

REPORTS OF THE BOARD OF TRUSTEES

The following 18 reports were presented by Jesse M. Ehrenfeld, MD, MPH, Chair:

1. LEGALIZATION OF THE DEFERRED ACTION FOR LEGAL CHILDHOOD ARRIVAL (DALCA) (RESOLUTION 205-I-18)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATION ADOPTED
IN LIEU OF RESOLUTION 205-I-18
REMAINDER OF REPORT FILED
*See Policy D-255.979***

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 205-I-18, “Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)” for study. Resolution 205-I-18 was introduced by the International Medical Graduates (IMG) Section. Resolution 205 asked that our AMA support legalization of DALCA; and that our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal.

BACKGROUND

DALCA is a new policy term not widely used by immigration attorneys or Members of Congress, and it is not a legally recognized term. The term was created to distinguish children of H-1B visa holders who legally entered the U.S. from Deferred Action for Childhood Arrivals (DACA) recipients. The term DACA applies only to children who were brought to the United States illegally and thus does not apply to children of H-1B visa holders, including International Medical Graduates (IMGs).

Under current U.S. immigration law, the spouse and children of a H-1B visa holder can accompany the worker to the U.S. by obtaining an H-4 visa. Each family member must obtain his or her own H-4 visa. There are a number of extensions for H-1B holders once an I-140 application (i.e., petition for green card) is approved. For those on H-4 spousal visas, there are no limitations as long as the related H-1B visa is valid. Additionally, in 2015 the Obama Administration issued [a final rule](#) allowing those on H-4 spousal visas to work if their H-1B visa spouse is applying to become a lawful permanent resident (i.e., green card holder). According to the U.S. Citizenship and Immigration Services ([USCIS](#)), there have been close to 91,000 initially approved employment authorization applications for H-4 spousal visas. However, children lose their H-4 visa status once they turn 21. These children have only two choices: they can have their H-4 visa changed to an international student visa, also called the student F-1 visa, so they can attend college/university in the U.S., or they can return to their home country and then return to the U.S. after their H-1B visa physician parent obtains permanent residency. Once these children finish their education while on the F-1 visa, they would need to seek H-1B employment sponsors of their own so they can work in the U.S. and eventually obtain their own green cards.

DISCUSSION

The sponsors of Resolution 205 assert that many DALCA children are in medical school or have already graduated from U.S. medical schools, but are subject to deportation because they are considered illegal once they are over age 21. Many of the DALCA children have matched in residency programs but are unable to attend due to their lack of proper legal status.

It is well known that there is expected to be a [physician shortage](#) in the U.S. The projected shortage of between 46,900 and 121,900 physicians by 2032 includes both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). Among specialists, the data project a shortage of between 1,900 and 12,100 medical specialists, 14,300 and 23,400 surgical specialists, and 20,600 and 39,100 other specialists, such as pathologists, neurologists,

radiologists, and psychiatrists, by 2032. Supporting permanent legal status for DALCA children could help in reducing the impact of the expected physician shortage and support the families of H-1B visa physicians.

The AMA has extensive policy supporting DACA students as well as permanent residence status for physicians; however, there is no policy directly supporting children on H-4 visas that have aged out waiting for their physician-parent to receive their green card. The Board concludes that Resolution 205 is consistent with existing AMA policy and should be adopted by appropriately amending existing policy to incorporate the intent of the resolution.

RECOMMENDATION

The Board recommends that our AMA amend Policy D-255.979, “Permanent Residence Status for Physicians on H1-B Visas,” by addition to read as follows, in lieu of Resolution 205-I-18 and that the remainder of the report be filed:

Our AMA will work with all relevant stakeholders to: 1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status, and 2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents’ green card applications are pending.

RELEVANT AMA POLICIES

Policy D-255.979, “Permanent Residence Status for Physicians on H1-B Visas”

Our AMA will work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status.

Res. 229, A-18

Policy D-255.980, “Impact of Immigration Barriers on the Nation’s Health”

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine. 2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion. 3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. 4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care. 5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice. 6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18

Policy H-255.988, “AMA Principles on International Medical Graduates”

Our AMA supports: 1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada. 2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE. 3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body. 4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada. 5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA’s representatives to the ECFMG Board of Trustees. 6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools. 7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care. 8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs. 9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. 10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower. 11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor. 12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. 13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities. 14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs

and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs. 15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members. 16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools. 17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine. 18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations. 19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return. 20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States. 21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation. 22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17

Policy D-255.99, “Visa Complications for IMGs in GME”

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. 2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs’ inability to complete accredited GME programs. 3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training. 4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12

Policy D-350.986, “Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages”

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Res. 305, A-15 Appended: Late Res. 1001, I-16

2. ENABLING METHADONE TREATMENT OF OPIOID USE DISORDER IN PRIMARY CARE SETTINGS (RESOLUTION 202-I-18)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS 1 AND 3 ADOPTED
IN LIEU OF RESOLUTION 202-I-18
RECOMMENDATION 2 REFERRED
REMAINDER OF REPORT FILED
*See Policy D-95.968***

INTRODUCTION

At the 2018 Interim Meeting, the House of Delegates referred Resolution 202-I-18, “Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings,” introduced by the Pennsylvania Delegation, which asked:

That our American Medical Association study the implications of removing those administrative and/or legal barriers that hamper the ability of primary care physician practices to dispense methadone, as part of medication assisted treatment;

That our AMA study the implications of working with other Federation stakeholders to identify the appropriate educational tools that would support primary care practices in dispensing ongoing methadone for appropriate patients as part of medication-assisted treatment.

Testimony on Resolution 202 was generally supportive of having the AMA study the implications of removing barriers that hamper the ability of physician practices to dispense methadone, one of the three main drug classes commonly referred to as medication-assisted treatment (MAT). There also was testimony that the AMA does not need to study working with state and specialty societies regarding the issues raised in Resolution 202 but instead should work directly with the Federation on supporting greater access to methadone treatment for opioid use disorder, including removing stigma. There was some confusion about what educational resources may exist to further these goals—one of the areas which this report seeks to resolve.

DISCUSSION

Background

As outlined in Board of Trustees Report 5-I-18, “Exclusive State Control of Methadone Clinics,” the AMA has been a strong supporter of methadone maintenance treatment (MMT) as an evidence-based option to help treat patients with an opioid use disorder. MMT has been used for more than 40 years to help patients, having been approved in 1972 by the U.S. Food and Drug Administration (FDA) for treatment of heroin addiction. The health and safety of methadone has been studied extensively and ample evidence exists supporting its use to aid in mortality and crime reduction.¹

There are 1,685 certified opioid treatment programs (OTPs) offering methadone in the United States.² According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to 2016 (345,443).³ With respect to opioid-related mortality, deaths attributed to methadone increased rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since. In the past five years, for example, methadone-related mortality has decreased from 3,493 (2015) to 3,078 (2019), according to the Centers for Disease Control and Prevention.⁴ It is beyond the scope of this report, however, to detail whether the methadone use in these deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a complicating polypharmacy factor. It is further beyond the scope of this report to try and ascertain how many of those persons were under the care of a physician or being treated in an OTP.

Administrative/legal requirements for dispensing methadone

SAMHSA has broad regulatory authority concerning MMT and OTPs. This includes the authority to certify an OTP, which is defined as “a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 USC 823(g)(1).”⁵

Regulations governing OTPs are generally contained in 42 CFR Part 8, which provides that the definition of “dispense” means “to deliver a controlled substance to an ultimate user by, or pursuant to, the lawful order of, a practitioner, including the prescribing and administering of a controlled substance.” Any medication dispensed at an OTP must be dispensed by a health care professional licensed to do so under state law as well as registered under applicable state and/or federal law.⁶ In most cases, methadone is dispensed on a daily basis to the patient at the OTP, and OTP staff must observe the patient taking the medication. Take-home use is permitted under federal regulations in certain situations—subject to considerable additional oversight, documentation and monitoring for appropriate use and preventing diversion.

Federal rules also provide that “methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse.” 42 CFR Part 8 also requires that for each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents, in the patient’s record, that 40 milligrams did not suppress opioid abstinence symptoms.

A study of primary care practices outside of an OTP providing MMT has been conducted.⁷ For the study to take place, prior approval from state and county officials and the Drug Enforcement Administration (DEA) and extensive additional documentation was required. In addition, significant controls were required, including a highly motivated group of physicians, patients who were stable for at least one year on MMT and multiple administrative requirements including regular and random toxicology screens, patient assessments, close affiliation with a cooperative OTP, close relationships with pharmacists, counselors and other staff as necessary. Notably, the primary care practice was required to have an ongoing relationship with the community OTP.

Patient selection and care coordination were two additional keys to the program’s positive outcomes. Of the 684 patients in the community OTP, 30 qualified and agreed to the primary care provider program managing their ongoing care. Of these, 445 of 449 urinalysis tests were negative, and all random callback urinalysis tests were positive for methadone and negative for other drugs of abuse. For at least this one study and primary care practice, adding 30 patients with complex medical needs may not cause undue strain on the practice—and even likely adds many benefits. In other words, experimental primary care models to provide MMT are possible, but whether this study can be a model for other practices is not clear.

Other studies also found that patients stable on long-term MMT have benefited from having their care provided in a primary care setting outside of an OTP.⁸ These studies also found that, in addition to low relapse and successful provision of additional primary care services (e.g., tobacco cessation, treatment for hypertension), there were increased services provided for treatment of infectious disease. Studies also found patient and physician satisfaction levels increased during the course of the study. In addition, physician education increased and there was a reduction in stigma.

Thus, while federal law has strict controls that methadone only be dispensed from an OTP, there have been experimental programs—subject to prior federal approval—that have demonstrated benefits of having MMT provided in a primary care setting outside of a traditional OTP. These experimental programs, however, are highly structured and still must comply with state and federal rules (including who can dispense, take-home rules for stable patients, patient monitoring, strict record-keeping, etc.) governing the provision of MMT.

Educational resources to support the provision of MMT

The AMA has broadly supported efforts to enhance physicians’ education with respect to many aspects of the nation’s opioid epidemic, including broad support for all forms of MAT. The AMA has broadly supported legislative and regulatory efforts at the state and federal levels to expand access to MAT. AMA model state legislation calls for all payers to make all forms of MAT available without prior authorization and placed on a formulary’s lowest cost-

sharing tier. AMA advocacy has led to more than one dozen states removing prior authorization for MAT, including methadone, in the commercial and/or Medicaid markets in 2019.

At the same time, a review of educational resources focused on methadone shows that the AMA opioid microsite (accessible here: www.end-opioid-epidemic.org) only has three titles focused on methadone education in its library of more than 400 resources.⁹ There are, however, several physician-led organizations that have considerable education and training resources on a wide variety of areas related to methadone, including induction, ongoing maintenance, stigma and more. This includes the Providers Clinical Support System (PCSS), which is led by the American Academy of Addiction Psychiatry (and of which the AMA is a steering committee member), American Society of Addiction Medicine, the *Journal of the American Medical Association* and other trusted organizations and resources.

While it is speculative to know whether the identification and promotion of these resources would lead to increased numbers of primary care physicians either determining to open their own OTP, providing services in an OTP or even pursuing office-based opioid treatment options that do not include MMT, the Board strongly supports additional educational efforts to, at the very least, reduce the stigma of MMT and increase general knowledge about MMT.

AMA POLICY

AMA policy supports MMT as an evidence-based treatment for opioid use disorder and supports having stable patients treated in a traditional office-based setting (Policy H-95.957, “Methadone Maintenance in Private Practice”). AMA policy also supports the types of investigational studies described above to further efforts to enable office-based physicians to use MMT “to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols” (Policy H-95.957, “Methadone Maintenance in Private Practice”). AMA policy also calls for broad support to expand MMT services (Policy D-95.999, “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”). This includes broad support of OTPs (Policy H-95.921, “Exclusive State Control of Methadone Clinics”). With respect to physician dispensing, the AMA “supports the physician’s right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA’s ethical guidelines” (Policy H-120.990, “Physician Dispensing”).

RECOMMENDATIONS

The Board recommends that the following recommendations be adopted in lieu of Resolution 202-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support further research into how primary care practices can implement MAT into their practices and disseminate such research in coordination with primary care specialties;
3. That the AMA Opioid Task Force increase its evidence-based educational resources focused on MMT and publicize those resources to the Federation.

[Note: The following recommendation was referred.]

2. That our AMA support efforts to expand primary care services to patients receiving methadone maintenance therapy (MMT) for patients receiving care in an Opioid Treatment Program or via office-based therapy;

REFERENCES

1. See, for example, Kleber HD. Methadone Maintenance 4 Decades Later. *JAMA*. 2008;300(19):2303–2305. doi:10.1001/jama.2008.648. Available at <https://jamanetwork.com/journals/jama/fullarticle/182898>
2. Opioid Treatment Program Directory. Substance Abuse and Mental Health Services Association. Available at <https://dpt2.samhsa.gov/treatment/directory.aspx> <https://dpt2.samhsa.gov/treatment/directory.aspx>; last reviewed July 17, 2019.
3. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2016 Data on Substance Abuse Treatment Facilities. Available at https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf
4. <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> The data points are from the predicted January 12-month total as reported by the National Vital Statistics System. Available at <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard>

5. 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=PART#se42.1.8_12
6. 42 CFR Part 8.12(h)
7. See, for example Joseph O Merrill, MD, MPH, et al, “Methadone Medical Maintenance in Primary Care, An Implementation Evaluation.” J Gen Intern Med. 2005 Apr; 20(4): 344–349.
8. See, for example, Fiellin DA, O’Connor PG, Chawarski M, Pakes JP, Pantalon MV, Schottenfeld RS. Methadone Maintenance in Primary Care: A Randomized Controlled Trial. JAMA. 2001;286(14):1724–1731. doi:10.1001/jama.286.14.1724
9. The resources that include “methadone” in the title on the microsite are from the American Society of Addiction Medicine and Providers Clinical Support System.

3. RESTRICTION ON IMG MOONLIGHTING (RESOLUTION 204-I-18)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED (RESOLUTION 204-I-18 NOT ADOPTED) REMAINDER OF REPORT FILED

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 204-I-18, “Restriction on IMG Moonlighting.” Resolution 204 was introduced by the Resident and Fellow Section.

Resolution 204 asks that our AMA advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight.

This report provides a brief background on the J-1 visa program and discusses the issues that are raised when considering changes to federal legislation that would allow physicians with a J-1 visa in fellowship training programs the ability to moonlight.

