

The AMA continues to be a powerful ally for physicians as it shapes the health of the nation by working to reduce dysfunction in the health care system, achieve health equity, train the next generation of physicians, and improve public health. The AMA produced strong results again in 2019 by advancing key policy objectives on physician payment, drug pricing, health insurer abuses, the opioid epidemic, and industry consolidation. The AMA’s stellar advocacy work is recognized by industry watchers including APCO Worldwide which ranked the AMA as a “top-rated association” in four of 15 categories in its TradeMarks report (coalition building, industry reputation steward, local impact, and bipartisanship) when compared to 50 other associations representing various industries. The AMA was the top-rated association in 11 of 15 categories when compared only to other health care stakeholders.

The AMA collaborates closely with the Federation of Medicine in its advocacy work and greatly appreciates the invaluable contributions made by the national medical specialty societies, state medical associations, and county medical associations to advance our collective goals.

While advocacy efforts continue in 2019, the AMA is already preparing for 2020 when the presidential election will bring even greater attention to many health care issues. Health care was the top issue for voters in 2018, and it is at the top of the list for voters heading into the 2020 elections.

DISCUSSION OF 2019 ADVOCACY EFFORTS

QPP implementation

Physicians need support as they continue the transition to the Medicare Quality Payment Program (QPP). The AMA is working to improve the QPP at both the regulatory and legislative levels. AMA Immediate Past President Barbara L. McAneny, MD, testified on May 8 before the Senate Committee on Finance on the Medicare Access and Chip Reauthorization Act (MACRA) and offered ways for Congress to continue improving the QPP.

Initial results from CMS show that AMA efforts have had an impact. Merit-based Incentive Payment System (MIPS) participation rates increased from 95 percent in 2017 to 98 percent in 2018, with 98 percent of clinicians earning an incentive payment that will apply to Medicare physician fee schedule payments in 2020. The AMA's strong push for additional flexibilities for small practices resulted in nearly 85 percent receiving a positive payment adjustment, up from 74 percent in 2017. Additionally, the number of eligible clinicians who qualified for a 5 percent APM incentive payment nearly doubled from 2017 to 2018, increasing from 99,076 to 183,306 clinicians. The AMA is encouraged by these results and will continue to work with CMS and the Federation to identify further solutions that will reduce the burden and cost to participate in MIPS and increase opportunities for physicians to move to alternative payment models (APMs).

Further on the APM front, the AMA was pleased to host the Secretary of Health and Human Services Alex Azar, along with Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma, and Director Center for Medicare and Medicaid Innovation (CMMI) Adam Boehler, as they announced two new primary care models. Under the programs, Medicare would reward practices for providing more convenient access to care, and start paying for services such as enhanced chronic disease care management, acute care in-home services and palliative care. CMMI is also implementing an APM covering emergency services and another on treatment for kidney disease. The AMA is supportive of the roll out of more APM options for physicians as they seek to be innovative in providing care to their patients.

Finally, CMS issued its 1700-page proposed 2020 Medicare physician payment rule in late July, with comments due at the end of September. Two notable policy provisions were included:

- The agency agreed to coding changes and revised relative work values for office-based evaluation and management (E/M) services that were initially developed by a Federation workgroup and ultimately approved by CPT and the RUC. These changes would be made in lieu of plans the agency announced last year to collapse office E/M codes and payments. The new proposal reflects the increasing complexity of these services and the resources required to provide them and streamlines reporting requirements. Unfortunately, the agency did not propose making the same adjustments to the E/M component of global surgical services, as recommended by the RUC, which would distort the relativity of the fee schedule. The AMA will continue pressing CMS to make these adjustments.
- Another provision of the proposed rule is the framework for a more cohesive Merit-based Incentive Payment System (MIPS) that would give physicians the choice to focus on episodes of care rather than following the current, more fragmented approach. Making MIPS more clinically relevant and less burdensome is a top priority for the AMA, and CMS is taking an important step toward this goal.

Prior authorization

Prior authorization (PA) is one of the most vexing issues for patients and physicians in the health care system today, and the AMA is addressing it in multiple venues. Key findings from the AMA's December 2018 PA physician survey include:

- 28 percent of physicians reported that the PA process required by health insurers for certain drugs, tests and treatments had led to a serious adverse event (e.g., death, hospitalization, disability, or another life-threatening event);
- On average, practices complete 31 PAs per physician, per week; and
- 91 percent of physicians surveyed said that PA processes delay access to necessary care.

The AMA has attempted to work directly with health insurers and other stakeholders by identifying joint principles to reform PA, but demonstrable progress by insurers in reducing PA burdens has been negligible. The AMA is also pressing for legislation at the federal and state levels on PA reform. Federal legislation, H.R. 3107, the “Improving Seniors’ Timely Access to Care Act,” was recently introduced, and the bill aims to streamline PA processes by Medicare Advantage plans. The AMA is supportive of the bill and assisted with a Federation sign-on letter to highlight the broad support for the bill in the physician community. Also at the federal level, CMS moderated its earlier proposed approach to use step therapy and other utilization management tools within the six protected classes of drugs used to treat complex conditions in final regulations on Medicare Advantage and Part D drug plans. While its earlier proposal would have allowed step therapy and other tools to be applied broadly across all six protected classes, the agency’s final policy allows step therapy within five of the six protected classes and limits its use to new starts.

Much of the legislative activity on PA in 2019 occurred at the state level. To date, Colorado, Kentucky, Maine, Maryland, Missouri, New Mexico, Texas, Virginia, and West Virginia have enacted PA laws this year despite the state medical associations in those states facing strong opposition from insurers and their local trade associations. Kentucky S.B 54 is a strong PA reform law based on AMA model legislation that was enacted this year, and it will require insurers to respond to PA requests for urgent care within 24 hours and for non-urgent care within 5 days. Another benefit of the Kentucky law for patients is that their prescriptions for maintenance drugs will be valid for one year or until the last day of coverage, and if there is a change in dosage, PA will not be required during this time period.

In 2019, the AMA enhanced its grassroots advocacy campaign—FixPriorAuth.org—directed at both physicians and patients to spur further activity on PA reform. Campaign components include a successful online hub, an active social media campaign, and videos featuring both patient and physician stories that illustrate the negative impact of utilization management restrictions on timely patient care. To date, the social media campaign has generated more than 610 patient and physician stories and 90,000 signatures on a petition to Congress.

CVS-Aetna

The AMA has taken a leading role in challenging the massive CVS-Aetna proposed merger, the largest in the history of U.S. health care. If approved, the merger would hurt competition in five key health care markets: Medicare Part D prescription drug plan (PDP); health insurance; pharmacy benefit management; retail pharmacy; and specialty pharmacy. The AMA opposition is evidence-based, the result of months of analysis by nationally-recognized health economists and legal experts. The AMA’s advocacy led to an almost unheard-of development: a federal judge holding hearings to evaluate the settlement between the U.S. Department of Justice (DOJ) and CVS-Aetna that led to the DOJ approving the merger.

The AMA’s main concerns about the proposed merger and subsequent agreement were contained in a March 2019 filing before Judge Richard Leon. The AMA contends that the DOJ settlement with Aetna, which requires Aetna to sell its PDP assets for the DOJ to approve the CVS-Aetna merger, would not adequately address the merger’s anticompetitive effects. The AMA has three main concerns:

- The divestiture would decrease the number of firms in already concentrated and rapidly consolidating PDP markets;
- New entry will not solve the problem because there are high barriers to entry into PDP markets; and

- The merger and divestiture would eliminate the unique and important role of competition between Aetna and CVS in the PDP market.

The AMA participated in closing arguments before Judge Leon on July 19. Many expected this merger to sail through the approval process, but that is clearly not the case. Judge Leon is giving the proposed merger a very rigorous review, and his ruling is expected later this summer/early fall.

Access to care

The AMA remains committed to protecting coverage for the 20 million Americans who acquired it through the Affordable Care Act (ACA) and expanding coverage for those who did not. The AMA also supports policies that would improve coverage options for many who are underinsured and/or cite costs as a barrier to accessing the care they need. The status quo is unacceptable, and federal policymakers need to build upon the ACA instead of attempting to weaken it.

The AMA filed an *amicus* brief with several Federation groups to defend the ACA in 2018 in *Texas v. United States*—a case challenging the validity of the ACA after the individual mandate tax penalty was repealed by Congress. The district court judge sided with those challenging the ACA, so the AMA has filed another *amicus* in 2019 at the appellate level to overturn the lower court ruling. A ruling on the appeal is expected shortly.

The AMA has also advocated for building on and fixing the ACA rather than scrapping it and adopting a single payer model. The AMA advocated in 2019 to build on the foundation of the current system to reach universal coverage through a pluralistic approach involving a strong competitive private market, employer sponsored coverage, a publicly financed safety net, and consumer protections such as the current prohibition against pre-existing condition coverage exclusions. This will be a major issue as the nation heads into a presidential election year where health care will again be front and center, although no legislative action is anticipated before 2021.

At the state level, the AMA has continued to advocate for Medicaid expansion. To date, 36 states and DC have expanded Medicaid eligibility under the ACA. In 2019, three states (Idaho, Nebraska, and Utah) moved forward with expansion plans that were approved by voters via ballot initiative in 2018. Arkansas and Montana reauthorized existing Medicaid expansion programs, and Georgia enacted a law authorizing a waiver for expanded coverage. Many states, however, are coupling burdensome work requirements with coverage expansions and the AMA continues to work with state medical associations to counter restrictions that will cause coverage losses. With AMA support, New Hampshire enacted a law to halt the state's work requirements if a substantial number of beneficiaries are negatively affected, and Montana passed a "trigger" provision requiring the state to reevaluate the work program if a substantial number of enrollees lose coverage. The AMA has also joined *amicus* briefs in legal challenges to Medicaid work requirements in Arkansas, Kentucky, and New Hampshire.

Regulatory relief

The Administration has made regulatory relief for physicians a priority. The AMA successfully called for a reduction in documentation requirements that were in the final Physician Fee Schedule rule last November. CMS is expected to undertake more regulatory reduction efforts for physicians as they issue various upcoming rules. The AMA has had a number of discussions with CMS on prior authorization and is optimistic that CMS will find ways to reduce this burden for physicians. The AMA is also working on responding to a CMS proposed rule regarding electronic prior

1 authorization (ePA). CMS is seeking comment about how to mitigate burden to support successful
2 adoption of ePA.

3
4 CMS also issued a Request for Information (RFI) seeking feedback on regulatory relief more
5 broadly. The AMA solicited input from the specialty societies, the Council on Medical Service, and
6 the Council on Legislation to help identify additional ideas regarding burden reduction to include
7 in the AMA response to the RFI. A lengthy comment letter with detailed recommendations for
8 easing physician regulatory burdens was submitted on August 9.

9
10 Lastly, the AMA has met with HHS about necessary changes to Stark and Anti-Kickback policies.
11 The AMA is providing extensive comments to the HHS RFI on the topic. At the time of this report,
12 there are two separate proposed rules looking to modernize the Stark and Anti-Kickback
13 regulations that are pending Office of Management and Budget (OMB) review. The AMA
14 anticipates clarification as to the definition of key terms and potential new exceptions/safe harbors
15 around value-based care and cybersecurity. The AMA also recommended in recent comments that
16 the federal ban on physician-owned hospitals be lifted.

