MSMA Council
July 14, 2019 – 8:30 a.m.
Paradise C
Margaritaville Resort
Osage Beach, Missouri

AGENDA

1. Approval of the minutes of the April 7, 2019, meeting
2. Remarks of the President – James DiRenna, DO
4. Report of the Budget & Finance Committee – David Pohl, MD
5. Report of the Executive Vice President – Patrick Mills
7. Report of the Commission on Continuing Education
8. Report of the Committee on Legislative Affairs
9. Actions and Recommendations on Resolutions from the 2019 Annual Meeting
10. Report of the Membership Committee – Joseph Corrado, MD
11. Report of the Physicians Health Committee
12. Report of the MSMA Alliance
13. Councilor Appointments
14. Reports of the Councilors
15. AMA Report – Edmond Cabbabe, MD
16. Prerogatives of the Chair
Meeting Schedule – July 13-14, 2019, Council Meeting

Saturday, July 13, 2019

MSMA Legislative Committee – 4:00-5:30 pm – Nautical Wheeler
MSMA Council Reception & Dinner – 6:30 pm – Windgate 62/63

Sunday, July 14, 2019

Council Executive Session – 8:00 am – Paradise C
MSMA Council Meeting – 8:30 am – Paradise C
MSMA Council

April 7, 2019
Century Ballroom
Westin Kansas City at Crown Center Hotel
Kansas City, Missouri

Presiding: James DiRenna, Jr., DO – President

Present: Sandra Ahlum, MD, Hannibal; Clark Andelin, MD, Mexico; Hossein Behniaye, MD, Hannibal; Scott Berndt, University of Missouri-Columbia; Brian Biggers, MD, Springfield; Robert Brennan, Jr., MD, St. Louis; Edmond Cabbabe, MD, St. Louis; Robert Corder, MD, St. Joseph; Joseph Corrado, MD, Mexico; Diana Corzine, St. Joseph; Louis DelCampo, MD, Springfield; Betty Drees, MD, Kansas City; Fola Fasuyi, MD, Rolla; Lancer Gates, DO, Kansas City; Rebecca Hierholzer, Leawood, KS; Alexander Hover, MD, Ozark; George Hruza, MD, Chesterfield; George Hubbell, MD, Lake Ozark; Priya Jain, University of Missouri-Kansas City; Ravi Johar, MD, Chesterfield; Sri Kolli, MD, Fenton; David Kuhlmann, MD, Sedalia; Joanne Loethen, MD, Leawood, KS; Warren Lovinger, Jr., MD, Nevada; Samantha Lund, Washington University; Michael O’Dell, MD, Kansas City; Sam Page, MD, Creve Coeur; David Pohl, MD, Town & Country; Keith Ratcliff, MD, Washington; Inderjit Singh, MD, St. Louis; Matthew Stinson, MD, Springfield; Christopher Swingle, DO, St. Louis; Marc Taormina, MD, Lee’s Summit; Lisa Thomas, MD, Columbia; Amanda Turner, MD, Nevada; Douglas Wallace, MD, Cape Girardeau; Sharon Wallace, MD, Cape Girardeau; Gill Waltman, St. Louis; Tom Weigand, MD, St. Joseph; Kevin Weikart, MD, Lake St. Louis; Daniel Young, MD, St. Louis; Lirong Zhu, MD, Rolla; MSMA Staff – Patrick Mills, Liz Fleenor, Stephen Foutes, Heidi Geisbuhler, Jeff Howell, Sarah Luebbert, Cheri Martin, Benita Stennis and Haley Wansing, Jefferson City.

On motion, duly seconded, Alexander Hover, MD, Ozark, was elected Council Chair.

On motion, duly seconded, George Hubbell, MD, Lake Ozark, was elected Council Vice Chair.

On motion, duly seconded, Brian Biggers, MD, Springfield, was elected MSMA Secretary.

On motion, duly seconded, David Pohl, MD, Chesterfield, was elected MSMA Treasurer.

On motion, duly seconded, Christopher Swingle, DO, St. Louis, was elected to fill the position of Councilor – District 3, as Dr. George Hruza moves to the position of President Elect.
Budget and Finance Committee – MSMA President, Dr. James DiRenna, appointed the following to serve on the 2019-2020 Budget and Finance Committee: David Pohl, MD, Chesterfield, Chair, Treasurer; Joseph Corrado, MD, Mexico, Past President; George Hruza, MD, Chesterfield, President Elect; Brian Biggers, MD, Springfield, Secretary; Alexander Hover, MD, Springfield, Council Chair; George Hubbell, MD, Lake Ozark, Council Vice Chair; Michael Weaver, MD, Kansas City, 1st Vice President; James DiRenna, DO, Gladstone, Vice Chair.

MSMA Insurance Agency – On motion, duly seconded, the following were elected to the MSMA Insurance Board of Directors, with the term to expire in 2022: Brian Biggers, MD, Springfield.

Next Council Meeting – The next MSMA Council meeting will be held July 13-14, 2019, at Tan-Tar-A Resort, Osage Beach, Missouri.

On motion, duly seconded, the meeting was adjourned.
MSMA Executive Committee Meeting Minutes
Thursday, April 4, 2019
Westin Crown Center Hotel
Kansas City, Missouri

Presiding:  Joe Corrado, MD

Present:    Drs. Jim DiRenna, George Hruza, Alex Hover, David Pohl, Brian Biggers, Warren Lovinger, and Mike Bukstein and Mr. Patrick Mills, MSMA Staff

The MSMA Executive Committee met at 3:40 p.m., Thursday, April 4, 2019, at the Westin Crown Center Hotel in Kansas City, MO, and addressed the following:

1. Approved the Minutes of the meeting of January 12, 2019.

2. Received an update on MSMA Reserves

3. Received a report on MSMA membership.

4. Approved the audit of MSMA.

5. Received an update on Medicaid changes including a Nov 2020 ballot initiative to move eligibility to 138% of federal poverty level.