BACKGROUND

The U.S. generally requires citizens of foreign countries to obtain a U.S. visa prior to entry. Based on the purpose of travel, an individual may receive one of two types of visas: immigrant and non-immigrant. Immigrant visas are issued to individuals who wish to live in the U.S. permanently, while non-immigrant visas are issued to individuals with permanent residence outside the U.S. who wish to be in the U.S. temporarily for tourism, business, temporary work, or other specified purposes.

The Exchange Visitor (J) non-immigrant visa category is for individuals approved to participate in work- and study-based exchange visitor programs. The first step in pursuing an exchange visitor visa is to apply through a designated sponsoring organization in the U.S. Physicians may be sponsored for J-1 status by the Educational Commission for Foreign Medical Graduates ([ECFMG](#)) for participation in accredited clinical programs or directly associated fellowship programs. These sponsored physicians have J-1 “alien physician” status and pursue graduate medical education or training at a U.S. accredited school of medicine or scientific institution, or pursue programs involving observation, consultation, teaching, or research. The J-1 classification is explicitly reserved for educational and cultural exchange.

J-1 status physicians are participants in the U.S. Department of State ([DoS](#)) Exchange Visitor Program. The primary goals of the Exchange Visitor Program are to allow participants the opportunity to engage broadly with Americans, share their culture, strengthen their English language abilities, and learn new skills or build skills that will help them in future careers. According to the DoS, for Calendar Year 2018, there were 2,738 new J-1 physicians participating in the exchange program. For CY 2018 the top three “sending countries” for J-1 physicians were: Canada 689; India

489; and Pakistan 248. The top three “receiving U.S. states” for J-1 physicians were: New York 556; Michigan 182; and Texas 163.¹

DISCUSSION

A J-1 visa holder may only perform the curricular activity listed on his/her Form DS-2019, or as provided for in the regulations for the specific category for which entry was obtained and with the approval of the Sponsor’s Responsible or Alternate Responsible Officer. As a result, J-1 physician participants are not currently permitted to engage in any work outside of their approved program of graduate medical education. If the proposed activity by the J-1 physician falls outside of the normal scope and/or is not a required component of the training program, then it is deemed to be “work outside of the approved training program” and not permitted for J-1 physicians.

In June 1999, the U.S. Information Agency issued a statement of policy on the Exchange Visitor Program. In the statement of policy, the agency specifically comments on the ability of J-1 physicians to moonlight, stating that, “...a foreign medical graduate is not authorized to ‘moonlight’ and is without work authorization to do so. A foreign medical graduate may receive compensation from the medical training facility for work activities that are an integral part of his or her residency program. The foreign medical graduate is not authorized to work at other medical facilities or emergency rooms at night or on weekends. Such outside employment is a violation of the foreign medical graduate’s program status and would subject the foreign medical graduate to termination of his or her program.”²

The Administration has further outlined its rationale on this issue in a formal Notice of Proposed Rulemaking ([NPRM](#)) and later a [final rule](#) which strengthens the program’s oversight by requiring management reviews for Private Sector Program sponsors of, for instance, alien physicians. The final rule confirmed the policy prohibiting moonlighting as outlined in 22 U.S. Code of Federal Regulations (CFR) §62.16:

22 CFR ([§62.16](#)) – Employment

- (a) An exchange visitor may receive compensation from the sponsor or the sponsor’s appropriate designee, such as the host organization, when employment activities are part of the exchange visitor’s program.
- (b) An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program.
- (c) The acceptance of employment by the accompanying spouse and dependents of an exchange visitor is governed by Department of Homeland Security regulations.

Currently, [42 CFR §415.208](#) provides substantial regulations for the services of moonlighting residents who are not foreign nationals. Again, the particular purpose of the J-1 program is to increase mutual understanding between the people of the U.S. and the people of other countries by means of educational and cultural exchanges. Thus, because J-1 physicians are foreign nationals participating in an educational/cultural exchange program offered by the DoS, they are not permitted to moonlight or receive additional compensation outside of the J-1 visa program.

DoS’ final rule states that strict oversight of the exchange program is critical as an affirmative step “to protect the health, safety and welfare of foreign nationals.” When problems occur, “the U.S. Government is often held accountable by foreign governments for the treatment of their nationals, regardless of who is responsible.” Any changes to program policy that may weaken protections could have “direct and substantial adverse effects on the foreign affairs of the U.S.”³

In accordance with the DoS policy, the AMA also has strong and lengthy policy outlining the rights of residents/fellows and limiting duty hours to ensure patient safety and an optimal learning environment for these physicians.

Those in support of Resolution 204 argue that moonlighting will improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Allowing J-1 physicians to moonlight would provide these physicians with an increased opportunity to provide care to underserved populations while at the same time garner increased training and education during their time in the U.S. However, under the current program’s purpose and restrictions, as set out by the Administration, this activity is not possible without significant changes to the J-1 program.⁴

Both the DoS and ECFMG ultimately desire that the J-1 visa program remain as a training/education program for which participants are paid. According to the DoS and ECFMG, if the alien physician program shifts to something other than a training/education program, then it will receive increased scrutiny (as is the case regarding the au pair and summer work travel programs) and could potentially be absorbed into the current immigration discussions between the U.S. Congress and the Administration. While the Board understands and appreciates the intent of the sponsors of Resolution 204, we conclude that the focus of the J-1 program should remain on the training and education of the physicians in the program and that our AMA should not pursue changes that could create a risk to those physicians and potentially the entire program.

RECOMMENDATION

The Board recommends that our American Medical Association not adopt Resolution 204-I-18, “Restriction on IMG Moonlighting,” and that the remainder of the report be filed.

REFERENCES

1. <https://j1visa.state.gov/wp-content/uploads/2019/03/Alien-Physician-Flyer-2018-web.pdf>
2. <https://www.govinfo.gov/content/pkg/FR-1999-06-30/pdf/99-16757.pdf>, 64 Federal Register 34983
3. <https://www.govinfo.gov/content/pkg/FR-2014-10-06/pdf/2014-23510.pdf>, 79 Federal Register 60305
4. Id.

RELEVANT AMA POLICY

CME Report on Duty Hours, CME Report 5, A-14

Policy H-255.970, “Employment of Non-Certified IMGs”

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.

Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

Policy H-310.907, “AMA Duty Hours Policy”

Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. 2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both duty hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours. 6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with duty hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to duty hours: a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-week period (Note: Total duty hours’ includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count

towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.” f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of duty hour limits should be borne by all health care payers. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees’ realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. CME Rep. 5, A-14

Policy H-310.912, “Residents and Fellows’ Bill of Rights”

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended. 5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWS’ BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings. B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows should expect

supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences. (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act. F. Duty hours that protect patient safety and facilitate resident well-being and education. With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16

Policy H-310.979, "Resident Physician Working Hours and Supervision"

(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services,

and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.” (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.

CME Rep. C, I-87 Modified: Sunset Report, I-97 Modified and Reaffirmed: CME Rep. 2, A-08

Policy D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”

Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.

Res. 314, A-03 Reaffirmation A-12

4. INVOLVEMENT OF WOMEN IN AMA LEADERSHIP, RECOGNITION AND RESEARCH OPPORTUNITIES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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 advisory committee was invited to participate in an electronic survey to ascertain the number of women members who held leadership positions in the AMA as of year-end 2018. In addition, this survey included questions on plenary speaker invitations, recognition awards, and grant

funding. Staff representing other units of the AMA were invited to participate in the survey so that additional information on speaker invitations, recognition awards, and grants could be collected. Of note, data on reference committee composition was extrapolated from the 2018 proceedings for the Annual and Interim Meetings of the AMA HOD.

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

RESULTS

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

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

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

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

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

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

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

CONCLUSION

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

Also, females are well represented among scholarship and grant recipients. These study findings demonstrate that female AMA members are actively involved in AMA professional activities. Of note, AMA membership is not a

requirement for the recipients of the Joan F. Giambalvo Award for the Advancement of Women, AMA Foundation scholarships and the Inspiration Award.

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

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 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%

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 American	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

D-65.989, Advancing Gender Equity in Medicine

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.

G-600.035, The Demographics of the House of Delegates

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

H-525.998, Women in Organized Medicine

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.

5. RESTRICTIVE COVENANTS OF LARGE HEALTH CARE SYSTEMS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

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

1. Our AMA, through its Organized Medical Staff Section will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.
2. Our AMA study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.

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

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

DISCUSSION

Restrictive covenants, which often are included as part of a physician employment contract, typically prohibit physicians from practicing medicine within a specific geographic area and time after employment. For example, a restrictive covenant may prohibit the physician from practicing medicine within 10 miles of the location where he or

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

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

Application to all care settings where restrictive covenants are concerned

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

Restrictive covenants to protect legitimate business interests

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

Concerns that Policy D-383.978 identifies

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

Aggressive enforcement of a restrictive covenant could also have negative consequences on patient care outside of a long-term patient-physician relationship. For example, depending on the geographic area, there may be just a few physicians, general practitioners or specialists, available to serve the needs of the patient population. This may be

particularly true in rural parts of the country. Even if several physicians practice in the community, requiring a physician to leave the area may reduce the number of available physicians. Although a replacement physician may ultimately be brought to the area, recruitment can be a lengthy process. In fact, it may be quite a while before the replacement physician can start seeing the community's patients. In the meantime, the absence of the physician subject to the restrictive covenant could hinder patient access by increasing patient wait times—assuming the community's remaining physicians have the capacity to take on new patients. The situation could be compounded if the community has only one general practitioner or physician of a needed specialty. In that case, obligating a physician to leave the area could deny the community those medical services until a new physician could commence practice. In the interim, patients may have to decide whether they can travel to other communities to obtain those services, which may not always be practically feasible, or do without for the time being.

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

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

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

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

- The AMA Career Planning Resource webpage has a wealth of information discussing physician employment issues, which includes information and tips regarding restrictive covenants. The AMA Career Planning Resource webpage may be accessed at <https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts>.
- The AMA also has two model employment agreements that discuss restrictive covenants, the Annotated Model Physician-Hospital Employment Agreement, 2011 edition: E-Book, free for AMA members at 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-Book, free for members at https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku2530104. These agreements contain model restrictive covenant language for potential physician employees to consider, which may prove useful in the employment negotiation process.
- Finally, staff at the AMA Advocacy Resource Center, the state advocacy unit of the AMA, work extensively on physician employment issues. AMA members are encouraged to contact the Advocacy Resource Center at arc@ama-assn.org, if they would like to obtain more 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.

6. PHYSICIAN HEALTH POLICY OPPORTUNITY (RESOLUTION 604-I-18) REQUEST TO AMA FOR TRAINING IN HEALTH POLICY AND HEALTH LAW (RESOLUTION 612-A-19)

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 604-I-18 AND 612-A-19
REMAINDER OF REPORT FILED
*See Policy G-640.035***

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) considered Resolution 604-I-18, "Physician Health Policy Opportunity," introduced by Washington State, which included the following three resolves:

That our AMA, working with the state and specialty societies, make it a priority to give physicians the opportunity to serve in federal and state health care agency positions by providing the training and transitional opportunities to move from clinical practice to health policy; and

That our AMA study and report back to the House of Delegates at the 2019 Interim Meeting with findings and recommendations for action on how best to increase opportunities to train physicians in transitioning from clinical practice to health policy; and

That our AMA explore the creation of an AMA health policy fellowship, or work with the Robert Wood Johnson Foundation to ensure that there are designated physician fellowship positions with their Health Policy Fellowship program to train physicians in transitioning from clinical practice to health policy.

The reference committee heard conflicting testimony on Resolution 604 and recommended its referral. Testimony agreed that it is critical to have physicians with clinical experience serve in government regulatory agencies to help shape health policy, and favored the AMA studying how best to increase opportunities to train physicians in transitioning from clinical practice to health policy. Testimony recommended broadening partnerships beyond the Robert Wood Johnson Foundation (RWJF), and also noted that developing a health policy fellowship program can be an intricate process, that should be carefully evaluated.

At the 2019 Annual Meeting, the HOD considered a second resolution on a similar topic, Resolution 612-A-19, “Request to AMA for Training in Health Policy and Health Law,” introduced by New Mexico, which asked that the AMA “offer its members training in health policy and health law, and develop a fellowship in health policy and health law.” Testimony on Resolution 612 was also mixed and the reference committee recommended its referral. Those testifying supported the AMA sharing resources and opportunities to serve its members but were uncertain whether the AMA should implement its own fellowship program.

This report responds to both referred resolutions. It reviews the currently available health policy fellowship programs for physicians and recommends that, in lieu of Resolutions 604-I-18 and 612 A-19, the AMA: significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy fellowship opportunities and help them to apply for and participate in them; engage with alumni of the existing programs and provide opportunities for them to share their health policy fellowship experiences with medical students, residents, fellows, and practicing physicians; and disseminate information to medical students and physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service.

EXISTING HEALTH POLICY OPPORTUNITIES FOR PHYSICIANS

The RWJF Health Policy Fellows program is funded by the RWJF but is administered by NAM. Initiated in 1973, the RWJF program is for mid-career health professionals, behavioral and social scientists, and others with an interest in health and health care. Fellows reside for 12 months in Washington, DC, beginning in September of each year. The AMA is one of the organizations that meets with the RWJF fellows during a 3.5-month orientation period at the beginning of their year during which they meet with national health policy leaders, think tanks, executive branch officials, and members of Congress and their staffs. Afterward, the fellows are placed in full-time positions with members of Congress, a congressional committee, or the executive branch. Under the supervision of the office in which they are placed, fellows:

- Help develop legislative or regulatory proposals;
- Organize hearings, briefings, and stakeholder meetings;
- Meet with constituents; and
- Brief legislators or administration officials on various health issues.

RWJF Fellows receive a stipend of \$104,000 for the year of their Washington residency. Fellows who are affiliated with a sponsoring institution may have their stipends supplemented by the sponsoring institution.

Testimony on Resolution 604 indicated concern that the number of slots for physicians in the RWJF program has been declining, but NAM data show otherwise. Physicians have always been an important part of this fellowship, and 58 percent of the nearly 300 program alumni are physicians. It is true that the percentage of physician *applicants* for the fellowship has been declining, but nonetheless 50 percent of the 2019-20 fellows will be physicians. Physicians who apply for the RWJF program fare extremely well in the selection process, so if more physicians apply, more are likely to be selected.