17 *Surprise billing*

18
19
20 Patients, physicians, and policymakers are deeply concerned about the impact that unanticipated
21 medical bills are having on patient out-of-pocket costs and the patient-physician relationship. The
22 AMA and more than 100 state and specialty organizations submitted a letter to Congress laying out
23 seven principles that the AMA believes must guide any federal legislation on surprise billing to
24 ensure that patients are not burdened by unanticipated out-of-network medical bills: (1) insurer
25 accountability; (2) limits on patient responsibility; (3) transparency; (4) universality; (5) setting
26 benchmark payments; (6) alternative dispute resolution; and (7) keep patients out of the middle. On
27 May 21, AMA Trustee Bobby Mukkamala, MD, testified before the House Ways and Means
28 Committee on surprise billing offering the AMA's proposed solutions in his remarks and written
29 testimony.

30
31 On July 17, the House Committee on Energy and Commerce reported out several health care bills
32 including the "REACH Act" which would extend funding for Community Health Centers, the
33 Teaching Health Centers GME program and the National Health Service Corps and also included
34 the "No Surprises Act" to address surprise medical billing. As originally introduced, the "No
35 Surprises Act" would have plans pay out-of-network physicians the median in-network contract
36 amount for the service provided in that particular geographic area. Not only would that bind out-of-
37 network physicians to contracted amounts they did not agree to accept, but it would eliminate much
38 of the incentive for plans to contract with an adequate number of physicians in the first place.
39 Furthermore, as the Congressional Budget Office (CBO) has noted on similar proposals, plans
40 would have an incentive to cancel or cut contracted amounts for any physicians currently above the
41 median rate, reducing payment for both in- and out-of-network physicians. Such a solution would
42 tilt the advantage in negotiating fair contracts even further in the direction of plans. On June 24, the
43 Senate Health, Education, Labor, and Pensions Committee approved similar legislation.

44
45 At the urging of Energy and Commerce Committee members Rep. Raul Ruiz, MD (D-CA), Rep.
46 Larry Buschon, MD (R-IN) and others, the committee adopted an amendment to provide for an
47 independent dispute resolution process. Under the proposal, if either party was dissatisfied with the
48 initial payment offer, an appeals process could be triggered that would allow an independent entity
49 to decide between the payment offer of the plan and the physician's billed amount while
50 considering a number of other factors related to the circumstances of the case and the training and
51 experience of the physician. While the proposal still needs improvement, it represents an important

step forward, and an improvement over the Senate bill, by recognizing that the resolution of these disputes requires a solution that is fair and encourages both sides to make reasonable offers to resolve the payment dispute. At the time of this report, the AMA is seeking to make further improvements to these provisions and has activated the AMA's grassroots networks. Two other House committees—Education & Labor and Ways & Means, also plan to produce surprise billing legislation.

At the state level, medical societies continue to push for fair solutions and push back on insurer-supported proposals that undercut fair contracting. So far in 2019, more than 40 bills in 20 states related to surprise billing were introduced and many remain in play. In Washington, Texas, Colorado, New Mexico, and Nevada, comprehensive bills were enacted this year (i.e., bills that established both patient protections and payment processes). While none of these new laws is squarely aligned with Federation principles, the new laws are fairer because of strong physician advocacy. Much of the work in these states now turns toward engagement in the regulatory process and implementation.

Opioid epidemic

The opioid epidemic continues to have a devastating effect on our nation; however, there is continuing progress in physicians' actions to help end it. Last fall, the AMA joined the Pennsylvania Medical Society to help secure a landmark agreement in Pennsylvania between the governor and the Commonwealth's seven largest health plans to remove prior authorization requirements for medication-assisted treatment (MAT) to treat a substance use disorder. Since then, AMA advocacy with state and specialty societies has helped enact/implement similar laws and policies in Arkansas, Colorado, Delaware, the District of Columbia, Iowa, Maine, Missouri, New Jersey, New York, Vermont, Virginia, and Washington. The AMA has also worked closely with Manatt Health on reports in Pennsylvania, Colorado, North Carolina and Mississippi to spotlight their efforts to combat the opioid epidemic and areas for future collaboration to strengthen these efforts. The AMA and Manatt will also roll out a national roadmap on this issue building on this state work in the fall.

The AMA Opioid Task Force issued a report in June 2019 updating some of the progress that is being made:

- From 2013-2018 annual opioid prescriptions dropped by one-third, from 251 million to 168 million. Every state has experienced a decrease in opioid prescriptions over the last five years.
- Use of prescription drug monitoring programs (PDMP) is growing—435 million queries were made in 2018—more than triple the total from 2016.
- Naloxone prescriptions increased from 136,000 in 2016 to nearly 600,000 in 2018.
- More than, 700,000 physicians and other health care professionals completed continuing medical education trainings and accessed other Federation resources in 2018; in addition, more than one million physicians and other readers of the JAMA Network viewed opioid-related research and related material.
- The number of physicians trained/certified to provide buprenorphine in-office continues to rise—more than 66,000 physicians are now certified—an increase of more than 28,000 physicians and other providers since 2016.

The AMA was also pleased that the U.S. Centers for Disease Control and Prevention (CDC) recently clarified its opioid prescribing guidelines as recommended by the AMA, and the Food and Drug Administration also issued revised guidance to help protect patients.

Pharmaceutical cost transparency

In 2019, the AMA continued advocacy to increase drug pricing transparency. This includes successfully advocating for Medicare Advantage and Part D to require plans to provide real-time access to drug price data through at least one electronic health record (EHR) or drug e-prescribing system by 2021.

Immediate Past Chair of the Board Jack Resneck, Jr., MD, testified before the House Energy and Commerce Subcommittee on Health on May 9 to press Congress to take action on this issue. The House of Representatives is expected to consider drug pricing legislation this fall. On the Senate side, the Finance Committee recently marked up drug pricing legislation that attempts to reduce the cost of prescription drugs by among other provisions capping Medicare beneficiaries out-of-pocket costs at \$3100 on prescription drugs and placing a limit on prescription drug price increases in Medicare Part D. At the time this report was drafted, the AMA was reviewing the Senate legislation and will review any upcoming House legislation before activating further the AMA's grassroots networks. The AMA's TruthinRx.org grassroots campaign has created a strong network of over 338,000 advocates who have sent over 1 million messages to Congress already, so the AMA is poised to have further impact as the drug pricing debate continues.

The AMA is working on drug pricing at the state level and has developed model bills that focus on pharmacy benefit manager (PBM) practices. The AMA is also engaging the National Association of Insurance Commissioners, the National Conference of Insurance Legislators, and state attorneys general to reform PBM practices. Maine and New York made progress on this issue in 2019 with Maine enacting legislation that prohibits PBMs from retaining rebates from manufacturers and New York's new law increases transparency and requires PBMs to work "for the best interests primarily of the covered individual."

Vaccines

With the number of measles cases reaching the highest levels in more than 25 years, vaccine exemptions were a hot topic in states across the country, and the AMA was active on the advocacy front helping states address these bills. Several sought to eliminate all nonmedical exemptions to the childhood immunizations required for parents to enroll children in school—including enactments in Maine and New York. These two states join California, Mississippi and West Virginia to bring the total count of states that prohibit all nonmedical exemptions to five. Washington also strengthened its vaccine laws, barring personal and philosophical objection to the measles, mumps, and rubella vaccine. In addition, no new laws were enacted that would discourage immunization. In particular, the AMA worked closely with the Arizona Medical Association to defeat three high-profile bills that would have loosened vaccination laws. The AMA also wrote to major social media companies calling on them to eliminate false and misleading vaccine information from their platforms.

Gun violence

Gun violence in America has reached epidemic proportions. In 2019, the AMA continued its advocacy to find workable, comprehensive solutions to reduce gun violence. At the federal level, the House of Representatives passed a universal background check bill supported by the AMA. The sponsor of H.R. 8, Rep. Mike Thompson (D-CA), spoke at the AMA's National Advocacy Conference and expressed his thanks for AMA's support. The bill awaits consideration in the Senate.

At the state-level, several states made progress on the issue in 2019. Four states (Colorado, Hawaii, New York and Nevada) passed laws authorizing extreme risk protection orders (sometimes called “Red Flag laws”). Connecticut expanded safe storage requirements in the home. California approved a first-in-the-nation requirement that anyone purchasing ammunition must undergo a background check. Washington, New Mexico and Nevada strengthened background check requirements, and several states closed loopholes that enable domestic abusers’ access to firearms, including North Dakota, New Mexico and Washington. Lastly, while no state currently prohibits physicians from counseling patients about firearm safety and risks, the AMA continues to watch for such legislation.

Following the mass shootings in Gilroy, CA, El Paso, TX, and Dayton, OH, the AMA joined with other physician groups in a joint call to action that was published online by the *Annals of Internal Medicine* on August 7. The joint document calls for commonsense reforms such as expanded background checks, more federal support for firearms injury research, and other proposals.

Detention of children at the southern border

The AMA is very concerned about the treatment of children at the southern border and has expressed these concerns several times to federal officials. In June, the AMA signed on to a letter of support for H.R. 3239, the “Humanitarian Standards for Individuals in Customs and Border Protection Custody Act,” along with 13 other health care organizations. H.R. 3239 takes important steps toward ensuring that appropriate medical and mental health screening and care are provided to all individuals, including immigrant children and pregnant women, in U.S. Customs and Border Protection (CBP) custody. In July, the AMA called on the U.S. Department of Homeland Security (DHS) and CBP to address the condition of their facilities at the southern border, which are inconsistent with evidence-based recommendations for appropriate care and treatment of children and pregnant women. The AMA also issued a letter to the House Committee on Oversight and Reform in advance of the upcoming congressional hearings entitled, “Kids in Cages: Inhumane Treatment at the Border,” and “The Trump Administration’s Child Separation Policy: Substantiated Allegations of Mistreatment.” In the AMA letter, CEO and EVP James L. Madara, MD, stated: “Conditions in CBP facilities, including open toilets, constant light exposure, insufficient food and water, extreme temperatures, and forcing pregnant women and children to sleep on cement floors, are traumatizing. These facilities are simply not appropriate places for children or for pregnant women. We strongly urge the Administration and Congress to work with the medical community to develop policies that ensure the health of children and families is protected throughout the immigration process.”

Protecting the patient-physician relationship

The AMA filed two major lawsuits in 2019 that challenged governmental intrusion into the patient-physician relationship. Both cases are working their way through the litigation process. The first was filed in conjunction with the Oregon Medical Association and other plaintiffs in federal court in Oregon and argues that proposed Administration regulatory changes would decimate the successful Title X program. The AMA’s main concerns are that:

- The regulation imposes a “gag rule” on physicians that restricts them from providing complete information to patients about all of their health care options and providing appropriate referrals for care.
- It re-directs funds away from evidence-based contraception methods and to non-medical family planning services such as abstinence and “fertility awareness.”

- It withholds funds from qualified Title X providers that offer the full range of family planning services to vulnerable populations.