6. Received an update on MSMA operations and physician outreach plans.

7. Approved a motion to adjourn.
MSMA Executive Committee Meeting Minutes
July 2, 2019
Conference Call

Presiding: James DiRenna, DO

Present: Drs. Alex Hover, George Hubbell, David Pohl, Brian Biggers, Michael Weaver, and Joseph Corrado and Mr. Patrick Mills, MSMA Staff

The MSMA Executive Committee met at 6:00 p.m., Tuesday, July 2, 2019, by telephone conference call and addressed the following:

1. Approved the Minutes of the meeting of April 4, 2019.

2. Reviewed Executive Committee votes since the last MSMA Council meeting April 7:
   - Referred resolution #1 CTE and resolution #7 Climate Change to the MSMA Legislative Committee
   - Created an ad hoc committee of the MSMA Council to review the Annual Convention

3. Received an update on MSMA membership

4. Received a report on MSMA reserves.

5. Approved negotiating the MSMA 2023 convention contract for two nights (Fri & Sat).

6. Approved a one-day exhibit hall at the MSMA 2020 convention with fewer exhibitors.

7. Approved supporting a Nov 2020 ballot initiative for Medicaid expansion.

8. Approved MSMA support of the MHA CMS Clinician Quality Improvement Collaboration.

9. Received an update on the Physicians Health Program and approved a review of the program.

10. Received an update on proposed Association Health Plan.

11. Received an update on SHINE.

12. Received an update on MSMA building maintenance projects.

13. Approved a motion to adjourn.
INTENT TO PARTICIPATE
Clinician Quality Improvement Contractor (CQIC)
Clinician-Focused Task Order Statement of Work
CMS 12th Scope of Work

Throughout the next five years, 117,000 community-based primary and specialty ambulatory care clinicians across the nation — with emphasis on clinicians serving rural or medically underserved areas — will have the opportunity to participate in large-scale quality improvement efforts through the Centers for Medicare & Medicaid Services.

Serving as health care quality improvement experts, CMS works with communities and providers in every care setting to support clinicians as they work to increase health care safety, engage patients to encourage self-management of chronic conditions, reduce health disparities, promote best practices for healthy living, and improve accessibility and affordability of care.

This new opportunity demonstrates CMS’ ongoing commitment to support clinicians in their quality improvement efforts and will focus on the following four high-priority areas to maximize impact on the health care system.

Aim 1: Improve Behavioral Health Outcomes, Including Focus on Decreased Opioid Misuse
Aim 2: Increase Patient Safety
Aim 3: Chronic Disease Self-Management (Cardiac and Vascular Health, Diabetes, Chronic Kidney Disease)
Aim 4: Increase Quality of Care Transition

Each CQIC will be asked to achieve targets for maximum reach under each aim.

In support of these efforts and as one of the Network of Quality Improvement and Innovation Contractors, the Missouri Hospital Association will submit a proposal in mid-July.
BUT FIRST, WE NEED YOUR INTENT TO PARTICIPATE!

REASONS TO PARTICIPATE

- Optimize health outcomes for your patients, reduce variation and improve clinical care
- Promote connectedness of care for your patients
- Learn from high performers how to effectively engage patients and families
- Spend more time caring for your patients
- Align your practice with new and emerging federal policies
- Participate with national leadership in practice transformation efforts
- Influence patient care and cost efficiencies

CLICK TO PARTICIPATE
Complete a nonbinding participation form.
MHA MODEL

The Missouri Hospital Association's approach will focus on the following areas.
1. Support quality improvement across a variety of settings.
2. Develop effective multidisciplinary interventions, scale best practices and foster innovation.
3. Improve patient safety in the ambulatory setting.
4. Provide data-driven methodologies, as change agents for health care transformation.

Technical support will be provided through:
• tailored support specific to the needs of the clinicians and practice
• improvement advisors to assist clinic personnel in developing clinic-specific goals and deploying solutions
• cohort-based networks allowing for sharing of best practices
• access to education, training and certifications
• toolkits, guidelines, checklists and assessment resources to implement process change
• clear action steps and tracking tools used to measure progress
• use of data to drive change through decision-making and evaluation
• facilitation by a team leader, office manager support and engagement in improvement projects
• convene collaborative(s) on specific topic areas and clinician education
• providing national-level subject matter expert support and benchmarking opportunities

Practice Assessment:
An assessment will be conducted to establish a baseline, determine readiness for transformation and identify the customized level of support needed to successfully achieve the goals set forth in this contract. Periodic reassessments will be conducted to determine progress toward collaborative goals and will be based on achievement of both quantitative and qualitative milestones.
July 3, 2019

Ms. Noemi Edwards, Contracting Officer  
Centers for Medicare & Medicaid Services  
OAGM/ASG/DQC  
7500 Security Boulevard, Mailstop B3-30-03  
Baltimore, MD 21244-1850

Dear Ms. Edwards:

On behalf of the Missouri State Medical Association (MSMA), I am pleased to provide this letter of support to the Missouri Hospital Association (MHA) in partnership with the Iowa Healthcare Collaborative (IHC). I am committed to supporting their proposal, as the Compass Clinician Quality Improvement Contractor (CQIC), in response to the Task Order Request for Proposal (TORP) No. 190630 for the Centers for Medicare & Medicaid Services (CMS) Network of Quality Improvement and Innovation Contractors (NQIIC) - Clinician-Focused Task Order. MSMA will actively support the four bold aims of this task order, incorporating education and technical support into existing physician outreach.

MSMA has been engaged with MHA since 2006 on numerous quality improvement projects such as opioid prescribing guidelines, maternal mortality and establishing the Missouri Center for Patient Safety.

MHA is a proven leader in regional health care transformation engaging patients, families, hospitals, providers, and communities in improvement efforts. MHA is recognized among national peers for achieving results through convening and facilitating collaboration to reduce harm and opioid use disorder; engaging patients; improving management of chronic diseases and integrating social determinants, health equity and trauma awareness to improve health outcomes. MHA has successfully implemented quality improvement programs that effectively promote value, efficiency, safety, and quality. The Clinician-Focused Task Order presents the opportunity to extend clinician quality improvement into Missouri and surrounding communities as MHA, a champion of health care transformation, joins the regional Compass Physician Transformation Network.

Thank you for your consideration of MHA and IHC. We look forward to supporting MHA, IHC and CMS in this effort. If you require additional information, please feel free to contact me at pmills@msma.org.