At the same time, there are some barriers to greater physician participation. It is very difficult for practicing physicians to participate in a year-long, full-time, residence program in Washington, DC. Academic medical centers have become less willing over time to let their medical staff members leave for a year, and many physicians face pressure to continue providing billable services. The \$104,000 stipend represents a payment reduction for most practicing physicians, as does the transition to a policy role if they continue in health policy after their fellowship has ended.

In addition to the RWJF program, NAM administers seven endowed fellowships for professionals who are early in their careers, of which five are only for physicians:

- Norman F. Gant/American Board of Obstetrics and Gynecology Fellowship;
- James C. Puffer, MD/American Board of Family Medicine Fellowship;
- Gilbert S. Omenn Fellowship (combining biomedical science and population health);
- American Board of Emergency Medicine Fellowship;
- Greenwall Fellowship in Bioethics;
- NAM Fellowship in Pharmacy; and
- NAM Fellowship in Osteopathic Medicine.

Also, NAM's Emerging Leaders in Health and Medicine (ELHM) Scholars program annually selects up to 10 early- and mid-career professionals with demonstrated leadership and professional achievement in biomedical science, population health, health care and related fields for three-year terms as ELHM scholars. Unlike the full-time residency required in the RWJF program, the ELHM scholars continue to work at their primary institution while also participating in this NAM program. Participants provide input and feedback to help shape NAM's priorities and advance its work in science, medicine, policy, and health equity. Five of the 10 [current ELHM scholars](#) are physicians.

Another pathway that many physicians take to become involved in public service careers in the executive branch is joining the Commissioned Corps of the U.S. Public Health Service. Physicians serving as [Commissioned Corps](#) officers may be found throughout the federal government, including the Food and Drug Administration, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, National Institutes of Health, and the other agencies within the U.S. Department of Health and Human Services, as well as the U.S. Department of Homeland Security, Federal Bureau of Prisons, and the U.S. Department of Defense. The women and men of the Commissioned Corps fill essential public health, clinical, and leadership roles throughout the nation's federal departments and agencies, particularly those supporting care to underserved and vulnerable populations. The U.S. Surgeon General oversees the Commissioned Corps.

For medical students, according to the Association of American Medical Colleges, more than 80 medical schools provide opportunities to pursue a master's degree in public health. Some physicians also obtain their MPH degree separately from their MD degree, either before or after medical school. Adding an MPH degree can be an effective means for physicians to pursue health policy careers. Some medical schools with health policy departments or schools of public health also welcome participation by practicing physicians in their educational programs and activities. Also, the AMA Government Relations Advocacy Fellow (GRAF) program provides medical students with the opportunity to be a full-time member of the AMA federal advocacy team for one year. A key goal of this program is to educate medical student, resident and young physician AMA members about health policy and encourage activism and leadership in local communities. To date, 15 students have participated in the GRAF program.

HEALTH LAW OPPORTUNITIES FOR PHYSICIANS

In addition to training and experience in health policy, Resolution 612-A-19 also called for the AMA to offer members training and develop a fellowship in health law. It would probably be considerably more difficult for a mid-career practicing physician to transition to health law than health policy, as the practice of health law would likely require the individual to obtain a law degree. There are many physicians who pursue dual degree programs, and several universities offer joint MD/JD degree programs, including the University of Pennsylvania, Duke University, University of Miami, Boston University, Stanford University, and University of Virginia. Graduates of joint MD/JD programs may often be found in leadership positions in federal government regulatory agencies where they can use their expertise in both law and medicine.

Unlike medicine's specialty board certification process, the legal profession is dominated by state boards and does not offer legal specialty board certification in health law or similar topics. There are interest groups for professionals who

focus in this area, such as the American Health Lawyers Association. There do not appear to be fellowship opportunities that would allow physicians to transition to health law without obtaining a law degree.

AMA POLICY

AMA policy supports educating medical students, residents, and fellows in health policy. Policy H 310.911, “ACGME Allotted Time off for Health Care Advocacy and Health Policy Activities,” encourages the Accreditation Council for Graduate Medical Education and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarship and activities of organized medicine, including but not limited to health care advocacy and health policy. Policy H-295.953, “Medical Student, Resident and Fellow Legislative Awareness,” advocates that elective political science classes be offered in the medical school curriculum, establishes health policy and advocacy rotations in Washington, DC for medical students and residents, and states that the AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows. Policy H-440.969, “Meeting Public Health Care Needs Through Health Professions Education,” also states that courses in health policy are appropriate for health professions education. Current AMA policies focus on training medical students, residents and fellows in health policy, but the AMA does not currently have policy on mid-career physicians transitioning to health policy careers.

RECOMMENDATIONS

Based upon its review of existing opportunities for practicing physicians to pursue training and careers in health policy, the Board of Trustees does not believe it is necessary or desirable for the AMA to offer its own training and transitional opportunities for physicians to move from clinical practice to health policy. There are multiple avenues already available for physicians who wish to pursue careers in health policy, whether they choose to begin down this path during medical school, residency, or after some years in clinical practice. The Board does agree that the AMA should take a more active role in informing physicians of these opportunities; however, and in helping them to make these career choices. The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 604-I-18 and 612-A-19 and the remainder of the report be filed.

1. That our American Medical Association encourage and support efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy.
2. That our AMA recognize, encourage, and support the primary health policy training found in the physician specialties of public health / general preventive medicine, occupational and environmental medicine, and aerospace medicine.
3. That our AMA significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy training opportunities and help them to apply for and participate in them.
4. That our AMA engage with alumni of health policy training programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians.
5. That our AMA include health policy content in its educational resources for members.
6. That our AMA work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service.
7. That our AMA consider options for funding a one-year educational training program for practicing physicians who wish to transition from clinical practice to employment within the health policy sector.

7. 2019 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

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

Surprise billing

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

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

At the urging of Energy and Commerce Committee members Rep. Raul Ruiz, MD (D-CA), Rep. Larry Buschon, MD (R-IN) and others, the committee adopted an amendment to provide for an independent dispute resolution process. Under the proposal, if either party was dissatisfied with the initial payment offer, an appeals process could be triggered that would allow an independent entity to decide between the payment offer of the plan and the physician's billed amount while considering a number of other factors related to the circumstances of the case and the training and 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. While these three groups of non-physician health care professionals accounted for the vast majority of scope bills this year, hard fought battles also occurred in a number of states on other scope issues. With tough fights in all cases, most bills that threatened passage were defeated, often with AMA support and a coordinated approach from state medical associations and national medical specialty societies through the AMA-led Scope of Practice Partnership (SOPP). The SOPP has provided close to \$2 million in grants to states and specialties since its inception to help on the scope front.

CONCLUSION

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

8. IMPLEMENTING AMA CLIMATE CHANGE PRINCIPLES THROUGH JAMA PAPER CONSUMPTION REDUCTION AND GREEN HEALTHCARE LEADERSHIP (RESOLUTION 615-A-19)

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATION ADOPTED IN LIEU OF RESOLUTION 615-A-19 *See Policy D-135.968*

At the 2019 Annual Meeting, the House of Delegates referred Resolution 615, “Implementing AMA Climate Change Principles Through *JAMA* Paper Consumption Reduction and Green Healthcare Leadership,” to the Board of Trustees. Resolution 615, introduced by the Medical Student Section, asked:

That our American Medical Association (AMA) change existing automatic paper *JAMA* subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to receive paper *JAMA*, in order to support broader climate change efforts.

BACKGROUND

The JAMA Network contains a collection of 13 peer-reviewed, clinical research journals published by the American Medical Association, including *JAMA*, 11 specialty titles, and *JAMA Network Open*. The journals publish content online on a weekly basis, as well as in print journals on a periodic schedule (48 times per year for *JAMA*, once a month for specialty titles), except for *JAMA Network Open*, which is online only. The journals are highly prestigious with Impact Factors in the top 10 in their fields, many in the top 3, and acceptance rates for most at 10% or less. The reach of these journals is global, particularly *JAMA*, with countries outside the US accounting for approximately half of the total views. As a benefit of membership, all AMA members receive online access to the entire collection of journals in the JAMA Network. In addition, approximately 55% of members receive a print copy of *JAMA*. The overall business model for the JAMA Network consists of digital site licenses to institutions for access to the content, advertising (primarily print), and licensing/reuse of previously published content. This multifactor business model provides revenue to support the editorial and publishing operations of the JAMA Network, as well as providing funding to support overall AMA initiatives.

DISCUSSION

Over the past 15 years, the business model for Publishing has shifted from one that was previously driven by print advertising to one that is currently driven by institutional site licensing. As a result, the overall revenue mix has shifted from being 90% print to only 40% print in 2018. However, print advertising remains a key leg to the overall business model for Publishing, providing revenue to sustain the publishing and editorial functions of the journals. In addition,

this revenue stream has provided funding for the development of new modes of content distribution including a mobile app, podcasts, and video content. Although digital advertising has grown along with online views, it remains a fraction (1/7th) of the existing print revenue as growth in the broader digital ad market is focused on search advertising, which is dominated by Google and Facebook, while traditional banner ads that run on the JAMA Network have stagnated and/or declined. *JAMA's* print circulation of 295,000 in 2018 is a strategic benefit both to the JAMA Network as a value proposition for authors regarding the network's ability to communicate critical research as broadly as possible, and for the AMA as a consistently top-cited benefit of membership. Due to US Postal Service regulations, half of the individuals receiving print must be "requesters" in order to mail at periodical rates. Members account for 80% of this requester pool and are a key component to maintaining the overall ratio. A loss of members in print circulation would have a multiplier effect, leading to a 2-for-1 reduction in overall circulation to meet USPS regulations. This would reduce the overall reach of the journals, as well as inhibit the print advertising model, which currently provides a surplus of funds for the JAMA Network and the AMA.

CONCLUSION

Over the last 5 years, the Publishing group has reduced overall print copies by 33%, saving ~1,500 tons of paper on an annual basis, in efforts to reduce costs and paper waste. The print circulation level is evaluated on an ongoing basis and are exploring opportunities to move to digital printing, a cost-effective option to print at significantly lower quantities. The JAMA Network is now a digital-first portfolio, with most research content published online ahead of print. Along these lines and in deploying environmentally sustainable practices, the recently launched journal, *JAMA Network Open*, is an online-only title with zero print circulation. However, the breadth of circulation for *JAMA* remains a key asset for soliciting the best papers from the author community and supporting the overall business model to fund new digital-focused methods of distributing content.

RECOMMENDATION

JAMA's print circulation is a key asset, best supported by maintaining the current opt-out policy for AMA Members. However, based on the analysis that led to this report, the JAMA Network has accelerated the shift to digital printing for journals in the portfolio and will be moving forward with a pilot program to move *JAMA Surgery* to digital printing in 2020, which will reduce the overall circulation for that title by over 90%. If successful, this model will be extended as appropriate to other journals in the network to drive an overall reduction in print copies, consistent with reducing the AMA's carbon footprint.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 615-A-19, and the remainder of this report be filed:

That our American Medical Association continue to explore environmentally sustainable practices for JAMA distribution.

9. OPIOID MITIGATION (RESOLUTION 919-I-18)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 919-I-18 REMAINDER OF REPORT FILED

See Policies H-95.914, H-95.932, H-100.955, D-95.964 and D-95.981

INTRODUCTION

At the 2018 Interim Meeting, the House of Delegates referred Resolution 919-I-18, "Opioid Mitigation," introduced by the Indiana Delegation, which asked:

That our American Medical Association review the following opioid mitigation strategies based on their effectiveness in Huntington, WV, and Clark County, IN, and provide feedback concerning their utility in dealing with opioids:

- (1) The creation of an opioid overdose team that decreases the risk of future overdose and overdose death, increases access to opioid-related services and increases the likelihood that an individual will pursue drug rehabilitation.
- (2) A needle exchange program that is open multiple days a week and is mobile offers not only a source for needles but also Narcan, other supplies, health care and information.
- (3) The creation of a drug court that allows a judge to have greater flexibility in determining the legal consequences of an arrest for an opioid-related crime. It also allows for the judicial patience necessary to deal with the recidivism of this population.
- (4) Offering more acute-care inpatient drug rehab beds, although those ready for treatment need to be willing to travel significant distances to get to a treatment bed.
- (5) Make available Narcan intranasal spray OTC through pharmacies and the syringe exchange, overdose team, etc.
- (6) Encourage prevention education in K-12 programs that uses multiple media with anti-drug messaging delivered in the school system but also in the home.

This report takes each element of Resolution 919-I-18 and discusses relevant information. Additional discussion of the programs in Huntington, West Virginia and Clark County, Indiana is provided, as well as the relationship between the programs and existing AMA policy, ongoing AMA advocacy and other activities. This report makes several recommendations.

DISCUSSION

At a threshold level, determining the “effectiveness” of any program, initiative, treatment or policy aimed at ending the nation’s opioid epidemic must focus on three main areas. First, does the program, initiative, treatment or policy result in improved care for patients with pain and/or evidence-based treatment for opioid use disorder? Second, does the program, initiative, treatment or policy increase access to evidence-based care for patients with pain and/or care for a person with pain or with a substance use disorder? And third, does the program, initiative, treatment or policy result in fewer people overdosing and dying?

This is not to suggest that these three areas are the only important metrics to consider, but they are three that are uniquely focused on improving patient outcomes and reversing the nation’s opioid-related death toll. Using these three metrics, however, provides a consistent lens through which an evaluation can be made. At the same time, it is challenging to suggest that the programs underway in Huntington, West Virginia and Clark County, Indiana can easily be replicated in other jurisdictions. This is due to a variety of factors including support from policymakers and the general public, availability of state and federal resources and the unique socioeconomic, demographic, racial and ethnic differences between communities. In other words, what works in one community may provide lessons, but it may not be easily transferable to another community.

The AMA commends the efforts of Clark County, Indiana and Huntington, West Virginia, for their efforts to enhance access to treatment for opioid use disorder and reduce opioid-related morbidity and mortality.

Opioid overdose response teams

The City of Huntington, West Virginia was awarded a \$2 million federal grant in January 2017 to support, among other things, a “Quick Response Team” (QRT) to help address the city’s opioid epidemic.¹ The QRT is a multidisciplinary team that includes representatives from law enforcement, a paramedic, a faith-based leader and a health care provider. After an individual experiences an overdose and lives, the QRT visits the individual at the person’s home. (Individuals also can be referred to the QRT without having to first experience an overdose.)

According to news reports, the QRT provides non-judgmental information and assessment to provide referrals to treatment or other services. Data suggest that overdose has declined in Huntington, and the QRT is one of the reasons.² The use of QRTs is not unique to the City of Huntington, and in the communities where it has been used, the results appear positive.³ One of the common features of the QRTs and similarly named efforts is that they are largely funded as grant or pilot programs. It is not clear whether the QRT model could be scaled to larger communities.