The AMA also filed a lawsuit to challenge the constitutionality of two North Dakota laws that compel physicians and other members of the care team to provide patients with false, misleading, non-medical information about reproductive health. Filed in federal court in North Dakota, the lawsuit asks the court to block enforcement of North Dakota's compelled speech laws, which the AMA argues would inflict irreparable harm on patients and force physicians to violate their obligation to give honest and informed advice.

Nondiscrimination in health care

The AMA is assessing the full impact of the regulatory proposal issued in 2019 to remove anti-discrimination protections related to sexual orientation, gender identity, and termination of pregnancy across a wide range of health care programs and insurance plans. We strongly believe that discrimination on the basis of sex includes discrimination on the basis of gender identity and sexual orientation. Similarly, the AMA does not condone discrimination based on whether a woman has had an abortion. Respect for the diversity of patients is a fundamental value of the medical profession and reflected in long-standing AMA ethical policy opposing discrimination based on race, gender, sexual orientation, gender identity, pregnancy, or termination thereof. The AMA submitted comments that highlight these concerns on August 13.

Conversion therapy

The AMA opposes the practice of "conversion therapy" on minors and works with states to ban this practice. Four states (Colorado, Massachusetts, Maine and New York) enacted laws prohibiting the practice in 2019. This practice refers to interventions that attempt to change an individual's sexual orientation, sexual behaviors, gender identity, or gender expression. Eighteen states and Washington, DC now prohibit the harmful practice and one state, North Carolina, bars use of state funding for conversion therapy. The AMA produced an issue brief on this topic to assist states that seek to address it in coming legislative sessions.

Tobacco

Tobacco use particularly among youth remains a public health concern for the AMA. There are state and federal efforts to move to an age 21 threshold for tobacco purchase. This year 10 states (Arkansas, Connecticut, Delaware, Illinois, Maryland, Texas, Utah, Virginia, Vermont, and Washington) raised the minimum age to purchase tobacco products to 21 from 18, bringing the total number of Tobacco 21 states to 17 plus Washington, DC. The AMA is also reviewing federal legislation that would create a federal requirement as well. The AMA also has strong policy on e-cigarettes and is monitoring federal and state legislative and regulatory efforts closely. The AMA will continue to seek opportunities to advocate for AMA policy on this public health concern.

Scope of practice

State legislatures considered over 1000 bills seeking to eliminate team-based care models of health care delivery and/or expand the scope of practice of non-physician health care professionals in 2019. For example, nurse practitioners continued to seek independent practice authority and to chip around the edges of state law. Physician assistants were more emboldened this year to seek independent practice with the adoption of the optimal team practice act by the American Academy of PAs (AAPA) last year, and pharmacists sought prescriptive authority in at least a dozen states.

1 While these three groups of non-physician health care professionals accounted for the vast majority
2 of scope bills this year, hard fought battles also occurred in a number of states on other scope
3 issues. With tough fights in all cases, most bills that threatened passage were defeated, often with
4 AMA support and a coordinated approach from state medical associations and national medical
5 specialty societies through the AMA-led Scope of Practice Partnership (SOPP). The SOPP has
6 provided close to \$2 million in grants to states and specialties since its inception to help on the
7 scope front.

8
9 **CONCLUSION**

10
11 The AMA continues to be a powerful advocate for physicians as it attacks the major problems that
12 promote dysfunction in health care including payment issues, egregious health insurance practices,
13 industry consolidation, and drug pricing. At the same time, the AMA is seeking to improve public
14 health by working to solve the gun violence crisis, continue progress being made on the opioid
15 epidemic, and promote health equity across the board. AMA advocacy work will continue through
16 the rest of 2019, and the AMA will be prepared as health care policy will go under the microscope
17 again in the presidential primaries and general election in 2020.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-19

Subject: Re-establishment of National Guideline Clearinghouse

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

1 This report is pursuant to American Medical Association (AMA) Policy D-410.991, “Re-
2 establishment of National Guideline Clearinghouse (NGC)”, passed by the House of Delegates at
3 the 2019 Annual Meeting. The second paragraph of the policy calls on the AMA to research
4 possible and existing alternatives for the functions of the NGC with a report back to the House of
5 Delegates.

6 7 BACKGROUND

8
9 The mission of the NGC was to provide physicians and other health care professionals, health
10 plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining
11 objective, detailed information on clinical practice guidelines and to further their dissemination,
12 implementation, and use.

13
14 The NGC was created in 1997 by the Agency for Healthcare Research and Quality (AHRQ) in
15 partnership with the AMA and the American Association of Health Plans (now America’s Health
16 Insurance Plans [AHIP]). In January 1999, the database-driven NGC website was made available to
17 the public, and AHRQ maintained and enhanced the NGC for nearly 20 years. The partnership with
18 AMA and AHIP ended in 2002, but AMA remained committed to the mission of the NGC through
19 passage and reaffirmation of AMA Policy H-410.965, “Clinical Practice Guidelines, Performance
20 Measures, and Outcomes Research Activities.”

21 22 NATIONAL GUIDELINES CLEARINGHOUSE STATUS

23
24 The AMA discussed the NGC with AHRQ staff to understand why the NGC website was closed
25 and services suspended as of July 2018. Per AHRQ staff, it was never the intention of AHRQ to
26 eliminate or shut down the NGC. The AHRQ received funding to develop and maintain the NGC
27 per its mission. This funding ended, and the MITRE Corporation was contracted by AHRQ to
28 determine a path(s) to sustaining and advancing NGC without AHRQ funding. The MITRE
29 Corporation is a not-for-profit company that operates multiple federally-funded research and
30 development centers to provide innovative, practical solutions.

31
32 Prior to commissioning the study, AHRQ staff interviewed NGC stakeholders and customers to get
33 a thorough understanding of what they valued about the NGC to guide MITRE in their charge.
34 While clinical practitioners associated with large medical practices or health systems, and many
35 specialists have access to guidelines and related materials, the NGC was most used by researchers,
36 residents and small practices or solo practitioners. Among the stakeholder comments were a
37 continued interest in a repository of evidence-based clinical practice guidelines meeting certain
38 transparent criteria and continued support for public access to the repository (no fee or registration
39 required). During this transition some organizations stepped in to provide similar if not parallel
40 services to the NGC. One such organization, ECRI Institute, an independent, nonprofit patient

1 safety organization, launched the ECRI Guidelines Trust™, a portal to expertly vetted, evidence-
2 based guideline briefs and scorecards. The healthcare community has free access to the website.
3
4 The MITRE Corporation has completed its study and per its recommendations AHRQ will
5 transition the NGC to a private entity to sustain the site and thereby provide a source of evidence-
6 based guidelines for clinical decision making. The Agency will achieve this transition through a
7 mechanism that will ensure alignment with principles that have defined AHRQ's support for the
8 resource, including the requirement that guidelines meet specific criteria and adherence to the IOM
9 trustworthiness standards, public access, and protections of guideline developer copyright. AHRQ
10 will have a role in the NGC, which will be specified as the work continues. No information is
11 publicly available at this time regarding the financial support for the new NGC to be managed by a
12 private entity.
13
14 The timeline for migration to a private entity from AHRQ has not been determined but AHRQ will
15 continue to post updates to it website <https://www.ahrq.gov/gam/updates/index.html>. The AMA
16 will monitor additional plans as they become available.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-19

Subject: Distracted Driver Education and Advocacy

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

1 INTRODUCTION

2
3 At the 2019 Annual Meeting, the House of Delegates amended Policy H-15.952 asking that our
4 American Medical Association “make it a priority to create a national education and advocacy
5 campaign on distracted driving in collaboration with the Centers for Disease Control and other
6 interested stakeholders” and be it further “that our AMA explore developing an advertising
7 campaign on distracted driving.”
8

9 This report discusses the development of actions in response to Policy H-15.952, Paragraph 6.
10

11 BACKGROUND

12
13 Texting and driving is one of the most dangerous forms of distracted driving. According to
14 National Highway Traffic Safety Administration (NHTSA) at any given moment across America,
15 approximately 660,000 drivers are using or manipulating electronic devices while driving. A higher
16 percentage of U.S. drivers text or use hand-held cell phones while driving compared to drivers in
17 European countries. The CDC states that in 2016, 3,450 people were killed in crashes involving a
18 distracted driver. The CDC also found that in 2015, 391,000 people were injured in motor vehicle
19 crashes involving a distracted driver and one-fourth of all traffic accidents are associated with cell
20 phone use, a number that has held steady since 2010.
21

22 There are many external resources on this topic already – including national campaigns by the
23 National Highway Traffic Safety Administration (NHTSA) and AT&T. The NHTSA has four
24 national campaigns to educate on distracted driving: 1) Evergreen Campaign, 2) One Text Or Call
25 Could Wreck It All, 3) Phone In One Hand - Ticket In The Other, and 4) U Drive. U Text. U Pay.
26 Likewise, AT&T’s “It Can Wait” campaign has successfully received over 38 million pledges to
27 drive distraction free.
28

29 STATUS OF IMPLEMENTATION

30
31 Enterprise Communications will amplify the efforts of Advocacy, Health and Science, and JAMA
32 through appropriate media channels and will work with Physician Engagement to amplify via
33 AMA owned channels such as social media, AMA Wire, etc. Enterprise Communications will
34 evaluate opportunities to support current and future advertising campaigns on distracted driving to
35 highlight the risks to the public.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-19

Subject: Hospital Closures and Physician Credentialing

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

1 American Medical Association Policy D-230.984, “Hospital Closures and Physician
2 Credentialing,” instructs our AMA to: (a) continue to monitor the development and implementation
3 of physician credentialing repository databases that track hospital affiliations, including tracking
4 hospital closures, as well as how and where these closed hospitals are storing physician
5 credentialing information; and (b) explore the feasibility of developing a universal clearinghouse
6 that centralizes the verification of credentialing information, and report back to the House of
7 Delegates at the 2019 Interim Meeting.

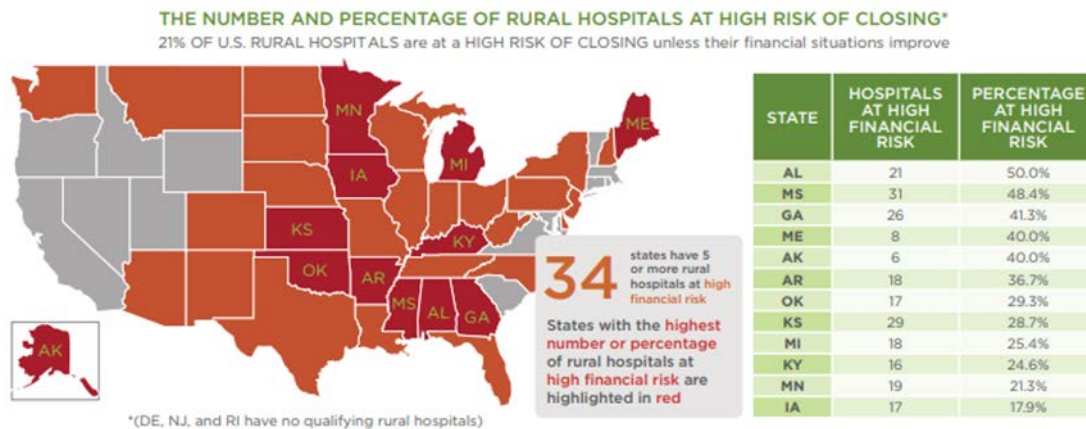
8
9 The testimony on the original resolution (Resolution 716-A-18) was largely supportive of the intent
10 to develop a universal clearinghouse that centralizes the verification of credentialing information;
11 however, some members noted that the cost of implementation may be significant and that there
12 were still many unanswered questions about the demand for such a service and how it would work.
13 Others were concerned as to whether the AMA is the organization best positioned to take up the
14 issue.