Sincerely,

Patrick Mills  
Executive Vice President
Be it resolved by the people of the State of Missouri that the Constitution be amended:

Article IV of the Constitution is revised by adding one new section to be known as Article IV, Section 36(c) to read as follows:

Section 36(c). 1. Notwithstanding any provision of law to the contrary, beginning July 1, 2021, individuals nineteen years of age or older and under sixty-five years of age who qualify for MO HealthNet services under 42 U.S.C. Section 1396a(a)(10)(A)(i)(VIII) and as set forth in 42 C.F.R. 435.119, and who have income at or below one hundred thirty-three percent of the federal poverty level plus five percent of the applicable family size as determined under 42 U.S.C. Section 1396a(e)(14) and as set forth in 42 C.F.R. 435.603, shall be eligible for medical assistance under MO HealthNet and shall receive coverage for the health benefits service package.

2. For purposes of this section, “health benefits service package” shall mean benefits covered by the MO HealthNet program as determined by the department of social services to meet the benchmark or benchmark-equivalent coverage requirement under 42 U.S.C. Section 1396a(k)(1) and any implementing regulations.

3. No later than March 1, 2021, the Department of Social Services and the MO HealthNet Division shall submit all state plan amendments necessary to implement this section to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

4. The Department of Social Services and the MO HealthNet Division shall take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section.

5. No greater or additional burdens or restrictions on eligibility or enrollment standards, methodologies, or practices shall be imposed on persons eligible for MO HealthNet services pursuant to this section than on any other population eligible for medical assistance.

6. All references to federal or state statutes, regulations or rules in this section shall be to the version of those statutes, regulations or rules that existed on January 1, 2019.
Chapter 208, RSMo, is amended by adding thereto one new section, to be known as section 208.207, to read as follows:

208.207. 1. Notwithstanding any provision of law to the contrary, beginning July 1, 2021, individuals nineteen years of age or older and under sixty-five years of age who qualify for MO HealthNet services under 42 U.S.C. Section 1396a(a)(10)(A)(i)(VIII) and as set forth in 42 C.F.R. 435.119, and who have income at or below one hundred thirty-three percent of the federal poverty level plus five percent of the applicable family size as determined under 42 U.S.C. Section 1396a(e)(14) and as set forth in 42 C.F.R. 435.603, shall be eligible for medical assistance under MO HealthNet and shall receive coverage for the health benefits service package.

2. For purposes of this section, “health benefits service package” shall mean benefits covered by the MO HealthNet program as determined by the department of social services to meet the benchmark or benchmark-equivalent coverage requirement under 42 U.S.C. Section 1396a(k)(1) and any implementing regulations.

3. No later than March 1, 2021, the Department of Social Services and the MO HealthNet Division shall submit all state plan amendments necessary to implement this section to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

4. The Department of Social Services and the MO HealthNet Division shall take all actions necessary to maximize federal financial participation in funding medical assistance pursuant to this section.

5. No greater or additional burdens or restrictions on eligibility or enrollment standards, methodologies, or practices shall be imposed on persons eligible for MO HealthNet services pursuant to this section than on any other population eligible for medical assistance.

6. All references to federal or state statutes, regulations or rules in this section shall be to the version of those statutes, regulations or rules that existed on January 1, 2019.
May 24, 2019

Honorable Michael L. Parson
State Capitol Building
PO Box 720
Jefferson City, MO 65102

Dear Governor Parson:

On behalf of the physicians, residents, and medical students who comprise the Missouri State Medical Association, I urge you to veto SB 147, which would repeal Missouri’s motorcycle helmet law.

Head injury is the leading cause of death in motorcycle accidents. While appropriate protective headgear does not prevent every head injury, the National Highway Traffic Safety Administration (NHTSA) reports that helmets are 67 percent effective in preventing brain injuries and 73 percent effective in preventing fatalities in motorcycle accidents.

It is well established that the cost of treating and caring for brain injury patients is astronomical. And that is a price all Missourians pay, whether it be through uncompensated care, state-funded care, or even higher insurance premiums. But the cost of medical care pales in comparison to the price of emotional pain and suffering borne by families and communities torn apart by a death or head injury that could have been prevented by a motorcycle helmet.

Missouri’s mandatory helmet law serves the state well, saving lives, preventing injuries, and saving countless dollars in unnecessary health care costs. Please do not permit this law to be repealed. Please veto SB 147.

Thank you for your consideration.

Sincerely,

James DiRenna, Jr, DO
President
June 3, 2019

The Honorable Mitch McConnell  The Honorable Charles Schumer
Majority Leader Minority Leader
United States Senate United States Senate
Washington, DC 20510 Washington, DC 20510

The Honorable Nancy Pelosi The Honorable Kevin McCarthy
Speaker Minority Leader
United States House of Representatives United States House of Representatives
Washington, DC 20515 Washington, DC 20515

Dear Leader McConnell, Leader Schumer, Speaker Pelosi and Leader McCarthy:

Since the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), the undersigned organizations have worked closely with both Congress and the Centers for Medicare and Medicaid Services (CMS) to promote a smooth implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). While MACRA represents an improvement over the flawed sustainable growth rate payment methodology and legacy quality and cost reporting programs, its implementation has been a significant undertaking for CMS and physicians. We strongly supported the improvements to MACRA included in the Bipartisan Budget Act of 2018, which allowed for a more gradual transition into the program and helped many physician practices avoid penalties they likely would have otherwise incurred under the MIPS program. However, further refinements are needed to improve the program and ensure physicians can be successful going forward.

In order to foster the continued success of MACRA, we urge Congress to implement positive payment adjustments for physicians to replace the payment freeze over the next six years, extend the Advanced APM bonus payments for an additional six years, and implement several additional technical improvements to MACRA, which are outlined below.

**Implement Annual Positive Payment Updates**
MACRA included modest positive payment updates in the Medicare Physician Fee Schedule, but it left a six-year 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 and 0.25 percent for physicians participating in APMs or MIPS, respectively. By contrast, other Medicare providers will continue to receive regular, more stable updates. As physician practice payments fall increasingly below their costs, patient access issues would arise.