Needle and syringe exchange programs

The AMA has clear policy in support of the establishment of needle and syringe exchange programs, including encouraging state medical societies to support legislation and other efforts to provide injection drug users with needles and syringes without a prescription. This also includes protecting those who distribute needles and syringes from prosecution. The Clark County, Indiana Health Department correctly states “[p]ersons who inject drugs can substantially reduce their risk of getting and transmitting HIV, viral hepatitis and other blood borne infections by using a sterile needle and syringe for every injection.”⁴ According to the National Institute on Drug Abuse (NIDA):

People who engage in drug use or high-risk behaviors associated with drug use put themselves at risk for contracting or transmitting viral infections such as human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or hepatitis. This is because viruses spread through blood or other body fluids. It happens primarily in two ways: (1) when people inject drugs and share needles or other drug equipment and (2) when drugs impair judgment and people have unprotected sex with an infected partner. This can happen with both men and women.⁵

NIDA also encourages use of the North American Syringe Exchange Network to help identify where needle and syringe exchange programs are available.⁶ The Centers for Disease Control and Prevention (CDC) points to numerous benefits of needle and syringe service programs (SSP), including reducing the risk of infection, preventing outbreaks and preventing viral hepatitis, HIV, endocarditis and other infections. The CDC also notes that SSPs “serve as a bridge to other health services including, hepatitis C virus and HIV diagnosis and treatment and MAT for substance use.” In addition, according to the CDC, “people who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP. SSPs do not increase illegal drug use or crime.”⁷

One of the issues that has arisen with needle and syringe exchange services is that while some states and municipalities may allow distribution of sterile needles and syringes, the law may be less clear about the harm reduction organization possessing used needles and syringes.⁸ The AMA has model legislation promoting needle and syringe exchange, but it has not been updated since May 2000, and would benefit from revisions to reflect current public health research and AMA policy.

Legal consequences for an opioid-related crime

The AMA Opioid Task Force (Task Force) recently issued a new recommendation that emphasizes that:

all persons entering jails or prisons (both for men’s and women’s facilities), while incarcerated, and upon release, will benefit from enhanced opioid use disorder screening protocols to identify those persons arrested if they are currently on medication assisted treatment (MAT), or would like to begin treatment.

Furthermore, the Task Force also “supports the use of evidence-based protocols for maintaining continuity of care for persons released from jail or prison, including—as necessary—enrollment in Medicaid, coordination with peer counseling or other services to ensure the person has linkages to treatment providers in the community, and other such services so as to maintain access to and a continuum of care to sustain and promote recovery.” Directly relevant to Resolution 919-I-18, the Task Force recommendation states, “[t]his recommendation also applies drug courts and other diversion services to support evidence-driven care for persons with an opioid use disorder.”⁹

The Board strongly agrees with the need for the judicial system and correctional settings to view those with an opioid use disorder through a public health and medical lens. For example, AMA policy supports pregnant women who use drugs to receive treatment rather than be subject to criminal sanctions. Moreover, recent AMA advocacy has included strong support for increased access to MAT in jails and prisons¹⁰ and the AMA was the lead amicus in a case supporting a person’s right to receive MAT in a correctional facility.¹¹ Thus, it is not just an “opioid-related crime”

that should be part of this discussion, but protection for evidence-based medical treatment for those with an opioid use disorder.

Sites of care for persons with a substance use disorder

One of the primary challenges in ending the nation's opioid epidemic remains the inability of most patients to obtain evidence-based care for a serious mental illness or substance use disorder. Of the nearly 57 million adults in the United States with a mental or substance use disorder, nearly 40 million did not receive any treatment in the previous year, according to the 2017 National Survey on Drug Use and Health (NSDUH).¹² More than 92 percent of those 12 and older did not receive treatment for a substance use disorder, according to the NSDUH.¹³

The fourth element of Resolution 919-I-18 raises multiple issues concerning sites of care, capacity of insurance networks, available addiction medicine and psychiatric care providers and related geographic realities of the availability of treatment providers. It would be challenging for any report to sufficiently address these complicated issues. In Huntington, West Virginia, securing enough local beds for acute or long-term care is an ongoing challenge.¹⁴ In Clark County, Indiana, for example, local emergency departments work to either admit medically unstable patients for treatment, or a patient may be assessed to be cleared for outpatient management.

Capacity to treat all patients who require it, however, is an issue that affects the nation. While network adequacy laws require a sufficient number of addiction medicine and psychiatric physicians in a patient's network, health insurance companies are falling far short of their obligation and enforcement of these requirements is lacking. Moreover, payers also are falling short of compliance with state and federal mental health and substance use disorder parity laws.¹⁵

AMA advocacy in this regard has been substantial and multipronged—focusing on both increasing capacity and increasing payers' demand for mental health and substance use disorder providers. The AMA is working at the state and federal levels to strengthen network adequacy requirements and enforcement and promote meaningful oversight and enforcement of mental health and substance use disorder parity laws. AMA has partnered with the American Psychiatric Association, American Society of Addiction Medicine and many other organizations in the Federation to simultaneously address capacity and access and will continue to do so.

Naloxone has saved tens of thousands of lives

Naloxone is a lifesaving opioid antagonist that can reverse the effects of an opioid-related overdose. It has no potential for abuse. Naloxone is a 40-year old medication used mainly by first responders and medical staff. Due to its history of safe and effective use, states have enacted standing orders and other laws that permit anyone to obtain a naloxone prescription. The aim of such laws is to provide civilian bystanders who witness an overdose the ability to utilize the overdose reversing medication and save a life. Hundreds of towns and cities have seen the benefits of naloxone firsthand.

A 2017 study found that of opioid overdoses, bystanders were present 40 percent of the time, but naloxone was rarely administered until first responders arrived.¹⁶ Between 2012 to 2016, the rate of emergency medical services (EMS) administered naloxone events increased by 75.1 percent (from 573.6 to 1004.4 administrations per 100,000 EMS events).¹⁷ It is not known how often EMS or others administer multiple doses to a person experiencing an opioid-related overdose. Additionally, in 2018, the number of naloxone prescriptions reached a record high in the United States to more than 598,000 prescriptions, a 107 percent increase from 2017 and a 338 percent increase from 2016.¹⁸ While it has been documented that naloxone can save lives, it is unknown how often it is used by all stakeholders or the number of naloxone administrations that are saving lives.¹⁹

AMA advocacy and partnership with harm reduction advocates and other stakeholders has resulted in every state enacting laws to increase availability of naloxone to patients, bystanders, first responders and others who may be in a position to help someone experiencing an overdose. AMA policy also supports standing orders, strong Good Samaritan protections, needle and syringe exchange and other harm reduction efforts. The AMA supports all forms of naloxone being made available—and does not endorse any specific brand or route of administration. Further, the AMA has called for naloxone manufacturers to submit applications for naloxone to receive over-the-counter status from the U.S. Food and Drug Administration. Moreover, the Task Force has been urging physicians to co-prescribe naloxone as one of its first recommendations in 2015²⁰, and AMA leadership emphasizes this message in nearly every public speaking engagement. These efforts must continue.

Education and prevention efforts for children and young adults

In reviewing the effectiveness of programs that “[e]ncourage prevention education in K-12 programs that uses multiple media with anti-drug messaging delivered in the school system but also in the home,” two main themes emerge. First, education programs in Huntington, West Virginia and Clark County, Indiana do not exist in a vacuum. That is, the youth-focused education programs are part of both county- and state-wide efforts to increase awareness of the dangers of drug use. Second, it is not clear whether the programs are having a targeted and beneficial effect on reducing youth drug use or mortality. The State of Indiana does, however, promote a wide range of resources for parents ranging from “What every parent needs to know about Indiana’s Opioid Epidemic” to “Indiana State Department of Health’s Tips on Substance Use During Pregnancy: How to Have a Healthier Baby” to a “National Institute of Health 2017 National Drug & Alcohol IQ Challenge.”²¹ Huntington, West Virginia is also engaged in a wide number of areas ranging from programs aimed at high school and local college students, providing resources for parents, and working with multiple public health and law enforcement stakeholders.²²

It is worth highlighting that AMA already has clear policy in support of a public health approach to: reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction (Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction”).

AMA POLICY

Each of the areas covered in this report also has broad support in current AMA policy. This includes policy that “encourages all communities to establish needle exchange programs,” and supports “legislation providing funding for needle exchange programs for injecting drug users” (Policy H-95.958, “Syringe and Needle Exchange Programs”). Current policy (and AMA model state legislation) also includes “support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level” (Policy D-95.977, “911 Good Samaritan Laws”).

AMA also supports a public health—not criminal—approach to treatment for those who use illicit drugs or misuse prescription medication. This includes policy whereby “transplacental drug transfer should not be subject to criminal sanctions or civil liability” (Policy H-420.962, “Perinatal Addiction - Issues in Care and Prevention”). It also includes support for “the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and encourages legislators to establish drug courts at the state and local level in the United States” (Policy H-100.955, “Support for Drug Courts”).

AMA has extensive policy in support of widespread access to naloxone, including support for “legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery” (Policy H-95.932, “Increasing Availability of Naloxone”).

Current AMA policy also broadly covers parity issues, including support for “health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation.” (Policy H-165.888, “Evaluating Health System Reform Proposals”) (Also see Policy D-180.998, “Insurance Parity for Mental Health and Psychiatry,” Policy H-185.974, “Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs.”)

RECOMMENDATIONS

The Board recommends that the following recommendation be adopted in lieu of Resolution 919-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) encourage relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and that the AMA share that information with the Federation;
2. That our AMA update model state legislation regarding needle and syringe exchange to state and specialty medical societies;
3. That our AMA amend Policy H-100.955, "Support for Drug Courts;"

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

4. That our AMA urge state and federal policymakers to enforce applicable mental health and substance use disorder parity laws; (Directive to Take Action)
5. That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone;" and
6. That our AMA reaffirm Policy D-95.981, "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction."

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Board of Trustees Report 10 was withdrawn.

11. RE-ESTABLISHMENT OF NATIONAL GUIDELINE CLEARINGHOUSE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

BACKGROUND

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

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

NATIONAL GUIDELINES CLEARINGHOUSE STATUS

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

Prior to commissioning the study, AHRQ staff interviewed NGC stakeholders and customers to get a thorough understanding of what they valued about the NGC to guide MITRE in their charge. While clinical practitioners associated with large medical practices or health systems, and many specialists have access to guidelines and related materials, the NGC was most used by researchers, residents and small practices or solo practitioners. Among the stakeholder comments were a continued interest in a repository of evidence-based clinical practice guidelines meeting certain transparent criteria and continued support for public access to the repository (no fee or registration required). During this transition some organizations stepped in to provide similar if not parallel services to the NGC. One such organization, ECRI Institute, an independent, nonprofit patient safety organization, launched the ECRI Guidelines Trust™, a portal to expertly vetted, evidence-based guideline briefs and scorecards. The healthcare community has free access to the website.

The MITRE Corporation has completed its study and per its recommendations AHRQ will transition the NGC to a private entity to sustain the site and thereby provide a source of evidence-based guidelines for clinical decision making. The Agency will achieve this transition through a mechanism that will ensure alignment with principles that have defined AHRQ's support for the resource, including the requirement that guidelines meet specific criteria and adherence to the IOM trustworthiness standards, public access, and protections of guideline developer copyright. AHRQ will have a role in the NGC, which will be specified as the work continues. No information is publicly available at this time regarding the financial support for the new NGC to be managed by a private entity.

The timeline for migration to a private entity from AHRQ has not been determined but AHRQ will continue to post updates to its website ahrq.gov/gam/updates/index.html. The AMA will monitor additional plans as they become available.

12. DISTRACTED DRIVER EDUCATION AND ADVOCACY

Reference committee hearing: see report of Reference Committee K.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-15.952 and D-15.993

INTRODUCTION

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

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

BACKGROUND

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

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

STATUS OF IMPLEMENTATION

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

RECOMMENDATIONS [Note: Recommendations added to what had been an informational report.]

1. Policies H-15.952 and D-15.993 be reaffirmed.
2. Our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House at Annual 2020.
3. Remainder of report filed.

13. HOSPITAL CLOSURES AND PHYSICIAN CREDENTIALING

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

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

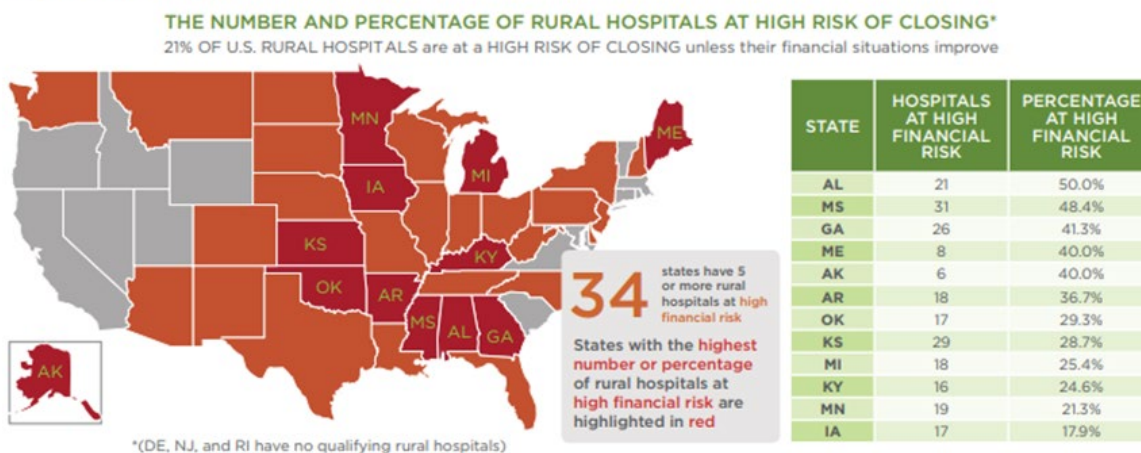
This informational report provides an update on hospital closure activity, changes and updates to associated legal or regulatory requirements, and the status of various efforts to centralize records for impacted institutions.