15
16 This informational report provides an update on hospital closure activity, changes and updates to
17 associated legal or regulatory requirements, and the status of various efforts to centralize records
18 for impacted institutions.

19 20 DISCUSSION

21
22 According to Becker’s Hospital CFO Review, at least 12 hospitals have closed between January
23 and June of 2019 with another 12 filing for bankruptcy from January through April. This does not
24 include the 100+ year old Philadelphia-based Hahnemann University Hospital, which is the
25 primary teaching hospital affiliated with Drexel University College of Medicine. This announced
26 bankruptcy and facility closure will displace approximately 40% of the hospital’s physician and
27 other clinical staff, some 571 residents, fellows, and medical students currently in training.
28 Additionally, a report issued by Navigant Consulting in Chicago, Illinois found that over twenty
29 percent of rural hospitals across the U.S. are at risk of closure. All indications are that this will
30 continue to be an issue that significantly impacts students, residents, and physicians from multiple
31 angles.

Figure 1: Rural Hospital Financial Risk



As previously reported, a thorough review of existing law revealed few requirements for the retention of physician credentialing records when a hospital closes. Some states have legislation requiring the hospital to implement policies for the preservation of medical staff credentialing files (e.g., Illinois and New York); however, most states have no specific law or regulations providing for the timely transfer of medical staff credentialing files and proper notification to physicians.

Despite the lack of specific legislation, industry credentialing experts have shared anecdotal examples that indicate that institutions generally recognize the importance of these records and often attempt to make arrangements for their files prior to closure. Reportedly, this usually leads to shipping boxes of paper to another local institution for safekeeping. In the case of bankruptcy, the records may be included as part of the bankruptcy proceedings.

Various industry stakeholders have developed processes and programs to manage and store certain information that would traditionally be verified by a hospital or training program with varying success. The Federation of State Medical Boards (FSMB) offers a graduate medical education (GME) closed program service. Through this program, FSMB offers to permanently store the records of residents who attended the program. FSMB charges a fee to the closing program that fluctuates depending on whether they are providing electronic or paper records. They have also consulted with The Joint Commission, the National Committee for Quality Assurance (NCQA), URAC and state licensing boards to ensure that the information provided through this program meets the primary source verification requirements. FSMB charges an institution verifying the credentials of an impacted physician \$60 per physician per program validation. They currently maintain the records from over 30 closed facilities representing well over one hundred individual training programs. FSMB has been in contact with the previously mentioned Hahnemann University Hospital about their services. This program, however, is limited in its scope. Currently it is specific to the storage and maintenance of training records and does not extend to work history or the evaluation of voluntary or involuntary termination of medical staff membership or the voluntary or involuntary limitation, reduction or loss of clinical privileges.

In January of 2013, the National Association of Medical Staff Services (NAMSS) launched NAMSS Pass, a secure online database that provides access to primary source affiliation history for clinicians. The information includes affiliation history with verified dates. In some instances, a letter of good standing may be included. NAMSS reports that less than 10% of U.S. hospitals have elected to utilize the program. The most common reasons cited for not participating are that it is extra work that does not improve the credentialing process and that the facility's legal department

1 prohibits the provision of this information to NAMSS Pass. NAMSS continues to work to garner
2 greater adoption and make necessary changes to secure additional information beyond affiliations
3 in the event of a hospital closure.

4
5 As noted in previous reports, various states have also been looking at centralizing credentialing
6 activities which has the potential to address the hospital closure issue. Oregon, one of the more
7 recent efforts, announced their decision to suspend their Common Credentialing program citing
8 complexity and expense.

9
10 The AMA has been in contact with these organizations as well as others in an effort to identify
11 ways to address the issue of ensuring accessible data after an institution closure as well as to reduce
12 the burden placed on physicians during the credentialing process. Today, the AMA through its
13 Credentialing Profile service acts as a centralized repository of certain credentialing data, including
14 state licensure and actions, board certification, drug enforcement agency (DEA), medical education
15 and Accreditation Council for Graduate Medical Education (ACGME) accredited training. The
16 AMA continually explores the expansion of this service offering, however, recognizes that certain
17 aspects of the credentialing and privileging information maintained by the medical staff office will
18 be extremely challenging to centralize. For example, these files customarily include peer reviews
19 that institutions are reluctant to store outside their organization.

20 21 AMA POLICY

22
23 AMA policy supports the appropriate disposition of physician credentialing records following the
24 closure of hospitals, ambulatory surgery facilities, nursing homes, and other health care facilities.
25 Policy H-230.956, "Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care
26 Facility Closure: Physician Credentialing Records" states that, where in accordance with state law
27 and regulations, "...the governing body of the hospital, ambulatory surgery facility, nursing
28 home, or other health care facility shall be responsible for making arrangements for the disposition
29 of physician credentialing records or CME information upon the closing of a facility..." and "make
30 appropriate arrangements so that each physician will have the opportunity to make a timely request
31 to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and
32 medical staff status." Policy H-230.956 also states that the closing facility "...shall attempt to make
33 arrangements with a comparable facility for the transfer and receipt of the physician credentialing
34 records or CME information."

35 36 CONCLUSION

37
38 When a hospital closes, there are significant impacts to students, residents, and physicians, that
39 impact their personal lives and careers including ensuring their training and/or privileging history
40 can be verified during future credentialing events. While several stakeholders are looking to
41 address this issue, currently a universally accepted solution does not exist. Further, because this is
42 not regulated or legally mandated, any planning or transition is primarily voluntary. Institutions,
43 however, generally have the desire to ensure a responsible transition for these records. This is a
44 complex issue that the AMA continues to monitor. The AMA stands committed to exploring cost
45 effective and scalable solutions that preserve medical staff credentialing files and avoid undue
46 delays in future credentialing events.

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APPENDIX – AMA POLICIES RELATED TO THIS REPORT

H-230.956, "Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records"

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:
 - A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.
 - B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.
 - C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.
 - D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.
 - E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.
2. Our AMA advocates for the implementation of this policy with the American Hospital Association.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-19

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

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

MACRA IMPROVEMENT

The AMA has continued work with the Centers for Medicare & Medicaid Services (CMS) to make improvements to the Merit-based Incentive Payment System (MIPS) program. While initial data on 2018 results show that 98 percent of eligible clinicians successfully participated in the program, the program's requirements have proven both costly and burdensome for physicians and will likely be increasingly so in coming years. For the past year, the AMA has worked extensively with the physician community and CMS to develop reforms that would move the program from multiple silos of reporting requirements to a more relevant and less burdensome construct centered around episodes of care, conditions, or other public health priorities.

We are pleased that the 2020 proposed rule introduces MIPS Value Pathways (MVPs) to begin in 2021. The proposed framework would incorporate a foundation that leverages promoting interoperability measures and a set of administration claims-based quality measures to focus on population health priorities, limiting the number of required specialty or condition specific measures physicians are required to report. While this proposal is an important step forward in making the MIPS program more clinically relevant and less burdensome, there are concerns such as the inclusion of population health administrative claims measures which the AMA fought to eliminate from the initial MIPS program. The AMA will work closely with state and national medical specialty societies to analyze the full impact of these and other related proposals in the 2020 proposed rule and make detailed recommendations to CMS to ensure successful implementation of proposed reforms.

While CMS can make considerable improvements to MACRA through regulations, other improvements will require statutory changes by Congress. As outlined in previous editions of this report, the AMA and state and national medical specialty societies have developed a series of recommended reforms that would build on the current efforts of CMS by providing additional flexibility for participating clinicians in MIPS, better alignment of reporting requirements, and facilitating the adoption of Alternative Payment Models (APMs). While many of these proposals could likely be implemented in a budget neutral manner, there are several which will trigger potentially significant scores.

1 The most significant (and costly) proposal would be to eliminate the zero percent update included
2 in the original MACRA statute for calendar years 2020-2025. Under the law, updates through the
3 year 2019 were to have been 0.5 percent annually, followed by zero percent for the years
4 2020-2025. Beginning in 2026, physicians participating in MIPS would see updates of 0.25 percent
5 and those participating in APMs would realize updates of 0.75 percent. Updates for the years
6 2016-2019, however, did not materialize due to subsequent legislation that significantly reduced
7 expected updates to offset the cost of other priorities. The history of minimal updates (and cuts) for
8 the period following the initial SGR-produced cut in 2002 until MACRA passage in 2015 followed
9 by lower than expected updates in the five years following MACRA adoption, has resulted in
10 Medicare physician payment rates that have increased only 6 percent since 2001. Over the same
11 period, the cost of running a medical practice has increased 32 percent as measured by the
12 Medicare economic index. The AMA believes that it is critical that Medicare payment policies
13 provide an adequate margin so that practices may make the necessary investments required to
14 successfully implement MIPS and APMs. Discussions are underway with Congressional staff to
15 address these shortfalls.

16 17 STEPS TO LOWER HEALTH CARE COSTS

18
19 For much of this year, Congress has been heavily focused on lowering health care for consumers
20 by reducing the cost of prescription drugs, addressing unanticipated (or “surprise”) medical bills,
21 and other proposals to increase transparency and improve public health.

22
23 In the U.S. House of Representatives, the committees on Energy and Commerce, Ways and Means,
24 and Judiciary have all reported legislation aimed at increasing transparency and spurring
25 competition in the prescription drug markets, consistent with AMA priorities. In all, more than 100
26 proposals have been introduced that, among other goals, would increase access to data to evaluate
27 the practices of entities within the prescription drug supply and financing chain as well as eliminate
28 incentives and deter practices that impede market entry of generics.

29
30 Significantly, prior to the August recess, the Senate Finance Committee reported bipartisan
31 legislation, the “Prescription Drug Pricing Reduction Act of 2019.” This bill includes many AMA
32 supported initiatives such as requiring manufacturers to pay rebates to HHS if a drug price
33 increases faster than the rate of inflation, increased transparency of PBM and manufacturer rebate
34 and discount arrangements, promotion of biosimilar products, and site-of-service payment
35 neutrality for Part B drug administration. There are provisions in the bill, however, that require
36 close scrutiny to determine their impact on physician practices, such as capping ASP add on
37 payments for Part B drugs at \$1,000 and excluding the amount of patient coupons from the
38 calculation of ASP. While the Finance Committee proposal received bipartisan support, there are
39 significant issues that must be addressed prior to consideration by the full Senate, including
40 opposition by multiple members to the provision linking permissible price increases to inflation.

41
42 It is also expected that following the August recess House Democratic leadership will put forward
43 legislation to empower the government to negotiate with manufactures for lower prescription drug
44 prices. The bill will focus on drugs on the market without competition and give drugmakers the
45 opportunity to recoup their investments but not maintain long standing monopolies, according to
46 the Speaker’s office.