The recent 2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds (Medicare Trustees Report) found that scheduled physician payment amounts are not expected to keep pace with increases in physicians' costs, which are forecast to average 2.2 percent per year in the long range. The *Medicare Trustees Report* also found that “absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.” We agree with this assessment—annual updates to the Medicare physician fee schedule need to reflect increases in practice costs, including compliance with health information technology regulations, quality reporting requirements, and a multitude of other regulatory requirements. According to CMS, current Medicare
physician fee schedule payments only cover approximately 60 percent of the direct costs that CMS agrees are typical in the provision of services. Therefore, we urge Congress to replace the upcoming physician pay freeze with a stable and sustainable revenue source that allows them to sustain their practice and provides a margin to invest in the practice improvements needed to transition to more efficient models of care delivery and better serve Medicare patients.

**Extend the Advanced APM Incentive Payments**

The undersigned organizations also urge Congress to extend the Advanced APM incentive payments for an additional six years. One goal of MACRA was to provide physicians with a glide path to transition into more innovative payment models. Changing the way physicians deliver care requires significant investment in new technologies, workflow systems, personnel and training. To help physicians implement these changes, MACRA provided a five percent incentive payment for the first six years of the program for physicians who participate in Advanced APMs.

These payments were intended to create a margin for physicians to invest in changing the way they deliver care. Unfortunately, there were a limited number of Advanced APMs in which physicians could participate during the first three MACRA performance years, and there are only three years left in the program for physicians to receive an APM incentive. The dearth of Advanced APMs available for physicians limited their ability to take advantage of the APM incentive that Congress provided to assist physicians with moving to new, innovative payment models. Therefore, the AMA urges Congress to extend the Advanced APM payments for an additional six years to provide physicians with an onramp to move to APMs once they become available, as intended in the original legislation.

**Implement Technical Improvements**

The undersigned organizations urge Congress to continue to engage with the medical community to make additional technical changes to MACRA. There are numerous creative solutions that could be implemented to simplify MIPS and make reporting more clinically meaningful for physicians. For example, Congress and CMS could make the program more cohesive by allowing physicians to focus their participation around a specific episode of care, condition, or public health priority. By allowing physicians to focus on activities that fit within their workflow and address their patient population’s needs, rather than segregated measures divided into four disparate MIPS categories, the program would be more likely to improve quality of care for patients, reduce Medicare spending, and be more meaningful and less burdensome for physicians.

CMS should also have explicit 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. This provision could also allow CMS to award bonus points at the composite score level, which would allow for a simplified scoring methodology. The primary goal of this approach is to allow physicians to spend less time on reporting and more time with patients and on improving care, and to create a more sustainable MIPS program. It also creates a glide path towards participation in APMs by encouraging physicians to focus on more clinically relevant measures and activities, improvement, and providing better value care to patients.
Other technical changes we urge Congress to pass to improve MACRA include:

- eliminating the requirement to set the MIPS performance threshold at the mean or median so CMS, rather than a pre-set formula, can determine whether physicians are ready to move to an increased threshold based on available data;
- allowing CMS to develop multiple performance thresholds, such as one for small and rural practices, to ensure a level playing field for all physicians;
- giving CMS authority to revise the participation thresholds needed to achieve Qualified Participant status for those participating in Advanced APMs;
- excluding Part B drug spending from calculations of APM financial risk, which would be analogous to technical corrections to MIPS made in the Bipartisan Budget Act of 2018;
- updating the Promoting Interoperability performance category to allow physicians to use certified electronic health record technology (CEHRT), health information technology that interacts with CEHRT, or a qualified clinical data registry (or a combination of all three technologies);
- prioritizing cost measures that are valid, reliable, and demonstrate variation by removing the requirement that episode-based cost measures account for half of all expenditures under Medicare Parts A and B;
- removing the total cost of care measure mandate as the existing measure is flawed and risks holding physicians accountable for costs that are outside their control, such as drug prices;
- allowing pay-for-reporting on new measures or when significant refinements to a measure or composite have been made (precedent already exists for introducing measures via pay-for-reporting in other value-based purchasing programs);
- providing authority for the Physician-focused Payment Model Technical Advisory Committee to provide technical assistance and data analyses to stakeholders who are developing proposals for its review; and
- aligning and improving the methodologies of MIPS and Physician Compare, as physicians currently receive two different scores and reports, which is confusing to physicians and patients and does not lead to quality improvement.

We appreciate your attention to these issues and look forward to working with you and your colleagues to foster the success of MACRA.

Sincerely,

American Medical Association
Advocacy Council of ACAAI
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Physical Medicine & Rehabilitation
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Geriatrics Society
American Medical Women’s Association
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Echocardiography
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Clinical Oncology
American Society of Dermatopathology
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urogynecologic Society
American Urological Association
American Vein and Lymphatic Society
Association of American Medical Colleges
Association of University Radiologists
College of American Pathologists
Congress of Neurological Surgeons
Endocrine Society
Infectious Diseases Society of America
International Society for the Advancement of Spine Surgery
Medical Group Management Association
North American Neuromodulation Society
North American Neuro-Ophthalmology Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
   Society for Vascular Surgery
Society of Cardiovascular Computed Tomography
   Society of Critical Care Medicine
Society of Gynecologic Oncology
   Society of Hospital Medicine
Society of Interventional Radiology
   Spine Intervention Society
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
   Alaska State Medical Association
   Arizona Medical Association
   Arkansas Medical Society
   California Medical Association
   Colorado Medical Society
   Connecticut State Medical Society
   Medical Society of Delaware
Medical Society of the District of Columbia
   Florida Medical Association Inc
   Medical Association of Georgia
   Hawaii Medical Association
   Idaho Medical Association
   Illinois State Medical Society
   Indiana State Medical Association
   Iowa Medical Society
   Kansas Medical Society
   Kentucky Medical Association
   Louisiana State Medical Society
   Maine Medical Association
MedChi, The Maryland State Medical Society
   Massachusetts Medical Society
   Michigan State Medical Society
   Minnesota Medical Association
   Mississippi State Medical Association
   Missouri State Medical Association
   Montana Medical Association
   Nebraska Medical Association
   Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

Dear Representatives Ruiz and Roe:

On behalf of the undersigned state and national medical specialty organizations, we are writing to express our appreciation for, and support of, the “Protecting People from Surprise Medical Bills Act of 2019.” We are united in our desire to protect patients from unanticipated (“surprise”) out-of-network medical bills in cases where their health insurance plan’s network and circumstances left them no meaningful opportunity to select in-network physicians, such as in emergencies or when receiving care from physicians not usually directly selected by patients like anesthesiologists, radiologists, pathologists, or on-call specialists.