DISCUSSION

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

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

Figure 1: Rural Hospital Financial Risk



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

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

The AMA has been in contact with these organizations as well as others in an effort to identify ways to address the issue of ensuring accessible data after an institution closure as well as to reduce the burden placed on physicians during the credentialing process. Today, the AMA through its Credentialing Profile service acts as a centralized repository of certain credentialing data, including state licensure and actions, board certification, drug enforcement agency

(DEA), medical education and Accreditation Council for Graduate Medical Education (ACGME) accredited training. The AMA continually explores the expansion of this service offering, however, recognizes that certain aspects of the credentialing and privileging information maintained by the medical staff office will be extremely challenging to centralize. For example, these files customarily include peer reviews that institutions are reluctant to store outside their organization.

AMA POLICY

AMA policy supports the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes, and other health care facilities. Policy H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records” states that, where in accordance with state law and regulations, “...(t)he 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...” and “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.” Policy H-230.956 also states that the closing facility “...shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information.”

CONCLUSION

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

14. REDEFINING AMA'S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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.

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

STEPS TO LOWER HEALTH CARE COSTS

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

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

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

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

The Administration has also put forth several proposals to address the cost of prescription drugs. Most recently, on July 31, HHS announced the “Safe Importation Action Plan” which will be the subject of an upcoming proposed regulation from the department. The plan would offer two potential pathways predicated on the invocation of Section 804 of the Federal Food, Drug and Cosmetics Act by the Commissioner of the Food and Drug Administration. Under this provision, the Commissioner may allow for the importation from Canada of drugs if he or she certifies that doing so would not jeopardize the public health and would result in significant cost reductions. Under the proposal, there would be two possible pathways. Under the first, states, wholesalers and pharmacies could submit proposed demonstration projects for HHS review. Under a second pathway, manufacturers themselves could import FDA approved medications. HHS noted that manufacturers have told them that they would like to offer lower cost versions of their own drugs but are prevented from doing so because they are locked into contracts with other parties in the supply chain. This option would allow them to import their own drugs produced for the Canadian market for that purpose. Certain drugs, such as controlled substances, drugs subject to REMS, and biologics, including insulin, would not be eligible for this program.

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

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

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

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

CONCLUSION

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

**15. REPEALING POTENTIAL PENALTIES ASSOCIATED WITH MIPS
(RESOLUTION 206-I-18)
REDUCING THE REGULATORY BURDEN IN HEALTH CARE
(RESOLUTION 231-I-18)
IMPROVING THE QUALITY PAYMENT PROGRAM AND PRESERVING PATIENT ACCESS
(RESOLUTION 243-A-19)**

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred two resolutions, and at the 2019 Annual Meeting, a third resolution was referred, for a combined Board of Trustees (Board) Report at the 2019 Interim Meeting related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The first resolution, Resolution 206-I-18, “Repealing Potential Penalties Associated with MIPS,” was introduced by the Florida Delegation and asks that:

Our American Medical Association advocate to repeal all potential penalties associated with the MIPS program.

The second resolution, Resolution 231-I-18, “Reducing the Regulatory Burden in Health Care,” was introduced by the Pennsylvania Delegation and asks that:

Our American Medical Association work to support the repeal of the Merit-Based Incentive Payment System (MIPS); and that upon repeal of MIPS, our AMA oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served.

The third resolution, Resolution 243-A-19, “Improving the Quality Payment Program and Preserving Patient Access,” was introduced by the Texas Delegation and asks that:

Our American Medical Association strongly advocate for Congress to make participation in MIPS and alternative payment models (APMs) under the Quality Payment Program (QPP) completely voluntary, that our AMA strongly advocate for Congress to eliminate budget neutrality in MIPS and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians, and that our AMA call on the Centers for Medicare and Medicaid Services (CMS) to provide a transparent, accurate,

and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

The reference committee heard mixed testimony on Resolutions 206, 231, and 243. Some testified that MIPS should be repealed, as many practices that serve Medicare beneficiaries cannot sustain additional reductions in their Medicare payments. Others testified that our AMA should continue working with Congress and the Administration to ensure that all physician practices, regardless of size or specialty, have the opportunity to succeed in the QPP. Also, there was significant testimony that our AMA should continue advocating to simplify and improve the MIPS program and increase the number and variety of APMs available to physicians.

BACKGROUND

Our AMA was supportive when Congress replaced the flawed, target-based sustainable growth rate (SGR) formula with a new payment system under MACRA. Scheduled payment cuts prior to the implementation of MACRA exceeded 20 percent. Those cuts would have had a devastating impact on physician practices and patient access to care. Under MACRA, the SGR formula was replaced with specified payment updates for 2015 through 2019, and for 2026 and beyond. MACRA also created an opportunity to address problems found in existing physician reporting programs, including the chance to earn incentives. In addition, the law sought to promote innovation by encouraging new ways of providing care through APMs.

Our AMA worked closely with CMS and Congress on implementation of the MIPS program, and AMA advocacy efforts resulted in a policy allowing physicians who reported on one measure, one time, for one patient to avoid a penalty. This transition period allowed many physician practices to be successful in the first performance year of MIPS, with 93 percent of eligible clinicians receiving a modest positive payment adjustment and nearly three-quarters qualifying for an additional exceptional performance bonus. (Notably, the exceptional performance bonus is funded at \$500 million annually in the MACRA statute and is not budget neutral.)

Following the first year of the MIPS program, our AMA was also successful in getting Congress to make needed technical changes to MACRA in the Bipartisan Budget Act of 2018. These changes helped many practices avoid penalties that they likely would otherwise have incurred under the MIPS program. Specifically, our AMA worked with Congress to exclude Medicare Part B drug costs from MIPS payment adjustments, as including these additional items and services created significant inequities in the administration of the program. In addition, our AMA helped achieve changes that allow CMS to reweight the Cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS, instead of increasing it to 30 percent as the law previously required, and to set the performance threshold for three additional years instead of basing it on the mean or median of previous MIPS scores.

DISCUSSION

Ongoing AMA Advocacy Efforts

Since the enactment of MACRA, our AMA has worked closely with both Congress and CMS to promote a smooth implementation of the QPP. Despite these efforts, Resolutions 206, 231, and 243 illustrate that the implementation of a new quality and payment program for physicians is a major undertaking and significant improvements to the program are still needed. As is noted in the resolutions, there are numerous improvements that must still be made to the MIPS program, including more accurate risk adjustment for cost and quality measures, timelier program feedback for physicians, and a more cohesive program structure. In addition, physician practices, especially small and rural physician practices, cannot shift to new payment models without adequate resources.

In an effort to address these outstanding issues, our AMA has convened MIPS and APM workgroups made up of representatives from across the physician community, which have developed creative solutions to improve the QPP. Feedback from the MIPS and APM workgroups, as well as other state and specialty medical societies, has led our AMA to focus its efforts to improve the QPP on several key issues: replacing the upcoming Medicare physician pay freeze with a stable revenue source that allows physicians to sustain their practice; eliminating budget neutrality; extending the Advanced APM payments for an additional six years; simplifying the MIPS scoring system and creating a more meaningful MIPS program; and ensuring small and rural practices have the opportunity to succeed.

Replace Physician Payment Freeze

Resolution 206 notes that many physician practices cannot sustain additional reductions in their Medicare payments. Our AMA agrees, and while MACRA included modest positive payment updates in the Medicare Physician Fee Schedule, it left a gap from 2020 through 2025, during which there are no updates at all. Following this six-year freeze, the law specifies physician payment updates of 0.75 or 0.25 percent for physicians participating in APMs or MIPS.

Our AMA recognizes that these payment updates are not sufficient, particularly while physicians are investing resources to improve the quality of patient care and shift to new payment models. Therefore, our AMA recently testified before Congress, urging Congress to pass legislation providing physicians with positive payment updates beginning in 2020. The Board strongly supports advocating for positive payment updates, which are needed to provide physicians a margin to maintain their practice, as well as transition to more efficient models of care delivery.

Extend APM Payments

In addition to providing positive physician payment updates, Congress and the Administration must also work to provide physicians with adequate resources to move into new payment models. One goal of MACRA, in addition to the MIPS program, was to provide physicians with a path to transition into new, innovative APMs that could allow physicians to be paid for services that add value to patient care.

To help facilitate this transition, Congress provided a five percent incentive payment for physicians who participate in Advanced APMs during the first six years of the program. Unfortunately, through the first three participation years, very few physicians had the opportunity to earn this incentive payment due to the small number of Advanced APMs approved by CMS. While our AMA is working closely with numerous physician groups, as well as the Center for Medicare and Medicaid Innovation (CMMI), to develop and test physician-led APMs, it will take time to implement the number of APMs needed to allow most physicians a realistic opportunity to participate in these models. Therefore, our AMA is urging Congress to extend the Advanced APM incentive payments to provide support to physicians as they transition to new payment models. The Board strongly supports efforts to ensure there are voluntary APMs available for physicians in all specialties and practices of all sizes.

Impact of Budget Neutrality

The Board strongly supports providing physicians with the resources necessary to improve quality and patient care. The Board is therefore concerned about reports from numerous physicians who have worked diligently to comply with the numerous MIPS requirements, yet have ended up investing more in health information technology and care management processes than they received through their resulting MIPS incentive payment. The negative return on investment from MIPS participation is a serious problem. Also, several witnesses have testified in reference committee that funding positive MIPS incentive payments with penalties imposed on practices that do not score above the MIPS performance threshold exacerbates this problem for smaller practices. The Board supports language in Resolution 243-A-19 noting that physicians need dedicated funding for MIPS incentive payments in order to ensure physicians have the capital they need to move into models that provide patients with the utmost value. Basing positive payment adjustments on penalties also creates uncertainty in the program, which further discourages practices from making the up-front investments needed to transition to value-based payment and care delivery models.

While supporting the elimination of budget neutrality in the MIPS program, the Board also understands that this is a complex issue that would involve some difficult trade-offs. It would be extremely difficult to secure funding from Congress both for positive MIPS incentive payments, which would help practices that participate in MIPS and exceed the MIPS performance threshold, and funding for positive conversion factor updates, which would help all practices that care for fee-for-service Medicare patients, including small practices that are excluded from MIPS because they are below the low-volume threshold. In addition, physicians in large practices have generally obtained higher MIPS scores than those in smaller practices, so this policy is more likely to help large practices than smaller practices. Partially or fully eliminating MIPS budget neutrality may also make it more difficult to achieve adoption of AMA recommendations to improve the MIPS program, because Congress and the Administration would view any increase in the number of physicians able to succeed in MIPS as increasing federal spending.

Despite these concerns, the Board determined that replacing or supplementing the budget neutrality requirements in MIPS with incentive payments would help support physicians as they continue to work to comply with the program.

Therefore, the Board supports MIPS incentive payments not limited by budget neutrality requirements to provide physicians a margin to transition into more efficient models of care delivery.

Simplifying and Streamlining MIPS

Our AMA has repeatedly urged CMS to make MIPS more clinically relevant for physicians and patients. As noted in Resolution 243, many physicians must report MIPS measures that are not linked to improved clinical care for their patients. Our AMA's MIPS workgroup has developed detailed recommendations that would make the MIPS program more cohesive and allow physicians to select more relevant measures to report.

For example, our AMA has urged CMS to streamline the MIPS program by allowing physicians to focus their participation around a specific episode of care, clinical condition, or public health priority. By allowing physicians to focus on activities that fit into their workflow and address their patient populations' needs, rather than segregated measures divided into four disparate MIPS categories, the program would be more likely to improve quality of care for patients and be more meaningful for physicians.

Our AMA has also urged Congress to allow CMS the flexibility to base scoring on multi-category measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS categories, and create a more unified program. Our AMA's goal is to help the administration develop an approach that allows physicians to spend less time on reporting and more time with patients and on improving care. The Board strongly supports the efforts to unify MIPS reporting while also making it more meaningful for physicians.

Support for Small and Rural Practices

As noted in Resolution 231, our AMA agrees that small physician practices could be disproportionately impacted by penalties under MIPS. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for small practices were 43.46 and 37.67. Our AMA agrees that the lower scores achieved by small practices illustrate the need for AMA to continue advocating for changes to MACRA that will help small practices and solo practitioners.

In order to help small practices become more successful in the MIPS program, our AMA has engaged in advocacy efforts in multiple areas. First, our AMA has been a strong supporter of the low-volume threshold exemption which was increased and now excludes physicians with allowed charges of \$90,000 or less, 200 or fewer unique Medicare patients, or 200 or fewer covered professional services to Medicare Part B beneficiaries from the MIPS program. Our AMA has also supported MIPS policies including reduced reporting requirements for small practices in the Quality performance category, hardship exemptions from the Promoting Interoperability performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small and rural practices succeed in the program. Finally, our AMA is advocating for a legislative change that would allow CMS to develop separate thresholds for small and large practices, so that small physician practices are compared to practices with similar resources. The Board agrees that additional changes are needed to ensure small and rural practices have the opportunity to succeed in the MIPS program.

Other Advocacy Efforts

In addition to these major program changes, our AMA also continues to urge CMS and Congress to address more nuanced issues in the QPP such as:

- Stabilizing the performance threshold until program improvements are tested and implemented;
- Revamping the Virtual Group option to encourage small practices to participate;
- Improving risk adjustment methodologies to account for social risk factors;
- Reducing the number of quality measures a physician must report under the Quality performance category;
- Maintaining a minimum point floor for physicians reporting on quality measures that meet the data completeness threshold, regardless of performance on the measure;
- Eliminating the requirement that physicians must report on an outcome or high priority measure and eliminating the requirement to report on all-payer data;
- Developing a phased approach for removing "topped-out" measures from MIPS and improving the benchmark methodology;
- Aligning the MIPS and Physician Compare calculation methodologies;

- Maintaining the Cost performance category weight while new episode-based cost measures are developed and piloted;
- Modifying the threshold levels of APM participation required to be eligible for the APM incentive payments;
- Securing adoption of physician-focused payment models with realistic targets for improving patient health outcomes and generating savings;
- Eliminating the Total Cost of Care and Medicare Spending Per Beneficiary measures within the Cost performance category as improved episode-based cost measures are developed;
- Allowing physicians to attest to their use of Certified Electronic Health Information Technology (CEHRT) in the Promoting Interoperability performance category;
- Reducing the number of measures physicians are required to report in the Promoting Interoperability performance category; and
- Providing credit for the use of health information technology beyond CEHRT.

As illustrated by the list above, our AMA has spent significant staff time working with both Congress and CMS to improve the QPP. Our AMA has specifically been advocating persistently for MIPS to be more meaningful to physicians and less administratively burdensome, and to increase the number of available APMs. Our AMA advocacy team meets regularly with both CMS officials and Congressional staff to work to improve MIPS and the APM pathway for physicians and will continue to do so going forward.