47
48 The Administration has also put forth several proposals to address the cost of prescription drugs.
49 Most recently, on July 31, HHS announced the “Safe Importation Action Plan” which will be the
50 subject of an upcoming proposed regulation from the department. The plan would offer two
51 potential pathways predicated on the invocation of Section 804 of the Federal Food, Drug and

1 Cosmetics Act by the Commissioner of the Food and Drug Administration. Under this provision,
2 the Commissioner may allow for the importation from Canada of drugs if he or she certifies that
3 doing so would not jeopardize the public health and would result in significant cost reductions.
4 Under the proposal, there would be two possible pathways. Under the first, states, wholesalers and
5 pharmacies could submit proposed demonstration projects for HHS review. Under a second
6 pathway, manufacturers themselves could import of FDA approved medications. HHS noted that
7 manufacturers have told them that they would like to offer lower cost versions of their own drugs
8 but are prevented from doing so because they are locked into contracts with other parties in the
9 supply chain. This option would allow them to import of their own drugs produced for the
10 Canadian market for that purpose. Certain drugs, such as controlled substances, drugs subject to
11 REMS, and biologics, including insulin, would not be eligible for this program.

12
13 In February 2019, the Administration proposed to eliminate safe harbor protections for rebates paid
14 by manufacturers to PBMs, Part D plan sponsors, and Medicaid MCOs. That plan was withdrawn
15 in July as it became clear that plan sponsors, faced with a loss of rebate revenue, would likely raise
16 premiums for Medicare beneficiaries.

17
18 The issue of unanticipated, or “surprise,” medical bills continues to be the focus of intense activity
19 in Congress as it has since last year. All parties agree that patients who are cared for by physicians
20 outside of their insurer’s network, either due to the emergent nature of their condition or in cases of
21 hospital-based physicians not generally selected by the patient, should not be penalized due to the
22 fact that their plan did not have a contract with that physician. In these cases, the AMA agrees that
23 patients should only be held liable for the same amounts they would have paid had they been seen
24 by an in-network physician. Most of the leading legislative proposals are consistent with this goal.
25 Significant differences exist, however, in how these proposals determine the appropriate amount
26 that the plan should pay the physician for their services.

27
28 The “Lower Health Care Cost Act,” S. 1895, was reported by the Senate Committee on Health,
29 Education, Labor, and Pensions on June 26, 2019. While this bill contains numerous other
30 provisions to lower health care costs, the primary source of the bill’s savings is Title I, “Ending
31 Surprise Medical Bills.” Under the proposal, out-of-network (OON) physicians would be paid at
32 the median in-network rate for physicians contracted by the plan in the same geographic region and
33 would be banned from balance billing patients. The Congressional Budget Office has noted that
34 since physicians who decline to accept contract terms offered by plans would be paid at the median
35 in-network rate regardless of their contract status, average rates could fall by 15-20 percent as the
36 average rates coverage around the median—though the absolute number of physicians who will see
37 increases (those now below the median) and those who will see decreases (those above the median)
38 will be roughly the same. It is noteworthy that 80 percent of the savings is derived from lower in-
39 network rates. Going forward, CBO expresses a good deal of uncertainty on the long-term impact
40 of these changes, with one possibility being increased provider consolidation results in upward
41 pressure on price growth.

42
43 The AMA and impacted specialties continue to strongly advocate in the alternative that Congress
44 adopt an independent dispute resolution (IDR) process, like the successful program in New York,
45 to resolve physician-payer disputes while continuing to hold the patient harmless. Support for this
46 approach has been voiced by several members of the HELP committee, including Sen. Bill
47 Cassidy, MD (R-LA), Sen. Maggie Hassan (D-NH), and Sen. Lisa Murkowski (R-AK). During the
48 committee consideration of the bill, Chairman Lamar Alexander (R-TN) and Ranking Member
49 Patty Murray (D-WA) committed to consideration of an IDR process, though no resolution has
50 been reached as of this writing.

Of the other health care cost provisions in S. 1896, many are well intentioned though potentially burdensome or impractical for physicians. One would require that all bills would have to be sent to a patient with 45 days or patients would not have to pay. Another would increase physician responsibility for the accuracy of plan's provider directories. The AMA continues to discuss these and other provisions with the committee.

On July 17, the House Committee on Energy and Commerce reported H.R. 2328, the "Reauthorizing and Extending America's Community Health Act" or the "REACH Act." Title IV of the bill is the text of the "No Surprises Act" offered by Committee Chairman Frank Pallone (D-NJ) and Ranking member Greg Walden (R-OR). The bill follows the general outline of the HELP bill, holding patients harmless from unanticipated bills and paying the OON physician at the in-network median rate. During the committee's consideration of the bill, an amendment by Rep. Raul Ruiz, MD, (D-CA) and Rep. Larry Bucshon, MD, (R-IN) was adopted to include a limited independent dispute resolution process for claims above a \$1,250 threshold. While the provision is not ideal, it represents an important step forward in the efforts of organized medicine to include a fair and independent process to resolve disputes with payers.

Two additional committees of the House, Ways and Means and Education and Labor, are expected to consider proposals addressing unanticipated medical bills following the August recess. The AMA, state medical associations, and many national medical specialty societies are continuing efforts to ensure the any legislation adopted to address "surprise" bills provides for a fair resolution of payment disputes while holding patients harmless.

COVERAGE

Several House committees have reported legislation to strengthen the Affordable Care Act by increasing funding for Navigator programs, expanding the availability of ACA subsidies, providing support for the establishment of state-based marketplaces, increasing outreach and enrollment activities and other actions to preserve and strengthen current coverage options. Despite these actions, it is unlikely that similar legislation will emerge from the Senate in the current environment. Much of the current attention has been focused on single payer plans put forth in both the House and the Senate. The AMA continues to oppose this approach and remains focused on strengthening what works and expanding access to and choice of affordable, quality health insurance. Despite pressure from many members of the Democratic caucus, House leadership remains reluctant to take up single payer proposals. Polling has shown that while the concept of single payer, or "Medicare for All" proposals is popular, support falls off sharply when the implications of doing away with current coverage pathways is more closely examined. The AMA continues to support health insurance coverage for all Americans that is focused on pluralism, freedom of choice, freedom of practice and universal access for patients and will direct our advocacy efforts toward these goals.

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

Though the previous Administration determined that no action was necessary to implement the non-physician provider non-discrimination provision of the Affordable Care Act, proponents continue to encourage efforts by the Administration to propose regulations. During the July 17 mark-up of legislation in the House Committee on Energy and Commerce, an amendment was offered and later withdrawn to require the Administration to initiate rulemaking. Though legislation to repeal this provision has not been introduced during the past two Congresses, AMA will continue to seek opportunities to implement HOD policy related to this provision.

1 CONCLUSION

2

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

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-19

Subject: For-Profit Medical Schools or Colleges

Presented by: Jacqueline A. Bello, MD, Chair

American Medical Association (AMA) Policy D-305.954, “For-Profit Medical Schools or Colleges,” states:

That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (1) attrition rate of students, (2) financial burden of non-graduates versus graduates, (3) success of graduates in obtaining a residency position, and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting.

The Council on Medical Education recognized the importance and timeliness of this topic and agreed that appropriate resources and data collection were needed to study this issue and prepare the report. However, meaningful and constructive review of this issue and the data collection required additional time. The Council therefore is presenting this report at the 2019 Interim Meeting.

For-profit medical schools are a rare phenomenon within the United States, and the numbers of these schools have not increased substantially, with only six for-profit U.S. medical schools. That said, there are a large and growing number of for-profit medical schools located in the Caribbean that are attended by U.S. citizens. This report focuses on for-profit medical schools located in the United States, and provides available attrition rates, general financial information associated with students who attend for-profit vs. not-for-profit medical schools, and data on student transition into residency programs. Very limited data are also included on for-profit medical schools located in the Caribbean, as such data are not publicly available.

BACKGROUND

In the 19th century, the majority of medical schools were the property of the faculty and, therefore, could be considered “for-profit.” In 1906, early accreditation standards from the Council on Medical Education required that schools not be conducted for the financial benefit of the faculty. A 1996 ruling against the American Bar Association, related to restraint of trade, opened up the possibility of accreditation of for-profit law schools and set a legal precedent for the establishment of for-profit medical schools.¹⁻³ Currently, medical school accreditation bodies, including the Liaison Committee on Medical Education (LCME) and American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), are responsible for reviewing the financial status of U.S. medical schools and monitoring graduation rates and student debt.

Four for-profit osteopathic medical schools are in various stages of becoming accredited by COCA. In 2007, provisional accreditation was granted to investor-owned Rocky Vista University College of Osteopathic Medicine in Colorado.¹ The College was founded to address the need for community-based primary care physicians in the Mountain West region. The Burrell College of

Osteopathic Medicine at New Mexico State University, a privately funded osteopathic medical school founded in 2013, holds pre-accreditation status from COCA, and is expected to be fully accredited when its first class graduates in 2020.⁴ In 2016, the Idaho College of Osteopathic Medicine and the California Health Sciences University College of Osteopathic Medicine were founded to help address regional physician shortages in underserved areas.⁵ Both schools have initiated the accreditation process with COCA.

The LCME, by comparison, has granted accreditation to two for-profit allopathic medical schools. In 2013, the LCME modified its standards to remove mention of “for-profit” in the accreditation of allopathic medical schools.¹ One year later, Ponce Health Sciences University School of Medicine (a 35-year-old not-for profit institution in Puerto Rico reported to be in financial distress) was acquired by Arist Medical Sciences University, a for-profit public benefit corporation, making it the first for-profit allopathic medical school accredited by the LCME.¹ In 2015, California Northstate University College of Medicine, a private, for-profit medical school focused on educating, developing, and training physicians to address the primary care physician shortage in northern California, gained preliminary accreditation from the LCME and enrolled its first class of students.⁶

FOR-PROFIT MEDICAL SCHOOLS IN THE CARIBBEAN

There is a growing number of for-profit medical schools located in the Caribbean, often referred to as “offshore medical schools.”⁷ Accreditation/approval of these schools is the purview of a variety of bodies, each with varying standards and requirements for quality and duration of education. Currently, 75 offshore medical schools are acceptable to the Educational Commission for Foreign Medical Graduates (ECFMG) for graduates to obtain ECFMG certification.⁸ Offshore schools typically engage in minimal clinical or scientific research. As a result, offshore proprietary schools have a profitable business model in that their costs are mainly related to the educational program. These schools use their tuition revenue to pay faculty to teach in the basic sciences at U.S. hospitals, and as part of their tuition third- and fourth-year medical students pay to take clinical rotations in the United States.

There are no summary data available on the enrollment of U.S. citizens in offshore medical schools. However, an estimate can be made based on the number of U.S. citizens pursuing certification by the ECFMG. Of the 9,430 ECFMG certificates issued in 2018, 2,398 (25.4 percent) were issued to U.S. citizen graduates of offshore medical schools.⁹ The students/graduates registering for certification were from medical schools located in countries in the Caribbean.

ATTRITION RATES

Not-for-profit U.S. Medical Schools

The Association of American Medical Colleges (AAMC) reports that from 1993-1994 through 2012-2013, the total national attrition rate for not-for-profit medical schools remained relatively stable at an average of 3.3 percent (Appendix A, Table 1).¹⁰ The AAMC notes that more medical students left medical school for nonacademic than for academic reasons, and that attrition rates appeared to vary by type of degree program—that is, the attrition rates of students in combined degree programs, such as MD-MPH programs, differ from those for students in MD programs.