We appreciate that your legislation meets this goal by taking a balanced and proven approach to reconciling differences between physician charges and plan payments while at the same time protecting the patient by removing them completely from the dispute. Your approach, modeled on the successful law in New York State, provides for an independent dispute resolution (IDR) process whereby a neutral third party chooses between the physician charge or the plan’s initial payment amount. This “baseball style” arbitration is efficient and encourages both parties to make reasonable offers at the outset.

Furthermore, the IDR entity shall consider a wide variety of factors, including the 80th percentile of actual charges for the geographic area in which the service was provided as determined by an independent medical claims database. The bill also provides for important transparency requirements so that patients can better understand which providers are included in their networks and how frequently their plans pay or deny claims.

Again, we appreciate your considerable efforts to protect patients from surprise medical bills and we look forward to supporting your continued work in addressing this important issue.

Sincerely,

SUMMARY OF THE PROPOSED BILL FOR REFERENCE ONLY PROVIDED BY REP. RUIZ’S OFFICE (will not be included in final letter):

Protecting People From Surprise Medical Bills Act
Congressman Ruiz, M.D.
Section by Section

Section 1:
Title
“Protecting People From Surprise Medical Bills Act”

Section 2:
Prohibition on Surprise Balance Billing
Out-of-network (OON) providers will no longer be permitted to balance bill a patient for unanticipated out-of-network care, which includes the following situations:

- Emergency care in both in-network and out-of-network facilities
- Scheduled anticipated care with unanticipated out-of-network providers
- Out-of-network after-emergency care when a patient cannot travel without medical transport
- Out-of-network imaging or lab services when ordered by an in-network provider

The patient shall not be liable to pay the insurer any amount in excess of the applicable in-network cost-sharing amount and deductible, and the insurer or provider shall not bill any such excess payment. Entities who violate the ban and balance bill a patient will be subject to civil monetary damages if the patient has not been reimbursed the amount that they were balanced billed within 30 days of the entity being made aware of the error.

**Initial payment**
The plan/issuer will pay the provider a commercially reasonable rate within 30 days.

**Direct Negotiation**
If either party is dissatisfied with that amount, they will have 30 days to privately settle on a payment amount.

**Establishment of Independent Dispute Resolution (IDR) Process**
If no agreement between the parties is met, either party may trigger the independent dispute resolution (IDR) process described below.

The Secretaries of HHS and Labor shall establish an IDR process for resolving disputes between health plans and out-of-network providers for emergency services or unanticipated care rendered to enrollees.

The patient will be completely out of the process and will only be billed for their in-network cost-sharing rates.

The IDR is “baseball style” – the arbiter will select either the initial provider charge or the payment that the plan initially paid the provider, whichever they deem to be more reasonable.

If the parties reach a settlement prior to completion of the arbitration process, then they split the costs of the process. Any payment owed by one party to the other must be made within 15 calendar days.

HHS shall maintain a database of arbitrators (which responsibility may be delegated to the American Arbitration Association or to a state that already undertakes a similar function) who are qualified to resolve billing disputes of this nature and are unbiased and free from actual or potential conflicts of interest.

Providers shall be permitted to submit multiple claims of identical code(s) from a single site of service for simultaneous consideration under the arbitration process. The dates of service for these claims shall occur within 60 days of each other.
Once arbitration is requested, the arbitration process shall be completed within sixty (60) days; this timeframe includes 30 days for both parties to submit information and data and 30 days for the arbiter to render a decision.

Providers/issuers may submit supporting documents, and the IDR entity shall consider:

- The usual and customary cost of the service, which is defined as 80th percentile of charges for comparable services for that specialty in the geographical area in which the services were rendered, determined through reference to an independent medical claims database;
- If previously contracted, the history of commercial network contracting between the plan and the provider, including the prior in-network rates;
- The training and specialization of the provider, as well as the characteristics of the practice setting (including the acuity level and cost intensity);
- The provider’s quality and outcome metrics;
- The circumstances and complexity of the case, including time of the service;
- The physician’s usual charge for comparable services with regard to patients in health care plans in which the physician is not participating;
- If there is a wide discrepancy between what the plan is attempting to pay this OON provider vs. other OON providers and between what the provider is charging for this OON patient vs. other OON patients;
- Individual patient characteristics; and
- Other economic and clinical circumstances relevant to the case.

The final judgment of the arbitrator on the reasonable amount shall be binding and enforceable in any court with subject matter jurisdiction, and not subject to appeal unless it is determined that fraudulent or corrupt actions have been taken by any of the parties involved in the IDR process.

Section 3:
Deductible transparency
A health plan/issuer shall clearly print in-network and out-of-network deductible amounts on insurance cards distributed to the beneficiaries.

Section 4:
Transparency for In-Network Patients
The Secretary shall establish transparency standards to provide better information to covered patients about which providers are in-network of the covered plan. Such standards shall include at a minimum a requirement that plans offer provider directories online and in print; annual audits of provider directories; monthly updates of the online directory; and disclosures on accuracy of the print directories.

A patient cannot be held responsible for out-of-network costs if the patient could not have reasonably known they were out-of-network because insurers are not compliant. For example, if a patient checks the website and verifies with the plan that they are in-network, they cannot be balance billed if that turns out not to be true.

Section 5:
Reporting Requirements
Each group health plan and issuer must submit the following information annually to the Secretary of HHS and Secretary of Labor:
• The number of claims submitted by in-network providers, including how many of those claims were paid and how many were denied;
• The number of claims submitted by out-of-network providers, including how many of those claims were paid and how many were denied;
• Patient out-of-pocket costs for out-of-network services; and
• For unanticipated care out-of-pocket claims, how many of the claims are for emergency care and how many are for out-of-network care in an in-network facility.