Among the concerns raised with seeking repeal of the MIPS penalties at this time is that the cost would need to be offset and would potentially come at the expense of bonuses or across the board cuts in physician payments, which would impact physicians who are currently exempt from MIPS, such as small practices. Another concern is that repealing penalties associated with MIPS or repealing the entire program at this time could result in an alternative quality payment program that may be less desirable. Furthermore, such a shift in our AMA's advocacy position would effectively preclude our AMA from continuing our advocacy efforts with state and specialty medical societies in support of the Administration's and Congress' efforts to advance successful, innovative payment models as well as the technologies needed to support such models.

AMA POLICY

Our AMA has numerous existing policies on MACRA including Policies D-395.999, D-395.998, H-390.838, D-390.950, and D-390.949. Together, these policies direct our AMA to work with CMS to advocate for improvements to MIPS, a reduction in MIPS requirements for all physicians, an exemption to MIPS for small practices, a period of stability in the MIPS program to allow for testing and stability and additional flexibilities for fragile practices. AMA policy also supports our advocacy to increase the number and variety of APMs available to physicians, extend the Advanced APM incentive payments to provide support to physicians as they transition to new payment models, and modify the threshold levels of APM participation required to be eligible for the APM incentive payments (Policies H-385.913, H-450.931, and H-385.908).

CONCLUSION

Our AMA understands that there is significant frustration with the MIPS program and continues to vigorously advocate that both CMS and Congress make needed changes. In addition to urging CMS to make additional improvements to the MIPS program, our AMA is joined with many state and specialty medical societies making it a priority to advocate that Congress provide physicians with positive Medicare payment updates and extend APM payments to provide physicians with additional resources to help transition to APMs. The Board believes that the lack of positive updates from 2020 to 2025 severely threatens physicians' ability to sustain their practices, especially while at the same time implementing quality improvements. Our AMA will work with due purpose to seek positive updates as we continue to reduce MIPS burdens.

While the Board recognizes that the QPP needs improvement, we also acknowledge that the MIPS program is only two years old. Detailed results from the 2017 performance year were recently released and CMS is still analyzing what those results mean for how practices will perform in the future. Implementation of a new quality and payment program is a significant undertaking and requires an iterative process with constant evaluation and improvement. In addition to our current policy, the Board believes that our AMA should have the ability to support legislation that could shift the budget neutrality dynamic of the current MIPS program. The Board understands that eliminating the budget neutrality requirements of the MIPS program is a complex issue and that there are many ways to achieve that

goal. Therefore, we offer a recommendation to support replacing or supplementing budget neutrality in a manner that provides flexibility to review and consider legislation without being so narrowly defined that we overlook an opportunity to improve the MIPS program in another way.

Therefore, the Board recommends, consistent with existing AMA policy, that our AMA continue its work with CMS and Congress to improve the MIPS program, increase APM opportunities for physicians, and provide additional resources for physician practices through positive updates and APM payments. Given that the repeal of MACRA could result in a more burdensome quality program with no opportunity to earn incentives and lower payment updates for physicians, we recommend not advocating for the repeal of MIPS penalties or the MIPS program at this time. However, the Board will continue to monitor the QPP's impact and burden on physicians, and if improvements to the program are not sufficient, we will reevaluate our advocacy policies and position in the future.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support legislation that replaces or supplements the budget neutrality in MIPS with incentive payments.
2. That our AMA reaffirm Policy D-395.999, "Reducing MIPS Reporting Burden," Policy D-395.998, "Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program," Policy H-390.838, "MIPS and MACRA Exemption," Policy D-390.950, "Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)," Policy D-390.949, "Preserving Patient Access to Small Practices Under MACRA," Policy H-385.913, "Physician-Focused Alternative Payment Models," Policy H-385.913, "Physician-Focused Alternative Payment Models," Policy H-450.931, "Moving to Alternative Payment Models," and Policy H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers."

APPENDIX - EXISTING AMA POLICY

Policy D-395.999, "Reducing MIPS Reporting Burden"

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

Policy D-395.998, "Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program"

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Policy H-390.838, "MIPS and MACRA Exemption"

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Policy D-390.950, "Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)"

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.

2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Policy D-390.949, "Preserving Patient Access to Small Practices Under MACRA"

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Policy H-385.913, "Physician-Focused Alternative Payment Models"

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
 2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
 3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.
 4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
 - A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
 - B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
 - C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
 - D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
 - E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
 5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models.
- Policy H-450.931, "Moving to Alternative Payment Models"
1. As physician payment moves to pay-for-value, our American Medical Association will help physician practices with the following: (a) physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models; (b) address physicians' concerns about the operational details of alternative payment models to improve their effectiveness; (c) to succeed in alternative payment models, physician practices need data and resources for data management and analysis; and (d) harmonize key components of alternative payment models across multiple payers, especially performance measures to help physician practices respond constructively.

2. Our AMA will, in partnership with other appropriate physician organizations, work with the Centers for Medicare & Medicaid Services to establish an appropriate timetable for implementation of pay-for-value models that takes into account the physician community's readiness to assume two-sided risk (up-side and down-side risk).

Policy H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers"

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.

3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.

4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):

a. Continue to expand technical assistance;

b. Develop IT systems that support and streamline clinical participation;

c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;

d. Identify methods to reduce the data collection burden; and

e. Begin implementing the 21st Century Cures Act.

5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:

a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;

b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and

c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.

6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:

a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;

b. Distinguish between services ordered by a physician and those delivered by a physician;

c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;

d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and

e. Provide physicians with lists of attributed patients to improve care coordination.

7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:

a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;

b. Account for costs that are not currently billable but that cost the practice to provide; and

c. Account for lost revenue for providing fewer or less expensive services.

16. TIME'S UP HEALTHCARE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2019 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-65.988, "TIME'S UP Healthcare," which directs our AMA to "evaluate the TIME'S UP Healthcare program and consider participation as a TIME'S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine."

Testimony was supportive, recognizing that a relationship with TIME'S UP Healthcare could advance AMA efforts to support women in medicine. At the same time, testimony recognized that our AMA should not enter into such a

relationship without first evaluating the organization and considering how a partnership would impact the AMA's reputation and help the AMA achieve its stated goals.

Since the 2019 Annual Meeting, our AMA has been in communication with the leadership of TIME'S UP Healthcare to learn more about the organization and opportunities for collaboration. This informational report provides background information on the organization and describes the ways in which AMA might partner with TIME'S UP Healthcare to advance our common goal of gender equity in medicine.

BACKGROUND

TIME'S UP Healthcare was launched in February 2019 with the mission "to unify national efforts to bring safety, equity, and dignity to our healthcare workplace."¹ From this mission flow the organization's goals:

- "Unite healthcare workers across fields. The problems of gender inequity and sexual harassment affect all workers who provide health care. TIME'S UP Healthcare aims to engage and support organizations and individuals at every level of health care delivery.
- Improve care for targets of harassment and inequity. Highlight the physical and mental health sequelae of workplace harassment and identify ways to provide access to resources for employees affected by it.
- Raise awareness and knowledge. Provide visibility to persistent gender inequities and harassment in health care through data and through narratives. We will also provide educational materials for training those in health care on how to combat gender inequity and sexual harassment.
- Support healthcare organizations in making this issue central and visible. Invite major healthcare organizations across the country to make an open and sustained commitment to ending gender inequity and sexual harassment.
- Provide a link to the TIME'S UP Legal Defense Fund. Strengthen the ability of limited-resource and low-income workers to obtain legal aid through the TIME'S UP Legal Defense Fund.
- Advocate for meaningful standards. Advocate for standards for policies, practices, and outcomes that ensure organizations are effective in preventing and responding to gender inequity and sexual harassment.
- Advance research on harassment and inequity. Serve as a repository for existing research on gender inequity and sexual harassment in the healthcare industry and identify and highlight critical gaps in the literature."

TIME'S UP Healthcare is an affiliate of the TIME'S UP Foundation, a 501(c)(3) organization advocating for safe, dignified, and fair workplaces. Other affiliates, which house working groups to activate and engage a broader network of working women, include TIME'S UP Tech, TIME'S UP Entertainment, and TIME'S UP UK. Other associated bodies include the TIME'S UP Legal Defense Fund, which is administered by the National Women's Law Center, and the TIME'S UP Impact Lab, the organization's 501(c)(4) research and policy center.

Although each affiliate is led by an Advisory Council, the activities of the overall organization ultimately are directed by the TIME'S UP Global Board, which includes representatives from each affiliate. The TIME'S UP Healthcare Advisory Council includes 12 healthcare executives, half of whom are AMA members, and two of whom are leaders within the AMA Minority Affairs Section and Women Physicians Section.

TIME'S UP Healthcare offers three categories for organizational collaboration:

- Sponsors are the only organizational entities that provide financial support. Current sponsors include FIGS; feminem; Horizon Pharma; InCrowd; Rosh Review; and the American Medical Women's Association.
- Partners work in close collaboration with TIME'S UP Healthcare to advance the common goal of bringing equity and inclusion to the healthcare workforce. Current partners include American College of Physicians, American Nurses Association, American Medical Women's Association, Council of Medical Specialty Societies, National Medical Association, and Service Employees International Union.
- Signatories (of which there are currently more than 40) are organizations that have pledged their commitment to TIME'S UP Healthcare's core statements:
 - "Sexual harassment and gender inequity have no place in the healthcare workplace.
 - We are committed to preventing sexual harassment and gender inequity and protecting and aiding those who are targets of harassment and discrimination.
 - We believe every employee should have equitable opportunity, support, and compensation.
 - We cannot address a problem without understanding its scope and impact; we will measure and track sexual harassment and gender-based inequities occurring in our institution."

¹ Citations throughout this report are drawn from the TIME'S UP Healthcare website: <https://www.timesuphealthcare.org/>.

Participation in any of these capacities requires a signed Memorandum of Understanding (MOU) between TIME'S UP Healthcare and the collaborating organization.

DISCUSSION

Our AMA and TIME'S UP Healthcare share a dedication to advancing gender equity in medicine (see for example, AMA Policies H-65.961, "Principles for Advancing Gender Equity in Medicine," and D-65.989, "Advancing Gender Equity in Medicine"), and our assessment of TIME'S UP Healthcare leads us to believe that a partnership would strengthen both organizations' efforts in this regard. Accordingly, your Board of Trustees will work with the leadership of TIME'S UP Healthcare to specify the terms of a formal partnership that will enable our organizations to work together to advance gender equity in medicine.

APPENDIX - Relevant AMA Policy

H-65.961, Principles for Advancing Gender Equity in Medicine

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. (BOT Rep. 27, A-19)

D-65.989, Advancing Gender Equity in Medicine

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.

17. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES: FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED** **REMAINDER OF REPORT FILED**

See Policies D-600.966 and D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2019 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, “Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.”

The following organizations were reviewed for the 2019 Interim Meeting:

- American College of Cardiology
- American College of Chest Physicians
- American College of Emergency Physicians
- American College of Gastroenterology
- American College of Nuclear Medicine
- American Medical Group Association
- National Association of Medical Examiners

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group’s membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association and the National Association of Medical Examiners are in compliance with all requirements for representation in the HOD.

Review of the materials submitted by the American Medical Group Association (AMGA), indicates that AMGA should be reclassified as a Professional Interest Medical Association (PIMA). Specifically, AMGA does not represent a field of medicine that is scientifically valid, but rather a practice setting. PIMAs are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. AMGA demonstrates that it represents and serves a professional interest of physicians that is relevant to our AMA’s purpose and vision and that the organization has a multifaceted agenda in accordance with PIMA requirements (Exhibit E).

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That the American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association and the National Association of Medical Examiners retain representation in the American Medical Association House of Delegates.
2. That the American Medical Group Association be reclassified as a Professional Interest Medical Association (PIMA).

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American College of Cardiology	6,403 of 32,145 (20%)
American College of Chest Physicians	2,388 of 12,370 (19%)
American College of Emergency Physicians	6,980 of 31,709 (22%)
American College of Gastroenterology	1,261 of 8,709 (14%)
American College of Nuclear Medicine	49 of 169 (29%)
American Medical Group Association	4,679 of 37,249 (12%)
National Association of Medical Examiners	193 of 888 (21%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

- 8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:
- 8.2.1 To cooperate with the AMA in increasing its AMA membership.
 - 8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
 - 8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
 - 8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
 - 8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

- 8 Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates
- 8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.
- 8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.
 - 8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.
 - 8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
 - 8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.
 - 8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:
 - 8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.
 - 8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through

the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

Exhibit E - Admission of Professional Interest Medical Associations to our AMA House G-600.022

- (1) Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):
 - (a) the organization must not be in conflict with the Constitution and Bylaws of our AMA;
 - (b) the organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association);
 - (c) the organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA;
 - (d) the organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
 - (e) physicians should comprise the majority of the voting membership of the organization;
 - (f) the organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office;
 - (g) the organization must be active within the profession, and hold at least one meeting of its members per year;
 - (h) the organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
 - (i) the organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization; and
 - (j) if international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.
- (2) The process by which PIMAs seek admission to the House of Delegates includes the following steps:
 - (a) a PIMA will first apply for membership in the Specialty and Service Society (SSS);
 - (b) using specific criteria, SSS will evaluate the application of the PIMA and, if the organization meets the criteria, will admit the organization into SSS;
 - (c) after three years of participation in SSS, a PIMA may apply for representation in our AMA House of Delegates;
 - (d) SSS will evaluate the application of the PIMA, determine if the association meets the criteria for representation in our AMA House of Delegates, and send its recommendation to our AMA Board of Trustees;
 - (e) the Board of Trustees will recommend to the House how the application of the PIMA should be handled;
 - (f) the House will determine whether or not to seat the PIMA; and
 - (g) if the application of a PIMA for a seat in the House is rejected, the association can continue to participate in SSS as long as it continues to meet the criteria for participation in SSS.

18. AMA'S IMMIGRATION ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

The American Medical Association (AMA) has been, and continues to be, deeply committed to ensuring the health and safety of all individuals regardless of immigration status. Through our advocacy at the federal level, the AMA continues to advance policies that support, protect, and promote immigrant health. This report provides a summary of AMA advocacy activities related to certain immigration reform policies proposed by the federal government.