The American Association of Colleges of Osteopathic Medicine (AACOM) calculates attrition rate by dividing the sum of students who withdrew or took a leave of absence by total enrollment. Withdrawals and dismissals are types of permanent attrition from the colleges of osteopathic

medicine (COM), while leaves of absence are types of temporary attrition that may become a withdrawal or dismissal after a period of time.¹¹ Reasons for students' withdrawals/dismissals include academic failure or school policy violation; poor academic standing; transferring to another medical school; medical or personal reasons; changes in career plans; and failure to take or pass COMLEX (per COM policy). Reasons for leaves of absence include poor academic performance/remediation; academic enrichment/research/study for another degree; medical or personal reasons; and failure to take or pass COMLEX (per COM policy). AACOM only reports on those schools with a full four-year enrollment.

Attrition rates for all COMs ranged from a low of 2.63 percent (2009-2010) to a high of 3.59 percent (2012-2013), with an average 3.03 percent attrition rate from 2009-2010 through 2018-2019 (Table 1).¹¹ AACOM reports that first- and third-year students had a higher rate of attrition than their second- and fourth-year counterparts, due largely to the struggles first-year students experience when adjusting to the rigors of medical school and to COMLEX being administered to third-year students.

For-profit Medical Schools

Ponce Health Sciences University School of Medicine reports on its website that its average attrition rate for 2016-2017 was 2.3 percent (Table 1).¹² Although actual attrition rates are not available for California Northstate University College of Medicine, the school's website notes that a total of 60 new students enrolled in fall 2015, one student left the program, and three students fell back a year, with a total attrition of one student (1.7 percent).¹³ Rocky Vista University College of Osteopathic Medicine, the only COM that has a full class (four years of students enrolled), reports on its website that 91 percent of Title IV students complete the program within four years.¹⁴ Data on attrition rates for newer U.S. medical and osteopathic schools as well as offshore medical schools are not available.

FINANCIAL BURDEN

Not-for-profit U.S. Medical Schools

In 2018-2019, the median annual tuition and fees at state medical schools were \$38,202; at private medical schools the median cost was \$61,533 (Appendix B, Table 2).¹⁵ In 2019, for students who attended state medical schools, the median debt was \$190,000; for students who attended private medical schools, the median debt was \$210,000.¹⁵ The overall mean osteopathic medical education debt reported by academic year 2017-2018 graduates is \$254,953 (\$222,972 for public schools and \$261,133 for private schools).¹⁶

For-profit Medical Schools

The four-year estimated tuition, fees, and cost of attending a for-profit U.S. medical school can range from \$209,000 to \$342,000 (Table 2). Rocky Vista University College of Osteopathic Medicine reports that four-year estimated tuition, fees, and costs is \$215,748, and its typical graduate leaves with \$294,018 debt.¹⁷ Median student loan debt accrued for attending an offshore medical school ranges from \$191,500 (Ross University School of Medicine) to \$253,072 (American University of the Caribbean School of Medicine).⁷

SUCCESS OF U.S. GRADUATES IN OBTAINING A RESIDENCY POSITION

Not-for-profit U.S. Medical Schools

The National Resident Matching Program (NRMP) defines a successful match into a residency program as “one that is measured not just by volume, but also by how well it matches the preferences of applicants and program directors.”¹⁸ In 2019, U.S. allopathic medical school senior students comprised 18,925 of the active applicants, and the first-year post-graduate (PGY-1) Match rate for U.S. seniors was 93.9 percent.¹⁸

In 2019, the transition to a single accreditation system resulted in higher participation among students and graduates of U.S. osteopathic medical schools. An all-time high of 6,001 DO candidates submitted NRMP rank and order lists of programs, and the 84.6 percent PGY-1 match rate was the highest in history.¹⁸

Earlier Match data reflected NRMP and AOA National Matching Service (NMS) systems. Data reported by the COMs show that 98.7 percent of spring 2018 graduates seeking GME successfully placed into GME as of April 12, 2018.¹⁹ This represents 6,224 new physicians beginning their graduate medical education in July 2018.¹⁹ This compares to the 2017 match/placement process, when 5,898 new physicians entered GME (99.3 percent of graduates seeking GME) and 2016, when 5,356 graduates were successfully matched/placed—99.6 percent of graduates seeking to enter GME.¹⁹

The 2020 Match will be the first single match system administered by the NRMP, to include both allopathic and osteopathic residency programs. This single system will simplify the matching process for osteopathic medical school students. A result of the new process will be a shift in the way the Match rate percentage is reported.

For-profit Medical Schools

The California Northstate University College of Medicine class of 2019 had a 96.3 percent overall Match rate.²⁰ Rocky Vista University College of Osteopathic Medicine reported that the majority of students (79 percent) found a residency placement through the 2019 NRMP match, while other students matched into their top choices through the AOA Intern/Resident Registration Program (12 percent) or into military-specific residency programs (nine percent).²¹

However, fewer students matched into U.S. residency programs at some of the other for-profit schools. For example, Ponce Health Sciences University School of Medicine reported that its 2016-2017 initial residency Match rate (aside from the Supplemental Offer and Acceptance Program, or SOAP) was 89.4 percent, vs. 84.4 percent in 2017-2018.¹² In 2019, 5,080 U.S. IMGs (primarily graduates of offshore medical schools) participated in the NRMP, and 59 percent (n=2,997) successfully matched.¹⁸

LEVEL OF SUPPORT FOR GRADUATE MEDICAL EDUCATION

All U.S. allopathic and osteopathic medical schools are required to prepare their students to successfully transition into Accreditation Council for Graduate Medical Education (ACGME)-accredited GME programs. Two new for-profit osteopathic medical schools are in the process of developing their GME programs. Burrell College of Osteopathic Medicine at New Mexico State University has facilitated the ongoing development of new residency programs in family medicine, internal medicine, orthopaedic surgery, and osteopathic neuromusculoskeletal medicine, and

1 additional new GME programs are under development.²² The leadership at the Idaho College of
2 Osteopathic Medicine body is also focused on being able to provide its students with a high-quality
3 academic and clinical clerkship experience and facilitating their placement into ACGME-
4 accredited residency programs.²³

5
6 Concern has been raised about the paucity of academic teaching hospitals associated with some
7 for-profit medical schools. For example, students who attend Rocky Vista University College of
8 Osteopathic Medicine complete clinical rotations at various hospitals throughout the state of
9 Colorado and the mountain west region.²⁴ Third- and fourth-year medical students in their
10 clerkships could be sent for rotations to nonacademic community hospitals without a strong
11 background in education and research.²⁴ Although the college was established on the premise that
12 physicians practice in locations close to their residency or fellowship programs, many of the
13 graduates have had to leave the state to complete residency training requirements.²⁴

14
15 Offshore for-profit medical schools, including those in the Caribbean, continue to provide a large
16 number of medical school graduates who return to the United States for GME.²⁴ However, the
17 accreditation standards these schools are held to, if any, vary widely and may not require that the
18 schools provide career counseling or support for the transition of their students into ACGME-
19 accredited programs.²⁵

20 21 RELEVANT AMA POLICY

22
23 The AMA has extensive policy related to the cost and financing of medical education.

24
25 Policy H-305.925 (20f), “Principles of and Actions to Address Medical Education Costs and
26 Student Debt,” states that the costs of medical education should never be a barrier to the pursuit of
27 a career in medicine nor to the decision to practice in a given specialty. To help address this issue
28 related to the Public Service Loan Forgiveness (PSLF) Program, the AMA will advocate that the
29 profit status of a trainee’s institution not be a factor for PSLF eligibility.

30
31 Policy H-200.949 (3), “Principles of and Actions to Address Primary Care Workforce,” directs the
32 AMA, through its work with stakeholders, to encourage development and dissemination of
33 innovative models to recruit medical students interested in primary care, train primary care
34 physicians, and enhance both the perception and the reality of primary care practice, to encompass
35 the following components: a) Changes to medical school admissions and recruitment of medical
36 students to primary care specialties, including counseling of medical students as they develop their
37 career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded
38 financial aid and debt relief options; d) Financial and logistical support for primary care practice,
39 including adequate reimbursement, and enhancements to the practice environment to ensure
40 professional satisfaction and practice sustainability; and e) Support for research and advocacy
41 related to primary care.

42
43 Policy D-295.309, “Promoting and Reaffirming Domestic Medical School Clerkship Education,”
44 directs the AMA to support agreements for clerkship rotations, where permissible, for U.S. citizen
45 international medical students between foreign medical schools and teaching hospitals in regions
46 that are medically underserved and/or that lack medical schools and clinical sites for training
47 medical students, to maximize the cumulative clerkship experience for all students and to expose
48 these students to the possibility of medical practice in these areas.

49
50 Additional related policies are provided in Appendix C.

1 SUMMARY

2
3 Stigma and reputational challenges associated with for-profit medical schools can be traced back to
4 the 1910 Flexner Report on Medical Education in the United States and Canada, which called for
5 quality education that linked medical schools with universities and teaching hospitals.³ The report
6 criticized for-profit schools, and the subsequent linkage between accreditation and licensure
7 requirements led to the collapse of many proprietary medical schools. However, for-profit medical
8 education has reemerged in the United States and has expanded in the Caribbean and elsewhere
9 around the world.^{7, 24} The Ponce Health Sciences University School of Medicine was recently
10 incorporated to facilitate the retention of public benefit.¹

11
12 For-profit schools are based on a tuition-dependent business model. For example, at Rocky Vista
13 University College of Medicine approximately 80 percent of revenue, as with the other private
14 osteopathic medical schools, comes from tuition and fees. In contrast, tuition and fees constitute
15 only 14 percent of public osteopathic medical schools' revenues.²⁴

16
17 As with any medical school, for-profit medical schools may have a positive impact on the
18 physician workforce. For example, the mission of California Northstate University College of
19 Medicine is to train primary care physicians to serve the needs in underserved areas in northern
20 California. As with other medical schools, however, the graduates of U.S. for-profit medical
21 schools are subject to competition for residency placements. Graduates from for-profit medical
22 schools in the Caribbean need to complete the requirements for ECFMG certification before they
23 can apply for residency training in the United States.

24
25 Through its Council on Medical Education, the AMA will continue to monitor the development of
26 for-profit medical schools, both allopathic and osteopathic, and report back to the House of
27 Delegates as needed.