Section 6: Impact Study
No later than 3 years after enactment, the Secretary of HHS shall report to Congress an analysis of the following effects of this statute:
• Financial impact on cost-sharing and overall health care spending;
• The incidence and prevalence of unanticipated out-of-network care broken down by type – emergency care vs. out-of-network care in an in-network facility;
• Network adequacy;
• Comparison of claims databases used and the impact on reimbursement rates;
• Number of bills that are settled in direct negotiation and the number that go to IDR;
• Administrative cost of IDR; and
• Impact of IDR on premiums and deductibles

Section 7: Billing feasibility study
The Secretary of HHS will conduct a feasibility study on the provision of a single bill for all services provided for a single episode of care.

Section 8: Scope and Applicability to States with Surprise Billing Laws
This act shall apply to all self-funded plans and Federal Employees Health Benefits Program plans, and to all fully-insured plans in states that do not have balanced billing laws or regulations. States do not have to use the IDR framework but must include the patient protections included in section 2 of this legislation regarding cost to patients.

Section 9: Billing Statute of Limitation
A patient cannot be billed for the first time for any services after one year of services rendered by either the provider or the payer.

Section 10: Effective Date
The Secretary of Labor and Secretary of Health and Human Services shall promulgate regulations pertaining to this law within one year of enactment. The provisions of this bill shall be effective for plans and providers starting on the January 1st that occurs after one year after enactment.

Section 11: Publication
HHS shall publish results of arbitration by geographic region in order to give more guidance to providers and plans.
Physicians’ progress toward ending the nation’s opioid epidemic
**OPIOID PRESCRIPTIONS DECREASED 33 PERCENT SINCE 2013.**

Between 2013 and 2018, the number of opioid prescriptions decreased by more than **80 million** — a **33 percent decrease** nationally. **Every state** has seen a decrease in opioid prescriptions over the last five years.¹

The nation saw a **12.4 percent decrease** – more than **20 million** fewer prescriptions – between 2017 and 2018 alone.

![Opioid prescriptions decrease chart]

**THE NEED TO RESTORE BALANCE**

The AMA Opioid Task Force continues to urge physicians to make judicious and informed prescribing decisions to reduce the risk of opioid-related harms, but acknowledges that for some patients, opioid therapy, including when prescribed at doses greater than recommended by some entities, may be medically necessary and appropriate.

Various health insurance plans, retail pharmacies, and local and state governments are implementing the CDC [Opioid Prescribing] Guideline as policy, limiting the number of days a patient can receive prescription opioids even when the seriousness of the injury or surgery may require opioids for adequate pain management for a longer period. A more even-handed approach would balance addressing opioid overuse with the need to protect the patient-provider relationship by preserving access to medically necessary drug regimens and reducing the potential for unintended consequences.

> “


¹ Xponent, IQVIA, Danbury, CT, Accessed May 2019
AMERICA’S PHYSICIANS ARE USING STATE PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) MORE THAN EVER.

WE URGE STATES TO TAKE ACTION TO IMPROVE INTEGRATION WITH ELECTRONIC HEALTH RECORDS AND DAILY WORKFLOW AT THE POINT OF CARE.

Today, nearly 2 million physicians and other health care professionals are registered to use state-based PDMPs — a 290 percent increase from 2014.

Physicians and other health care professionals made more than 460 million PDMP queries in 2018 — a 56 percent increase from 2017 and a 651 percent increase from 2014.

THE AMA OPIOID TASK FORCE ENCOURAGES ALL PHYSICIANS TO ENHANCE THEIR EDUCATION.

In 2018, more than 700,000 physicians and other health care professionals completed continuing medical education trainings and accessed other educational resources provided by the AMA, and state and specialty medical societies. These materials included opioid prescribing, pain management, screening for substance use disorders, and related areas.

---

2. Based on an AMA survey and responses from 49 state PDMP administrators. Figures will be adjusted as new information becomes available.
3. Based on an AMA survey and responses from 49 state PDMP administrators. Figures will be adjusted as new information becomes available.
4. Based on AMA survey and responses from 51 state and specialty society representatives.
THE AMA OPIOID TASK FORCE URGES EXPANDED ACCESS TO NALOXONE.

Access to naloxone has saved tens of thousands of lives, but we can do even more. The AMA Opioid Task Force encourages co-prescribing naloxone to patients at risk of overdose.

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 2016.5

WE NEED TO CLOSE THE TREATMENT GAP.

More than 66,000 physicians and other health care professionals now have a federal waiver to prescribe buprenorphine in-office for the treatment of opioid use disorder — an increase of more than 28,000 since 2016.

We must continue to work to remove stigma, reduce barriers to evidence-based care and close the gap between the number of patients who need treatment and the number who are receiving it.

end-opioid-epidemic.org
Washington removes prior authorization barriers to MAT

California Attorney General calls for removing prior authorization for MAT

Colorado removes prior authorization for MAT; expands key MAT pilot programs

Iowa removes prior authorization for MAT in Medicaid

Pennsylvania reaches agreement with state’s largest insurers to remove prior authorization for MAT

Maine & Massachusetts courts affirms patients’ rights to MAT in correctional systems

New York removes prior authorization for MAT; provides MAT in correctional settings

Vermont removes prior authorization for MAT

Illinois removes prior authorization for MAT

District of Columbia removes prior authorization for MAT in Medicaid

Maine & Massachusetts courts affirms patients’ rights to MAT in correctional systems

Rhode Island provides all three FDA-approved forms of MAT for inmates with OUD

Maryland first state in the nation to remove prior authorization for MAT

District of Columbia removes prior authorization for MAT in Medicaid

New Jersey & Virginia remove prior authorization for MAT in Medicaid and commercial plans

North Carolina implementing comprehensive, multidisciplinary pain care for Medicaid enrollees; removes prior authorization for MAT in Medicaid

Arizona removes prior authorization barriers for MAT

Arkansas enacts law that removes prior authorization for MAT in Medicaid and commercial insurance plans

Missouri House passes bill to increase access to MAT and MAT training

Mississippi expands access to naloxone and non-opioid pain management in Medicaid

Vermont removes prior authorization for MAT

Illinois removes prior authorization for MAT

District of Columbia removes prior authorization for MAT in Medicaid

New Jersey & Virginia remove prior authorization for MAT in Medicaid and commercial plans

North Carolina implementing comprehensive, multidisciplinary pain care for Medicaid enrollees; removes prior authorization for MAT in Medicaid

Who’s Next?
We are at a crossroads in our nation’s efforts to end the opioid epidemic. It is time to end delays and barriers to medication-assisted treatment (MAT)—evidence-based care proven to save lives; time for payers, PBMs and pharmacy chains to reevaluate and revise policies that restrict opioid therapy to patients based on arbitrary thresholds; and time to commit to helping all patients access evidence-based care for pain and substance use disorders. Physicians must continue to demonstrate leadership, but unless and until these actions occur, the progress we are making will not stop patients from dying.