DISCUSSION

Health and Safety Conditions at the Southern Border

On April 6, 2018, the U.S. Department of Justice (DOJ) instituted Zero Tolerance, a policy to prosecute violations of improper entry and attempted improper entry by an undocumented immigrant. On May 5, 2018, in response to the DOJ's Zero Tolerance policy for illegal entry and based on guidance from the U.S. Department of Homeland Security (DHS), the U.S. Customs and Border Protection (CBP) began referring greater numbers of violations for prosecution. On June 19, 2018, the AMA sent a [letter](#) to the DHS, the U.S. Department of Health and Human Services (HHS), and the DOJ, consistent with [AMA policy](#) adopted during the 2018 Annual Meeting of the House of Delegates, urging the federal government to rescind its Zero Tolerance Policy which resulted in the separation of children from their caregivers.¹ The AMA urged the Administration to give priority to supporting families and protecting the health and well-being of the children within those families.

On July 24, 2018, several national health care organizations, including the AMA, sent letters to the [U.S. House](#) and [U.S. Senate](#) asking for oversight hearings on the care provided to families in DHS-run detention facilities. In the letter the AMA urged Congress to hold oversight hearings with the DHS and HHS on the quality of care and treatment these families are receiving.

On December 18, 2018, the AMA joined other medical associations and specialty organizations in a [sign-on letter](#) strongly urging the DHS to implement specific meaningful steps to ensure that all children and pregnant women in CBP custody receive appropriate medical and mental health screening and necessary follow-up care by trained providers.

In July 2019, in accordance with AMA policy, the AMA [called on](#) the DHS and CBP to address the conditions in 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 provided [a written statement](#) to the House Committee on Oversight and Reform in advance of their hearings entitled, "Kids in Cages: Inhumane Treatment at the Border," and "The Trump Administration's Child Separation Policy: Substantiated Allegations of Mistreatment." Additionally, the AMA drafted its own [letter](#) and signed on to two letters of support ([letter 1](#) and [letter 2](#)) for H.R. 3239, the "Humanitarian Standards for Individuals in Customs and Border Protection Custody Act," along with several other health care organizations. H.R. 3239 takes important steps toward ensuring that appropriate medical and mental health screening and care is provided to all individuals, including immigrant children and pregnant women, in CBP custody.

Extension of Family Detention

On September 7, 2018, DHS and HHS released a [proposed rule](#) titled, "Apprehension, Processing, Care, and Custody of Alien Minors and Unaccompanied Alien Children." In the rule, the Administration proposed to expand long-term detention of migrating families. In accordance with AMA policy, the AMA submitted a [comment letter](#) opposing the proposed rule.

On August 21, 2019, the [final rule](#) was released. The final rule, as did the proposed rule, seeks to dismantle the Flores Settlement Agreement (FSA), a decades-old court settlement put in place to ensure the safety and proper care of children in immigration detention. The FSA set strict national standards for the detention, treatment, and release of all minors (both accompanied and unaccompanied minors) in immigration custody. The final rule seeks to undermine the FSA by allowing minors with their parents to be detained in DHS licensed family detention facilities for the entirety of their immigration proceedings.

In its comment letter the AMA voiced its concern about the proposed rule's potential negative impact on the health and well-being of immigrant children and their parents/caregivers and urged the Administration to withdraw the proposed rule. The AMA went on to urge the Administration to give priority to supporting families and protecting the health and well-being of the children within those families.

In addition, the AMA joined the American Academy of Pediatrics (AAP) in filing an [amicus brief](#) describing the impact of the final rule on the health of migrating children and their families. On September 27, 2019, a federal judge [blocked](#) the final rule from being implemented.

Deferred Action for Childhood Arrivals (DACA)

The DACA program protects more than 700,000 undocumented immigrants brought to the U.S. as children from deportation and enables them to obtain work permits since being implemented by the Obama Administration. On September 5, 2017, the Trump Administration [ended the program](#), but federal courts blocked that attempt. Following a brief pause, the government began accepting renewal applications from DACA participants. Over the years, and especially since 2017, the AMA has strongly advocated on behalf of the DACA program in accordance with existing AMA policy.

In 2017, the AMA sent a [letter](#) to Congressional Leaders voicing support for S. 128, the “Bar Removal of Individuals who Dream and Grow our Economy Act” (BRIDGE Act), which would provide employment authorization and temporary relief from deportation for undocumented young immigrants who have DACA status and DACA-eligible individuals. The AMA also [wrote](#) Congress urging prompt action to protect and provide stability for individuals with DACA status. Additionally in 2017, the AMA [asked](#) Congress to pass the “Development, Relief, and Education for Alien Minors (DREAM) Act of 2017” (S. 1615), which would offer a bicameral, bipartisan solution for the undocumented children and young adults who have been protected under the DACA program. Most recently, in July 2019, the AMA, along with approximately 70 other health care organizations, voiced our [support](#) for the American Dream and Promise Act of 2019 (H.R.6) and the Sens. Graham/Durbin sponsored Dream Act of 2019 (S.874). The AMA worked with the Association of American Medical Colleges (AAMC) to file an [amicus brief](#) with the U.S. Supreme Court related to the impact of changes in DACA policy on physicians. The U.S. Supreme Court will hear arguments on November 12, 2019.

Vaccinations

In September 2019, the AMA [wrote](#) the Administration expressing deep concern that asylum seekers and other immigrants detained by CBP were not given appropriate medical care, including preventive vaccinations. The letter strongly urges the Administration to allow asylum-seekers to receive all medically-appropriate care, including vaccinations, in a patient-centered, language, and culturally-appropriate way upon presentation for asylum regardless of country of origin.

Mental Health of Unaccompanied Children in HHS Custody

On September 18, 2019, the AMA submitted a [letter](#) to the U.S. House Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies regarding the hearing entitled, “Oversight Hearing: Mental Health Needs of Children in HHS Custody.” Specifically, the AMA voiced our concern that with the opening of additional HHS Office of Refugee Resettlement (ORR) shelters, immigrant minor children, in the custody of ORR could be administered psychotropic drugs despite the lack of evaluation by appropriate medical personnel, and potentially without parental or guardian consent or court order when the child is in no imminent danger to self or others, in violation of applicable laws. In that same letter the AMA also opposed the use of psychological records and social worker case files in immigration cases. A copy of the letter was also sent to the Administration.

Non-Military Deferred Action Requests

On September 6, 2019, the AMA sent a [letter](#) urging the DHS/U.S. Citizenship and Immigration Services (USCIS) to reverse its August 7, 2019 policy change that revoked its acceptance and adjudication of non-military deferred action requests at field offices. The AMA argued that this change in policy needlessly endangers vulnerable children and families who are seeking medical deferments from deportation due to serious illnesses or the need to receive life-saving medical treatments in the U.S.

USCIS has historically used deferred action, a form of prosecutorial discretion, to “provide limited relief to foreign nationals who do not qualify for other immigration benefits that are typically available to individuals in exigent circumstances.”² In recent years, this USCIS process has been used to account for the special circumstances of individuals suffering serious medical conditions. Medical deferred action in particular uses prosecutorial discretion to appropriately allow for USCIS to defer and deprioritize the deportation of an individual present in the U.S. while receiving medical treatment.³ The AMA argued in its letter that the discontinuation of medical deferred action will lead to the termination of needed care for vulnerable patients.

On September 11, 2019, the House Committee on Oversight and Reform held a hearing titled, “The Administration’s Apparent Revocation of Medical Deferred Action for Critically Ill Children.” The AMA submitted a copy of our September 6 letter to the Committee. On September 19, 2019, due to overwhelming public pressure, the Administration [reversed](#) its policy.

Public Charge

U.S. Department of Homeland Security Rule

On Saturday, September 22, 2018, DHS posted an unofficial draft Notice of Proposed Rulemaking (NPRM) regarding the Inadmissibility on Public Charge Grounds, and the AMA quickly responded with a [press statement](#) in opposition. On October 10, 2018, the Administration released its formal proposed rule regarding the Inadmissibility on Public Charge Grounds. The proposal denies entry or permanent legal status for noncitizens who may receive one or more public benefits including, for the first time, non-emergency Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and several public housing programs. Consistent with AMA policy adopted during the 2018 Annual Meeting, the AMA submitted a [comment letter](#) in opposition of the proposed rule. The Administration published its [final rule](#) on August 14, 2019.

On October 11, 2019, judges in separate cases before the U.S. District Courts for the Southern District of New York (SDNY) and Eastern District of Washington preliminarily enjoined the DHS from implementing and enforcing the [final rule](#) related to the public charge ground of inadmissibility. The public charge rule has already had a chilling effect, leading many immigrant families to avoid accessing vital health, nutrition and housing programs. The AMA joined with other health care organizations in submitting amicus briefs (SDNY: [amicus 1](#) and [amicus 2](#); Wash.: [amicus](#)) in the separate cases. The DHS’ final rule was slated to take effect on October 15, 2019, but two of the injunctions are nationwide and prevent the DHS from implementing the rule anywhere in the U.S. until there is final resolution in the cases. Linked [here](#) is a brief overview of the public charge test.

U.S. Department of State Rule

On October 11, 2019, the U.S. Department of State (DoS) issued an [interim final rule](#) updating its definition of public charge to align its procedures with DHS’ public charge final rule. On October 24, 2019, the DoS published a request for public comment on the [form DS-5540](#) or the public charge questionnaire. The DoS proposes to use the public charge questionnaire “to collect more detailed information on a visa applicant’s ability to support himself or herself. Consular officers will use the information to assess whether the applicant is likely to become a public charge [at any time], based on the totality of the circumstances.” On October 30, 2019, the DoS issued a “Notice of Information Collection Under OMB Emergency Review: Immigrant Health Insurance Coverage.” The DoS gave the public approximately 48-hours to comment on the collection of information included in the emergency notice regarding the DoS’ ability to collect information from visa applicants regarding the Presidential Proclamation (see more on the Presidential Proclamation below). As a result, the AMA submitted a [comment letter](#) to the DoS opposing the interim final rule, the expansion of the public charge questionnaire, and the information collection request related to the Presidential Proclamation.

U.S. Department of Justice Rule

The U.S. Department of Justice (DOJ), which oversees immigration courts and the Board of Immigration Appeals, is expected to publish a proposed rule that addresses the public charge deportability ground based on the DHS’ public charge final rule. The DOJ rule could potentially make it easier for the Administration to deport legal immigrants who use certain public benefits such as Medicaid. Once publicly released, the AMA will review the proposal to determine if a comment letter is warranted.

Presidential Proclamation

On October 4, 2019, the President issued a [Proclamation](#) that, beginning November 3, 2019, the U.S. would restrict legal immigration into this country by people who are uninsured and cannot pay the costs of their health care. It is our understanding that this restriction, would operate independently of the “public charge” determination. The AMA is extremely concerned about the proclamation’s potential negative impact on individuals and families, who are legally

immigrating to the U.S., to access health care services. The AMA submitted a [letter](#) to the President of the United States strongly urging him to rescind the proclamation. [Linked here](#) is a [brief overview](#) of the proclamation.

On November 2, 2019, a federal judge in Oregon blocked the Presidential Proclamation from taking effect for up to 28 days. The civil rights organizations behind the initial lawsuit must file, by November 8, 2019, a request to block the proclamation for a longer time period, while litigation continues.

REFERENCES

1. If a parent traveling with their child was accepted for prosecution by DOJ under Zero Tolerance, and thus, transferred to U.S. Marshals Service custody, the child could not remain with the parent during criminal proceedings and the service of any potential sentence upon conviction. That child would then be placed in the care of the HHS Office of Refugee Resettlement (ORR) to arrange for safe, longer-term placement of the child pending immigration proceedings.
2. <https://www.dhs.gov/xlibrary/assets/cisomb-combined-dar.pdf>
3. Id.

REPORT OF THE SPEAKERS

The following report was presented by Bruce A. Scott, MD, Speaker, and Lisa Bohman Egbert, MD, Vice Speaker.

1. SPEAKERS' REPORT: TASK FORCE ON ELECTION REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At this past June's meeting the House of Delegates adopted [policy](#) calling for the Speaker to appoint a task force that would recommend improvements to our AMA's election processes. The following members were appointed to the task force:

- Jenni Barlotti-Telesz, MD, American Society of Anesthesiologists
- Richard Evans, MD, Maine
- James Hay, MD, California
- Dan Heinemann, MD, American Academy of Family Physicians
- David Henkes, MD, Texas
- Jessica Krant, MD, American Society for Dermatologic Surgery
- Josh Lesko, MD, Resident Physician, Virginia
- John Poole, MD, New Jersey
- Karthik Sarma, immediate past medical student trustee
- Stephen Tharp, MD, Indiana
- Jordan Warchol, MD, MPH, Nebraska
- Bruce Scott, MD, Speaker, Kentucky
- Lisa Bohman Egbert, MD, Vice Speaker, Ohio

Interest in the task force was high, with more than 60 requests to serve. Selection was based primarily on experience with AMA elections, either as a candidate or part of a campaign committee, and most members had been involved multiple times and in multiple ways. Consideration was also given to ensuring a broad cross section of the House of Delegates.

BACKGROUND

The task force is not yet prepared to propose specific changes to the election rules, but rather is seeking broad input from the HOD. This report describes activities undertaken since the task force was launched and outlines topics that have been discussed among members. Your speakers have arranged for an open forum to be held during the Interim Meeting to solicit thoughts across topics outlined below. A report with recommendations should be expected at the 2020 Annual Meeting.

Current election rules are found in both AMA bylaws and policy (see [Appendix A](#)) but are also dependent on Speaker rulings and discretion (eg, the cap on expenditures for giveaways). Chief among expressed concerns were the expense and time invested in campaigns, but also mentioned were associated effects such as decisions by otherwise qualified candidates to not seek office and the limiting effect of election-related activities on the ability to fully address policy matters. In the view of the task force, costs are real, measured not only in dollars but in time, distractions and stress. Moreover, these costs are shared by both candidates and the larger House.

The task force is assessing the entirety of our election process, and while recommendations are forthcoming next June, the task force would note that its primary goal is to ensure that the best candidates are selected as AMA's leaders in free and fair elections and in furtherance of AMA's "Guiding [principles](#) for House Elections." For candidates, the task force hopes to make campaigns less expensive and more equitable, while removing obstacles that discourage qualified members from seeking election. At the same time, the task force seeks to ensure that electors constitute an informed electorate. While the task force believes the election process should not be unduly distracting from our policy discussions, we also recognize the importance of our elected leadership and believe it is appropriate for the House to spend time and focus on selecting these individuals.

Additionally, the task force holds that addressing our AMA's election rules should be an evolutionary process, with the task force's eventual recommendations only a step along a path that is sensitive to changes in technology, the needs of the profession, the diversity of AMA membership and the makeup of the House of Delegates. That said, the task force does not mean to suggest that it should be an ongoing entity. Rather changes should henceforth be organic.