APPENDIX A

TABLE 1. ATTRITION RATE OF STUDENTS ATTENDING U.S. MEDICAL SCHOOLS

<i>Not-for-profit</i>	<i>Attrition Rate:</i>
U.S. allopathic medical schools	From 1993-1994 through 2012-2013, the total national attrition rate remained relatively stable at an average of 3.3%. ¹
U.S. osteopathic medical schools	From a low of 2.63% (2009-10) to a high of 3.59% (2012-13), with an average of 3.03% attrition rate from 2009-10 through 2018-19. ²
<i>For-profit*</i>	<i>Attrition Rate:</i>
Ponce Health Sciences University School of Medicine	Average attrition rate is 2.3%; retention rate is 97.7% (2016-2017). ³
California Northstate University College of Medicine**	Total of 60 new students enrolled in the Fall of 2015; one student left the program and three students fell back a year; the total attrition of 1 student (1.7%). ⁴
Rocky Vista University College of Osteopathic Medicine**	91% of Title IV students complete the program within 4 years with an attrition rate of 9%. ⁵
Burrell College of Osteopathic Medicine at New Mexico State University**	Matriculated 162 students in 2018; retained 154 (95.06%) with an attrition rate of 4.94%. ⁶
Idaho College of Osteopathic Medicine***	Matriculated its inaugural class in August 2018. This class of 2022 is composed of graduates from 97 U.S. colleges and universities, with above average composite medical board (MCAT) scores and highly competitive undergraduate grade point averages. ⁷
California Health Sciences University College of Osteopathic Medicine***	Campus construction underway with targeted completion date of Spring 2020.

* *Similar quality data are not available from offshore medical schools*

** *Attrition rate is extrapolated from the retention rate posted on the medical school's website.*

*** *Data on attrition rates for newer U.S. medical schools are not yet available.*

1. AAMC Data Snapshot. Association of American Medical Colleges. Available at: <https://www.aamc.org/download/492842/data/graduationratesandattritionratesofu.s.medicalstudents.pdf> (Accessed April 9, 2019).
2. 2019-2020 Student Guide to Osteopathic Medical Colleges. American Association of Colleges of Osteopathic Medicine. 2019. Available at: https://www.aacom.org/docs/default-source/presentations/student-guide-for-web-5-28-19.pdf?sfvrsn=4aab3d97_2 (Accessed July 2, 2019).
3. Consumer Information and Student Achievement Guide 2017-2018. Ponce Health Sciences University. Available at: <https://www.psm.edu/wp-content/uploads/2016/09/Ponce-Health-Sciences-University-Consumer-Information-and-Student-Achievement-Guide.pdf> (Accessed July 2, 2019).
4. California Northstate University Fact Book, 2017-2018. California Northstate University. Available at: <https://www.cnsu.edu/shareddocs/Fact-Book-2017-2018.pdf> (Accessed July 2, 2019).
5. RVU At A Glance. Rocky Vista University. Available at: <http://www.rvu.edu/about/rvu-at-a-glance/> (Accessed July 2, 2019).
6. Burrell College of Osteopathic Medicine Institutional Snapshot. Burrell College of Osteopathic Medicine. Available at: <https://bcommm.org/wp-content/uploads/2019/05/Institutional-Snapshot.pdf> (Accessed July 2, 2019).
7. Idaho College of Osteopathic Medicine. About ICOM. Available at: <https://www.idahocom.org/> (Accessed July 2, 2019).

APPENDIX B

TABLE 2. FINANCIAL BURDEN OF NON-GRADUATES VERSUS GRADUATES OF U.S. MEDICAL SCHOOLS

<i>Not-for-profit</i>	<i>Financial Burden</i>
U.S. allopathic medical schools	In 2018-2019, the median annual tuition and fees at state medical schools were \$38,202; at private medical schools the median cost was \$61,533. ⁶ In 2019, for students who attended state medical schools the median debt was \$190,000; for students who attended private medical schools the median debt was \$210,000. ¹
U.S. osteopathic medical schools	The overall mean osteopathic medical education debt reported for academic year 2017-2018 graduates is \$254,953 (\$222,972 for public schools and \$261,133 for private schools). ²
<i>For-profit*</i>	<i>Financial Burden</i>
Ponce Health Sciences University School of Medicine	4-year estimated tuition, fees and costs range from \$233,456 to \$342,069. ³
California Northstate University College of Medicine	4-year estimated tuition, fees, and costs range from \$240,000 to \$255,000. ⁴
Rocky Vista University College of Osteopathic Medicine	4-year estimated tuition, fees, and cost are \$215,748; typical graduate leaves with \$294,018 in debt. ⁵
Burrell College of Osteopathic Medicine at New Mexico State University**	2018-2019 annual cost of attendance is \$80,165. ⁶
Idaho College of Osteopathic Medicine**	2018-2019 academic year annual tuition is \$49,750 plus \$2,500 in fees. ⁷
California Health Sciences University College of Osteopathic Medicine**	Fall 2020 enrollment annual cost of tuition is \$53,500. ⁸

**Data not available from offshore medical schools*

***Data on student debt for newer U.S. medical schools are not yet available*

1. Medical Student Education: Debt, Costs, and Loan Repayment Fact Card. Association of American Medical Colleges. Available at: https://store.aamc.org/downloadable/download/sample/sample_id/240/ (Accessed July 2, 2019).
2. 2017-2018 Academic Year Survey of Graduating Seniors Summary. American Association of Colleges of Osteopathic Medicine. Available at: https://www.aacom.org/docs/default-source/data-and-trends/aacom-2017-2018-academic-year-graduating-seniors-survey-summary-report.pdf?sfvrsn=e14d2197_6 (Accessed July 2, 2019).
3. Ponce Health Sciences University Educational Budget Academic Year 2019-2020 Doctor in Medicine Program (4 years). Ponce Health Sciences University. Available at: <https://www.psm.edu/coa/EDUC%20BUDGETS%20MD%204%20YRS.pdf> (Accessed July 23, 2019).
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8. California Health Sciences University College of Osteopathic Medicine. Tuition, Fees & Financial Aid. Available at: <https://choosedo.org/california-health-sciences-university-college-of-osteopathic-medicine-chsu-com/> (Accessed July 23, 2019).

APPENDIX C
AMA POLICY

D-305.954, “For-Profit Medical Schools or Colleges”

Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.

(Res. 302, A-18)

H-305.988, “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”

Our AMA:

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
 6. supports continued study of the relationship between medical student indebtedness and career choice;
 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
 9. encourages for profit-hospitals to participate in medical education and training;
 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
 12. will advocate that resident and fellow trainees should not be financially responsible for their training.
- (CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06 Appended: Res. 321, A-15 Reaffirmed: CME Rep. 05, A-16 Modified: CME Rep. 04, A-16)

H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt”

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the 20/220 pathway, and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the cost of attendance; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to lock in a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

(CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19)

H-200.949, "Principles of and Actions to Address Primary Care Workforce"

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and

enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and
e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice

in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

(CME Rep. 04, I-18)

D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education"

1. Our American Medical Association:

A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.

B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.

C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality,

curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.

D. Encourages relevant stakeholders to study whether the public service community benefit commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.

E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.

2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution's own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.

3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.

4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.

5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

(CME Rep. 01, I-17)

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-I-19

Subject: The Transition from Undergraduate Medical Education to Graduate Medical Education

Presented by: Jacqueline A. Bello, MD, Chair

INTRODUCTION

A critical step in the development of a physician is the transition from undergraduate medical education (UME), or medical school, to graduate medical education (GME), or residency training. Ensuring a seamless transition supports learners' well-being and their readiness to take on and master the many challenges in their chosen field of medicine. In addition, patient safety in our nation's teaching hospitals is paramount in the public eye, as evidenced by coverage of the "July Effect" in the media. This underscores the need for preparedness among first-year resident physicians as well as the need for a highly effective, efficient, and supportive educational environment.

The American Medical Association (AMA) has taken a lead role to address these issues and call for medical education to "mind the gap" between the various stages of medical education—in particular, the UME to GME transition—in part through its Accelerating Change in Medical Education initiative and Reimagining Residency initiative, as described in this report. The AMA is working to help smooth the transition from UME to GME as part of its effort to encourage innovation in the development of medical students, trainees, and physicians throughout their career. This report also provides relevant AMA policy on this topic (see the Appendix).

MEDICAL SCHOOL PREPARATION OF GRADUATES FOR RESIDENCY

One body of data that measures medical student preparedness for entry into residency is the Association of American Medical Colleges' (AAMC) Graduation Questionnaire (GQ), a national questionnaire administered to graduates of U.S. MD-granting medical schools accredited by the Liaison Committee on Medical Education (LCME).¹ The GQ is an important tool for medical schools to use in program evaluation and to improve the medical student experience.

The AAMC's [All Schools Summary Report for 2018](#)² includes GQ data for the five-year period 2014 to 2018. Eighty-three percent (16,223) of medical school graduates in academic year 2017-2018 (19,537) participated in the 2018 GQ.

Question 12 of the questionnaire asks respondents, "Indicate whether you agree or disagree with the following statements about your preparedness for beginning a residency program." Averaging the data for the five-year period (2014 to 2018) produces the following numbers. In the right-hand column, the percentages from the "Agree" and "Strongly agree" fields are combined; the table is sorted based on this variable, which ranges from a high of 98.3 percent ("I have the communication skills necessary to interact with patients and health professionals") to 90.2 percent ("I am confident that I have acquired the clinical skills required to begin a residency program").

Percentage of Respondents Selecting Each Rating					
Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total: Agree and Strongly agree
I have the communication skills necessary to interact with patients and health professionals.					
0.2	0.2	1.4	26.2	72.1	98.3
I understand the ethical and professional values that are expected of the profession.					
0.2	0.2	1.5	29.9	68.2	98.1
I believe I am adequately prepared to care for patients from different backgrounds.					
0.3	0.6	3.4	35.9	59.9	95.8
I have basic skills in clinical decision making and the application of evidence based information to medical practice.					
0.3	0.7	4.7	46.2	48.2	94.4
I have a fundamental understanding of the issues in social sciences of medicine (e.g., ethics, humanism, professionalism, organization and structure of the health care system).					
0.3	1.0	4.9	40.9	52.8	93.7
I have the fundamental understanding of common conditions and their management encountered in the major clinical disciplines.					
0.3	1.0	5.2	52.0	41.5	93.5
I am confident that I have acquired the clinical skills required to begin a residency program.					
0.5	1.9	7.4	47.9	42.3	90.2

- 1 Another assessment of medical schools' efforts in preparing medical students for residency is the
2 LCME's Annual Medical School Questionnaire Part II.
3
4 Particularly relevant to this report are data from the question, "Indicate where in the curriculum the
5 following topics to specifically prepare students for entry to residency training are covered"
6 (question 19 for the 2018-2019 questionnaire). Aggregate data for 151 medical schools are shown,
7 sorted by the sum of the numbers for the five places in the curriculum where the specific topic is
8 taught, as shown in the right-hand column.