— Patrice A. Harris, MD, MA, Chair, AMA Opioid Task Force

WE ALL HAVE TO WORK TOGETHER TO END THE EPIDEMIC.

THE AMA OPIOID TASK FORCE RECOMMENDS THE FOLLOWING:

1 Remove inappropriate administrative burdens or barriers that delay or deny care for FDA-approved medications used as part of medication-assisted treatment (MAT) for opioid use disorder (OUD).

2 Support assessment, referral, and treatment for co-occurring mental disorders as well as enforce meaningful oversight and enforcement of state and federal mental health and substance use disorder parity laws.

3 Remove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs.

4 Support maternal and child health by increasing access to evidence-based treatment, preserving families, and ensuring that policies are non-punitive.

5 Support reforms in the civil and criminal justice system that help ensure access to high-quality, evidence-based care for opioid use disorder, including MAT.
Opioid-Involved Overdose Deaths

In 2017, there were 952 overdose deaths involving opioids in Missouri—a rate of 16.5 deaths per 100,000 persons and higher than the national rate of 14.6 deaths per 100,000 persons. The greatest increase in opioid deaths occurred among cases involving synthetic opioids (mainly fentanyl), with an elevenfold increase from 56 deaths in 2012 to 618 in 2017 (Figure 1). Heroin involved deaths and those related to prescription opioids have remained steady in recent years.

Figure 1. Number of overdose deaths involving opioids in Missouri, by opioid category. Drug categories presented are not mutually exclusive, and deaths might have involved more than one substance. Source: CDC WONDER.
Opioid Pain Reliever Prescriptions

In 2017, Missouri providers wrote 71.8 opioid prescriptions for every 100 persons (Figure 2) compared to the average U.S. rate of 58.7 prescriptions for every 100 persons. Overall, this represents a less than 10 percent decline in Missouri opioid prescriptions since 2006 (CDC).

The rate of overdose deaths involving opioid prescriptions has followed this trend with overall rates unchanged in the last decade: 4.3 to 4.1 from 2007 to 2017 (Figure 2).

Figure 2. Missouri rate of overdose deaths involving prescription opioids and the opioid prescribing rate. Source: CDC and CDC WONDER.
Neonatal Abstinence Syndrome (NAS)

NAS or neonatal opioid withdrawal syndrome (NOWS) may occur when a pregnant woman uses drugs such as opioids during pregnancy. A recent national study revealed a fivefold increase in the incidence of NAS/NOWS between 2004 and 2014, from 1.5 cases per 1,000 hospital births to 8.0 cases per 1,000 hospital births. This is the equivalent of one baby born with symptoms of NAS/NOWS every 15 minutes in the United States. During the same period, hospital costs for NAS/NOWS births increased from $91 million to $563 million, after adjusting for inflation (Figure 3).

In 2016, there were 2,112 reported cases of NAS/NOWS in Missouri (Missouri Department of Health and Senior Services).

Figure 3. NAS/NOWS Incidence rate and hospital costs for treatment in the United States. Source: T.N.A. Winkelman, et al., 2018.
May 28, 2019

Steven D. Waldman, MD, JD
Vice Dean, UMKC School of Medicine
2411 Holmes
Kansas City, MO 64108

Dear Dr. Waldman:

I write on behalf of the Missouri State Medical Association in support of the University of Missouri Kansas City School of Medicine’s proposal to the CMS Health Resources and Services Administration for a grant to fund the training of more primary care physicians to practice in Missouri’s underserved communities. We strongly support this grant application and the focus on primary care in rural Missouri.

We look forward to UMKC School of Medicine making great strides with the work involved in this grant.

Sincerely,

James A. DiRenna, DO, FAAFP
President
## 2019 Actions on Resolutions from the Annual Meeting

<table>
<thead>
<tr>
<th>RES #</th>
<th>SUBJECT</th>
<th>HOUSE ACTION</th>
<th>RECOMMENDED COUNCIL ACTION</th>
<th>CURRENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chronic Traumatic Encephalopathy</td>
<td>Referred to MSMA Council</td>
<td>Executive Committee referred it to the Legislative Committee</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Addressing Healthcare Needs of Children of Incarcerated Parents</td>
<td>Substitute Resolution Adopted</td>
<td>Resolution submitted to AMA</td>
<td>AMA A19 adopted resolution 503</td>
</tr>
<tr>
<td>3</td>
<td>Creation of a Women Physicians Section within the Missouri State Medical Association</td>
<td>Amended Resolution Adopted</td>
<td>Bylaws updated</td>
<td>Bylaws updated</td>
</tr>
<tr>
<td>4</td>
<td>Support for Bleeding Control Training in Schools</td>
<td>Resolution adopted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Sexual Health Education in Missouri Public Schools</td>
<td>Amended Resolution Adopted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Abolishing Prior Authorization Requirements for Opioid Use Disorder Treatment</td>
<td>Substitute Resolution Adopted</td>
<td>...already included in legislative language</td>
<td>HB 399 passed 2019 Missouri Legislature</td>
</tr>
<tr>
<td>7</td>
<td>Supporting Common Sense Climate Change Legislation</td>
<td>Amended Resolution Referred to MSMA Council</td>
<td>Executive Committee referred it to the Legislative Committee</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>The Study of Physician and Trainee Suicide Based on the Show-Me Compassionate Medical Education Project</td>
<td>Amended Resolution Adopted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>AMA Delegate Term Limits</td>
<td>Resolution adopted</td>
<td>Bylaws updated</td>
<td>Bylaws updated</td>
</tr>
</tbody>
</table>

Updated 6/12/19
Resolution 1 – Chronic Traumatic Encephalopathy (Referred to MSMA Council)

RESOLVED, that the Missouri State Medical Association (MSMA) take a position that tackle football should not be played before the age of high school; and be it further

RESOLVED, that the MSMA would support any legislation to this effect introduced in our state.