For example, in some of the task force discussions questions arose about the value of certain actions or activities that more often than not are part of most candidates' election efforts. The consensus within the task force is that many of these actions add little, if any, value to a candidate's likelihood of election, but candidates or their supporters are hesitant to not continue the activity because "everyone does it." From the perspective of the task force, one would hope that both rules and practice would be modified over time when new norms become the standard.

Task Force Activity

After it was formed, the task force engaged in a series of email exchanges on multiple election-related topics; those have continued even with the approach of the Interim Meeting. Typically, the Speaker, Dr. Scott, proposed a relatively narrow item for discussion, with his initial question directed to all members of the task force and responses shared across the group. As an example, one of the early discussions dealt with the giveaways that are included in the not for official business bag at the opening session of the Annual Meeting. Each discussion thread was conducted independently and allowed to conclude naturally.

The task force also met face to face and will be meeting again during the Interim Meeting. The in-person meetings afford an opportunity for the members to interact and discuss ideas and concerns about more conceptual ideas, not easily handled by email because nuance and slight alterations can affect the ensuing dialog.

ITEMS FOR CONSIDERATION

The task force has discussed and would like input on multiple items, but it should be noted that inclusion on this list does not imply that the task force has concluded its discussion of the matter or that they have adopted a position.

Note in each area of consideration you will find highlighted questions to be discussed at the open forum. These should not be considered as all-inclusive or in any way exclusive of other comments. Open discussion of each topic is welcome.

Additionally, [Appendix B](#) includes a list of topics that will be discussed in the open forum.

Interviews

It is common for candidates to be interviewed by literally dozens of caucuses and delegations. This process stretches over several days and has been described as "grueling." Delegations and interview committees spend considerable time listening and evaluating candidates. Some complain that these presentations interrupt their policy discussions and delegates report hearing redundant presentations (others report hearing conflicting comments from some candidates in different venues). While there is no question that this process is time consuming for both the candidates and those interviewing them, others defend this as "the most important way candidates are vetted."

The Office of House of Delegates Affairs currently schedules 10-minute interviews for officer candidates in contested elections. Those interviews are scheduled only with geographic caucuses, because scheduling interviews with every interested group would be prohibitively complex and time consuming. Nonetheless, other groups can and do schedule interviews with officer candidates, and candidates in council elections are scheduled either by the interviewing group or the candidates themselves (or their campaign team). Some delegations employ committees to conduct candidate interviews, with the committee's recommendation then provided to members of that delegation (or caucus). Other groups and caucuses allow candidates to present to the entire delegation. Still other delegations handle officer and council candidates differently.

Open Forum Topic #1

The election task force wants to hear what changes, if any, would improve the interview process. Should there be formalized interview forums (like currently held for president elect candidates) before the entire HOD or large assembly, perhaps just for officers or for all candidates? Would delegations support being

grouped together to reduce the number of interviews or do delegations want to continue their individual or small group interviews? What measures should be taken to ensure interviews are equally available to all candidates for a given position? Should council and officer candidates be handled differently? (this same question could be asked about subsequent topics as well)

Campaign expenses

One of the major areas of expressed concern regarding campaigns is the real or anticipated expense. While there is wide variability in the costs of campaigns and some would argue that big budgets don't necessarily lead to election, it has been said that there are individuals that do not seek election because of the anticipated cost. Some delegations have more resources available than others, but most all associations are facing increasing budgetary concerns. In fact, financial concerns have been stated as a reason for some societies to not fill their entire delegation. Budgetary considerations should not be a deciding factor in the election of candidates.

Strict limits on campaign expense or required transparency of expenditures have been recommended to the task force. It is difficult to measure actual expenditures particularly for larger delegations that routinely have receptions, suites, dinners and giveaways. Some delegations are willing and able to spend more on campaigns. Some candidates have more available resources whether financial or otherwise (eg, web design expertise, video studio,) from their family, friends or medical association.

Open Forum Topic #2

Should there be a limit on campaign expense or required reporting? How would actual expenditures be accurately measured and reported? Is there a true correlation between expenditure and election? The possibility of "public funding" of elections has been raised – how would the funds be raised and distributed? Should AMA be expected to finance the election process? Would delegations be willing to share expense per capita or otherwise?

Campaign receptions

Campaign receptions are likely the largest single expenditure for most campaigns, with estimates ranging upward from \$20,000 and the overall cost dependent on decorations and refreshments, and some costs are shared across a caucus. Providing alcohol is already prohibited by the rules, which serves to some extent to limit the cost. While candidates have been elected without a reception (and others with well attended, elaborate receptions have not been elected) some may be deterred from running because of the perceived need for a reception and the anticipated expense. These continue to be well attended and candidates seem to have no hesitation (and feel welcome) attending other receptions, even that of their opponents, so there seems to be little exclusivity. While there is no question that most, if not all, open receptions have a campaign component, conversations typically include policy discussions and valued social interaction. Some have complained about long receiving lines that delay mingling and constructive discussion.

Open Forum Topic #3

Is there an option that would provide the opportunity for candidates to interact with a broad range of delegates outside the formal interviews and at the same time provide social interaction for others to encourage their attendance? Could individual receptions be replaced by a joint reception or perhaps separate receptions for different categories of candidates (eg, officers versus council candidates)? Some states and regional delegations have parties every year, with or without a candidate (eg, ice cream social, chili, chowder or wine tasting). If a general reception were offered, should separate receptions be allowed? If receptions are continued should receiving lines be discouraged or should this decision be left to the host?

Campaign memorabilia

Giveaways or gifts: Our current rules allow the Speaker to set an expenditure limit for the giveaways that are distributed via the not for official business bag or at a party. The limit is calculated on a per capita basis given the number of delegates and alternate delegates. This past June the aggregate limit was \$3200. Although not one of the larger campaign expenses, every dollar counts particularly for candidates with limited budgets. Many would say that while they enjoy the treats that this is not a factor in their vote; others argue these allow candidates to display their individuality and draw attention to literature that is often attached.

Open Forum Topic #4

Should gifts be “discouraged” or even disallowed altogether? What if a state wants to provide a gift that is not “tied to” a candidate? Some states put something in the bag or distribute a gift that they believe represents their state even when they don’t have a candidate (eg, Virginia peanuts, New England lobsters).

Pins, buttons and stickers: The rules separate pins, buttons and stickers from campaign giveaways, noting that they do not count against spending limits, but the rules also say they should be simple. Although not a major expenditure, concerns have arisen around their distribution and appropriateness for a professional association. Some individuals feel pressured to wear stickers and object to “forced stickering,” while others say that the stickers are used as a conversation starter and allow one to display their support for a candidate.

Open Forum Topic #5

Should pins / buttons / stickers be disallowed? Several specialty societies and some states have pins or stickers that may not necessarily include a candidate’s name but may still be perceived as campaign material. Where do we draw the line?

Campaign literature

Campaign mailings preceding the Annual Meeting are common, and the not for official business bag is generally filled with campaign material. Some of the materials attest to the qualifications of a candidate, while others include little more than a photo and endorsement. Under current rules electronic (email) communications to members of the House “must allow recipients to opt out” of future messages. Considerable effort and funds are spent on creating and distributing this material. Some delegates read the material considering it an important source of information and have commented that it gives them a sense of the candidate’s personality and background. Others believe this is a waste of resources, particularly the printed material, and should be banned or at least switched to electronic only.

An AMA election manual has been prepared for the last 33 years and starting in 2016 has appeared exclusively in electronic form on our AMA’s [website](#). Candidates are responsible for the content of their submissions, but our AMA does minimal copy editing to ensure a consistent style. The manual is intended in part to reduce the need for other forms of communication as well as provide a level playing field.

Open Forum Topic #6

Does the election manual alone provide sufficient information? If technically feasible, should individuals be allowed to select electronic communications only or opt out of receiving campaign literature altogether? Do materials in the not for official business bag provide meaningful information or are they a waste of resources and should be discouraged or even disallowed?

Election process

Elections are scheduled on [Tuesday](#) morning at the Annual Meeting, and the initial round of voting is conducted before the House opens its business session that morning. Runoffs, if they are needed, are held in the House by paper ballot once ballots are prepared. Comments have been heard regarding the timing of the vote, including the day it should occur, along with suggestions to employ electronic voting for runoffs and concerns about the disruptions caused by runoffs and victory and concession speeches. Electronic voting will expedite runoffs (and potentially initial voting as well) and reduce disruption. Victory and concession speeches could be time limited. Any change to the day or time of the elections would likely require other adjustments to our typical schedule.

Open Forum Topic #7

The task force is interested in members’ comments about any aspect of the processes associated with the actual voting. Assuming technology can provide secure voting from delegate seats within the House, does the HOD support a move to electronic voting? What are the advantages and disadvantages of moving the day or time of the election? Should post-election speeches be time limited or even not allowed?

Other issues

The task force has received comments regarding “pop up” candidates – previously unannounced candidates that are nominated from the floor when a new opening is created by the election of a sitting council member or trustee to a higher office. These candidates do not receive the scrutiny of the normal election process yet are elected to a full term. Further concern was expressed that the potential of opening a new seat has become a strategy for election. It has been suggested that sitting council or board members with unexpired terms that are nominated for higher office be required to resign their current position thus opening their seat regardless of the outcome of their new election. This would provide for nominations for the opened seat to follow the normal election process but would truncate the service of experienced leaders and possibly lead to more individuals remaining in their seats for full terms reducing opportunity for new leadership. Others have suggested that the vacated seat remain open until the next annual election. Still others have noted that pop-up candidates choose to “pop-up” because of the opportunity to run for a desired office without the burden of the campaign expense.

Open Forum Topic #8

Do pop-up candidates distort the election process? Should our process of electing individuals for newly opened positions after regular nominations are closed be changed? If so, how?

Concerns have been expressed about suites, dinners and other gatherings that are in effect campaign events occurring at our annual meeting and before “official campaigning” is allowed (National Advocacy Conference, State Legislative Conference and Interim Meeting). These add considerable expense. It is difficult to determine when a gathering in a suite or a dinner is simply a social event for individuals to interact socially, which your task force believes is important, or a campaign event.

Open Forum Topic #9

Would a restriction that dinners be “Dutch treat” if an announced candidate was present be effective? How can we tell delegations they can’t entertain their friends or colleagues? Would restrictions on campaign receptions considered above actually drive more resources to these less regulated events?

Final discussion

The election task force believes that while the current election process certainly can and should be improved that the current elected AMA leadership retains our fullest confidence. Your speakers have noted that while there have been general comments about behavior that might be considered a violation of the rules, formal reports of violations have been remarkably few.

Finally, in reviewing the history of our election process the task force wondered how familiar candidates, delegates and alternate delegates are with our current election rules. Many of the expressed concerns including those regarding vote trading, block voting, caucuses attempting to direct individual delegate votes and negative campaigning are contrary to our current “Guiding Principles.” Perhaps adherence to the policies and rules previously adopted by the HOD should be given greater emphasis. While one would hope that professionalism alone would demand compliance, the challenge for many of the concerns is surveillance and enforcement. We encourage everyone to review the current rules and principles listed in the appendix of this report.

Open Forum Topic #10

The question arises should election reforms simply discourage undesirable behavior or attempt to prohibit such behavior. The task force welcomes comments regarding monitoring and enforcement of what are often considered the most problematic potential violations which are also those most difficult to track and prevent.

CONCLUSION

The election task force seeks the appropriate balance between an informed electorate who are selecting the best candidates after adequate exposure and proper opportunity for due diligence while eliminating obstacles, particularly those that do not add to the selection of the most qualified candidates. We understand that any recommended changes to our election process must ensure that the best candidates are selected as AMA’s leaders in free and fair elections.

This report is meant as informational only. The task force has discussed all the issues detailed here and more. We have planned an open forum at Interim 2019 and look forward to hearing from members of the House. While the agenda of the open forum will include discussion of the topics highlighted above, these are not meant to be totally inclusive and certainly not exclusive. Within discussion of each of these topics we hope to hear what the HOD believes should be retained, modified or eliminated. What do delegates value, what helps you make an informed decision on the best candidates, how to balance distractions from policy discussion with appropriate attention on election of leaders? For candidates what can be done to remove obstacles and create a fair, equitable campaign? We will include time for additional comments on issues not detailed here and we continue to welcome written comments from individuals and delegations.

APPENDIX A – AMA Election-related policies

Policy G-610.031, Creation of an AMA Election Reform Committee

Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

Policy G-610.020, Rules for AMA Elections

- (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;
- (2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. The Speakers may use additional means to make delegates aware of those members intending to seek election;
- (3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;
- (4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;
- (5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;
- (6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;
- (7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

- (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;
- (9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;
- (10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;
- (11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);
- (12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;
- (13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;
- (14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and
- (15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy G-610.021, Guiding Principles for House Elections

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

- (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
- (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
- (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
- (4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
- (5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
- (6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

Policy G-610.030, Election Process

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

APPENDIX B – Topics for discussion during open forum.

This listing of topics and questions is not meant to be exhaustive. Rather it is illustrative, and other matters are welcome. An “open discussion” is included as the last topical section. Cutting across all topics, consider whether officer and council candidates should be treated differently.

See the text of the report for fuller discussion of each topic.

Topic 1 – Interviews

- Possibility of interview forums
- Reducing the number of interviews
- Equity of access to interviews across candidates in a race

Topic 2 – Campaign expenses

- Should expenses be limited / capped?
- Required reporting
- Public funding, i.e., AMA contributions and shared expenses among sponsors

Topic 3 – Campaign receptions

- Options to allow interaction with candidates
- Possibility of joint receptions
- Separate receptions for officers and council candidates
- Receiving lines
- Receptions with and without candidates

Topic 4 – Campaign memorabilia

- Giveaways – allowed or disallowed
- Gifts unrelated to campaigns

Topic 5 – Pins, buttons and stickers

- Allowed or disallowed
- Distribution and their role

Topic 6 – Campaign literature

- Mailings versus the election manual
- Option to choose electronic communications or to opt out of campaign literature
- Material in not-for-official-business bag

Topic 7 – Election process

- Day and time of election
- Secure voting from delegate seats using electronic devices
- Thank you and concession speeches

Topic 8 – Pop-up candidates

- A distortion of the process?
- Filling new vacancies

Topic 9 – Suites, dinners and gatherings

- “Dutch treat” dinners if a candidate is present
- Would rules changes for receptions lead to more campaign suites and dinners?

Topic 10 – Monitoring and enforcing rules

- Appropriate monitoring of rules
- Role of professionalism relative to active enforcement of rules

Topic 11 – Open discussion of any topic