Topic	Required 4th Year Transition to Residency Course		Required Sub-internship	Required 3rd Year Clinical Clerkship	Inter-session in 3rd or 4th Year	Total
	Specialty-specific	One course for all students				
Training in clinical procedures	55	57	105	135	51	403
Disease management (general or specialty-specific)	44	53	124	140	30	391
Working in teams	32	76	105	124	53	390
Working with the EHR/health records	22	43	110	135	48	358
Hand-off procedures	35	68	100	93	28	324

Patient safety/reporting medical errors	16	77	70	104	51	318
Advanced communication skills	26	68	84	85	44	307
Stress, wellness, and burnout in residency training	19	81	21	63	58	242
Health system content (e.g., team care, health care financing)	12	72	38	73	47	242
On-call emergencies	39	50	84	73	18	264
Experiencing the life of a resident (e.g., night call/float)	24	35	85	75	6	225
Medical regulatory content (e.g., licensure, discipline, DEA)	8	55	10	23	32	128
ACLS/ATLS training and certification	9	47	9	25	35	125

THE AMA'S ACCELERATING CHANGE IN MEDICAL EDUCATION AND REIMAGING RESIDENCY INITIATIVES

Phase one of the AMA's Accelerating Change in Medical Education initiative, launched in 2013, was intended to:

[F]oster... 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 [expanded to 37 schools in 2019], 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.³

Building upon that impetus, in early 2019 the AMA established the Reimagining Residency initiative—a five-year, \$15 million grant program to address challenges associated with the transition from UME to GME and the maintenance of progressive development through residency and across the continuum of physician training. Grants are intended to promote systemic change in GME and support bold, creative innovations that establish new curricular content and experiences to enhance readiness for practice, support well-being in training, and (of particular relevance to this report) provide a meaningful and safe transition from UME to GME. Learn more at: ama-assn.org/education/improve-gme/ama-reimagining-residency-initiative.

Included in the Accelerating Change in Medical Education and Reimagining Residency initiatives are grantees that are focusing on the UME/GME transition. For example, at Florida International University (FIU) Herbert Wertheim College of Medicine, readiness for residency is monitored by way of competency-based assessments using the Entrustable Professional Activities (EPAs).

As an awardee for both the UME and GME phases of the AMA's grants, New York University Langone School of Medicine is using its latest grant to further its coaching experience through the "NYU Transition to Residency Advantage." The goal of this work is to "enhance the transition from UME to GME through robust coaching, individualized pathways, and enhanced assessment

tools to enable GME programs to shift away from one-size-fits-all education.”⁴ Similarly, the University of North Carolina School of Medicine received funding from the Reimagining Residency initiative for Fully Integrated Readiness for Service Training (FIRST): Enhancing the Continuum from Medical School to Residency to Practice. Its goals include “implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum.”⁵ In addition, the Association of Professors of Gynecology and Obstetrics received a planning grant for its “Right Resident, Right Program, Ready Day One” project, intended to transform the UME to GME transition for residents entering obstetrics and gynecology programs.

CHALLENGES TO CHANGE

As noted in the introduction, certain innovations that improve the transition from UME to GME may challenge existing processes/systems managed by organizations responsible for medical education accreditation, certification, licensing, and residency matching. For example, one of the innovations being studied in the AMA-led consortium is competency-based medical education, in which learners are advanced to the next level of training upon satisfactory demonstration of the requisite knowledge and skills, versus a strictly time-based system that treats all learners alike. Despite the considerable value of this new paradigm from the learner perspective, it may present hurdles to the system of medical education accreditation, funding, and certification and further inhibit (at least in the short run) the development of a smoother UME/GME transition.

Another concern, which relates to the match into residency, is the growing number of residency program applications being submitted by applicants. This is due, in part, to a growing number of medical school graduates in the U.S. and concerns among residency applicants about limited availability of residency program slots. This issue is particularly pointed in competitive specialties. The increased number of applications is expensive and inefficient for applicants and burdensome for residency program directors and personnel, who must review and prioritize these applications. The rising volume of applications leads programs to employ applicants’ scores on the United States Medical Licensing Examination (USMLE) for screening purposes, eliminating applications below a certain arbitrary line.

This process for applicant screening, while understandable given the circumstances, runs counter to AMA policy, which reflects the principle that “selection of residents should be based on a broad variety of evaluative criteria,” and asks that ACGME requirements “state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.”⁶ It also lessens the opportunity for holistic review of candidates, through which more intangible attributes and life experience are given equal (if not greater) weight than school grades and examination scores. Indeed, as noted by the authors of a recent perspective in *JAMA*, “the current USMLE 3-digit scores may be distracting the medical education system from the goal of building an innovative, diverse, and resilient physician workforce.”⁷

Invitational Conference on USMLE Scoring (InCUS)

The AMA and other leading organizations in medical education convened an invitational conference in March 2019, the Invitational Conference on USMLE Scoring (InCUS), to explore issues around unintended uses of USMLE scores. As noted in a summary report and preliminary recommendations from the meeting, the general consensus among participants is that “[t]he current UME-GME transition system is flawed and not meeting the needs of various stakeholders. Over time, various stakeholder groups have tried to optimize the system for their own purposes, but this has left some, including applicants, with an undue burden and at worst negatively impacted

diversity.”⁸ One of the recommendations arising from the conference, also noted in the report, is to “[c]onvene a cross-organizational panel to create solutions for the assessment and transition challenges from UME to GME, targeting an approved proposal, including scope/timelines by end of calendar year 2019.” As further noted in the report, these challenges would include “[r]educing the number of applications perceived by residency applicants as necessary to obtain a position,” “[i]mproving Residency Program Directors’ ability to more holistically evaluate candidates,” and “[i]mproving the trust of school-based assessments for residency screening and selection.”

During the ensuing public comment period, the Council on Medical Education developed and submitted comments on the InCUS recommendations; key points included the following:

- The overemphasis on USMLE performance in the residency application process is unacceptable; a single three-digit score detracts from learning and engaging fully in the medical student experience, and may inhibit schools’ implementation of curricular innovation. A holistic approach to assessing applicants, in contrast, with attention given to life experience and emotional intelligence, among other qualities, allows for individual talents to emerge and minimizes the impact of any one point, and may help increase the number of successful applicants from racial/ethnic minority populations.
- Any changes made to the residency application process need to consider the alternative tools for evaluation that remain. Preclinical grades, clinical rotation evaluations, and school-based assessments such as the MSPE/Dean’s letter all have considerable shortcomings. Equally problematic is reliance on the reputation of the medical school, which is often determined by research dollars, not the quality of the teaching. Removing the numerical score may discriminate against medical students from new and lesser known U.S. medical schools and U.S. students attending international schools.
- All stakeholders in the process will need to “give” something as part of this transition. For example, students will need to be limited on the number of applications they submit, accrediting bodies (e.g., ACGME, LCME) will need to prohibit the use of USMLE as a program-level metric, and we need to reexamine the Match to see if it is really meeting the current needs. For program directors, a move to pass/fail scores may increase the burden they face in evaluating an ever-growing number of candidates.
- The overarching goal of this work needs to be broadened beyond “to decrease reliance on the USMLE Step 1 score for residency screening” and more toward “to improve and enhance the holistic evaluation of resident applicants.”

The dialogue leading to the Council’s response encompassed a rich and robust exchange of viewpoints among Council members—reflecting the complexity of these issues and the multiple levers, processes, and people affected by “the system” (including, and most importantly, our patients). Through the Council on Medical Education and senior staff, the AMA will continue to monitor, provide feedback on, and report back to the HOD on the status of outcomes from InCUS.

Additional issues in the UME/GME transition were limned in a forum hosted by the Council on Medical Education during the AMA’s 2019 Annual Meeting. These include:

For students:

- The need for honest self-reflection and assessment of strengths and weaknesses.
- The need for honest and effective coaching and mentoring.

For medical schools:

- The need for transparency, accuracy, and honesty in assessments of students.
- The need to balance the responsibility to students (to help them successfully match) with the responsibility to residency programs (to be honest about students' strengths and weaknesses).
- The fear of unsuccessful matches reflecting poorly on the institution.
- "Failure to fail" (that is, the failure to fail those students who should not be advanced).

For residency program directors:

- The need to provide feedback to schools about interns' performance.
- The growing popularity of the "residency boot camp" model (e.g., the Resident Prep Curriculum, a weeklong boot camp to help ease the transition into surgical residency⁹).
- The need for a more holistic review of applications and less reliance on USMLE scores.

Overall:

- Inadequacy of the medical student performance evaluation (MSPE) to distinguish among applicants to residency (in other words, the "Lake Wobegon" effect).
- The need to move beyond the UME, GME, and CME silos to the lifelong learning model.
- Consider high-frequency, low-stakes assessment models, to look at a learner's real-time, cumulative trajectory of growth in knowledge, clinical skills, and professionalism.
- Multiple "scouts" evaluating performance in many types of venues/situations (not just clinical), to average out multiple direct observations.
- The need for free flow of information (in particular, the "right" information—i.e., that which is insightful, without being overwhelming, such that the signal to noise ratio becomes weak).
- Lack of trust among all parties and "gaming" the system; the match process, by its very nature, encourages masking faults and flaws. "Warm handoffs" may help increase trust in the system.

ENTRUSTABLE PROFESSIONAL ACTIVITIES

One framework that may provide a more useful assessment of learners to improve the UME/GME transition are the Core Entrustable Professional Activities (EPAs) for Entering Residency of the AAMC. The EPAs "provide expectations for both learners and teachers that include 13 activities that all medical students should be able to perform upon entering residency, regardless of their future career specialty. The guidelines are based on emerging literature documenting a performance gap at the transition point between medical school and residency training."¹⁰

SUMMARY

The AMA has taken a lead role in improving and easing the transition from UME to GME for learners, program directors, and patients alike. The process has a wide array of variables and stakeholders. Chief pain points are students submitting an inordinate and increasing number of applications in an attempt to match into programs in their chosen fields, and the (mis)use of USMLE Step 1 scores as a primary screening criterion for interviews. The complexity of the issue demands a wide-ranging solution. Through InCUS and related work, such as the Reimagining Residency initiative, the AMA is working to encourage a transition of the residency application/matching system towards a more holistic evaluation of applicants' full range of competencies and traits that would provide a broader assessment of a student's capabilities and "fit" with a program. In addition, through its Council on Medical Education and its ability to convene key stakeholders involved in medical education, the AMA will continue working to ensure that new residents are ready to undertake the rigors of residency from day one and learn (under supervision) how to serve their patients, from both an individual and a population perspective.

APPENDIX: RELEVANT AMA POLICY

H-295.895, “Progress in Medical Education: Structuring the Fourth Year of Medical School”

It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences.

(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training.

(3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student’s fourth-year program, so as to remedy deficiencies and broaden clinical knowledge.

(4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives.

(5) Adequate and timely career counseling should be available at all medical schools.

(6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives.

(7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills.

(CME Rep. 1, I-98 Reaffirmed: CME Rep. 9, A-07 Reaffirmed: CME Rep. 01, A-17)

H-295.862, “Alignment of Accreditation Across the Medical Education Continuum”

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.

2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:

- a. Identify guidelines for the expected general levels of learners’ competencies as they leave medical school and enter residency training.
 - b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates’ preparedness for entry.
 - c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
- All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners’ progress in achieving the defined competencies across the continuum.

4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.

5. Our AMA encourages study of competency-based progression within and between medical school and residency.

a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.

b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.

6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.

7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

(CME Rep. 4, A-14 Appended: CME Rep. 10, A-15)

D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice"

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.

2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.

3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

(CME Rep. 3, A-14 Appended: CME Rep. 04, A-16)

H-275.953, "The Grading Policy for Medical Licensure Examinations"

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.

2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may

request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.

4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (CME Rep. G, I-90 Reaffirmed by Res. 310, A-98 Reaffirmed: CME Rep. 3, A-04 Reaffirmed: CME Rep. 2, A-14 Appended: Res. 309, A-17 Modified: Res. 318, A-18 Appended: Res. 955, I-18)

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