Resolution 2 – Addressing Healthcare Needs of Children of Incarcerated Parents (Substitute Resolution

RESOLVED, that our Missouri State Medical Association encourage the American Medical Association to support comprehensive and evidence-based care that addresses the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk.

Resolution 3 – Creation of a Women Physicians Section with the Missouri State Medical Association (Amended Resolution Adopted)

RESOLVED, that our Missouri State Medical Association create a Women Physicians Section (WPS); and be it

RESOLVED, that the Women Physicians Section serve to enhance leadership among Missouri’s women physicians, better engage women physicians in the MSMA, address issues unique to the practice of women physicians, and advocate on behalf of women’s health issues and the health of women physicians.

Resolution 4 – Support for Bleeding Control Training in Schools (Resolution Adopted - title amended to strike

RESOLVED, that the Missouri State Medical Association support legislation encouraging the training of high school students and teachers in life-saving bleeding control techniques.

Resolution 5 – Sexual Health Education in Missouri Public Schools (Amended Resolution Adopted)

RESOLVED, that our Missouri State Medical Association support the implementation of age-appropriate, medically accurate comprehensive sexual health education that stresses the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, teaches contraceptive choices and safe sex, and integrates sexual violence prevention, including conversations about consent, and the social and

RESOLVED, that our MSMA opposes the sole use of abstinence only based sex education.

Resolution 6 – Abolishing Prior Authorization Requirements for Opioid Use Disorder Treatment (Substitute Resolution Adopted)

RESOLVED, that the Missouri State Medical Association support legislation to abolish prior authorization requirements for FDA-approved generic medications for the treatment of opioid use disorders; and be it further

RESOLVED, that the Missouri State Medical Association support legislation to encourage that generic medications to treat opioid use disorders be reclassified on to the lowest cost-sharing tier of a health plan’s
Resolution 7 – Supporting Common Sense Climate Change Legislation  (Referred to MSMA Council)

RESOLVED, that our Missouri State Medical Association release a formal statement endorsing that climate change is a real phenomenon with health consequences; and be it further

RESOLVED, that our Missouri State Medical Association will advocate on behalf common sense policies to reduce carbon emissions, reduce environmental pollution, and improve the air/water quality of Missouri; and be it

RESOLVED, that our Missouri State Medical Association work with relevant stakeholders to lobby for Missouri legislation that will reduce greenhouse gas emissions and improve the environment for the sake of Missouri

Resolution 8 – The Study of Physician and Trainee Suicide Based on the Show-Me Compassionate Medical Education Project  (Amended Resolution Adopted)

RESOLVED, that our MSMA work with relevant stakeholders in the creation of a national database of student, resident/fellow, and physician suicides to track statistics in regards to those who commit suicide and relevant factors surrounding their suicide; and be it further

RESOLVED, that our MSMA endorse resident, fellow, and medical student participation on the Show-Me Compassionate Medical Education Committee.

Resolution 9 – AMA Delegate Term Limits  (Resolution Adopted)

RESOLVED, that the MSMA Bylaws be amended to create term limits for delegates (not alternate delegates) of the Missouri AMA delegation; and be it further

RESOLVED, that if this amendment to the MSMA Bylaws is approved it will go into effect beginning with the MSMA Convention in 2021 with past service being counted when considering the 2021 Missouri AMA delegation

RESOLVED, that the MSMA Bylaws, Chapter III. House of Delegates, Section 10 of said Bylaws include: “MSMA members may serve a maximum of eight years as an AMA Delegate; however, term limits are suspended while serving as a member of an AMA House of Delegates Council.”
### MSMA Leadership Recruitment


<table>
<thead>
<tr>
<th>Physician</th>
<th>new/re-joined members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbe, D.</td>
<td>3</td>
</tr>
<tr>
<td>Barbe, N.</td>
<td>1</td>
</tr>
<tr>
<td>Barjenbruch</td>
<td>2</td>
</tr>
<tr>
<td>Biggers</td>
<td>1</td>
</tr>
<tr>
<td>Cabbabe</td>
<td>1</td>
</tr>
<tr>
<td>Conant</td>
<td>1</td>
</tr>
<tr>
<td>Corrado</td>
<td>1</td>
</tr>
<tr>
<td>DiRenna</td>
<td>2</td>
</tr>
<tr>
<td>Drees</td>
<td>1</td>
</tr>
<tr>
<td>Florio</td>
<td>2</td>
</tr>
<tr>
<td>Gates</td>
<td>3</td>
</tr>
<tr>
<td>Hierholzer</td>
<td>7</td>
</tr>
<tr>
<td>Hover</td>
<td>4</td>
</tr>
<tr>
<td>Hubbell</td>
<td>2</td>
</tr>
<tr>
<td>Johar</td>
<td>2</td>
</tr>
<tr>
<td>Kuhlmann</td>
<td>2</td>
</tr>
<tr>
<td>Lovinger</td>
<td>2</td>
</tr>
<tr>
<td>O'Dell</td>
<td>6</td>
</tr>
<tr>
<td>Pohl</td>
<td>1</td>
</tr>
<tr>
<td>Taormina</td>
<td>4</td>
</tr>
<tr>
<td>Thomas</td>
<td>2</td>
</tr>
<tr>
<td>Van Way</td>
<td>3</td>
</tr>
<tr>
<td>Wallace, D.</td>
<td>2</td>
</tr>
<tr>
<td>Wallace, S.</td>
<td>4</td>
</tr>
<tr>
<td>Weikart</td>
<td>3</td>
</tr>
<tr>
<td>Zhu</td>
<td>1</td>
</tr>
</tbody>
</table>

63
## MSMA Membership

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>398</td>
<td>410</td>
<td>148</td>
<td>278</td>
<td>211</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>960</td>
<td>975</td>
<td>780</td>
<td>828</td>
<td>792</td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>1364</td>
<td>1456</td>
<td>1066</td>
<td>1280</td>
<td>1145</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>1936</td>
<td>1756</td>
<td>1526</td>
<td>1609</td>
<td>1536</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>2367</td>
<td>2345</td>
<td>1995</td>
<td>1855</td>
<td>1892</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>2771</td>
<td>2529</td>
<td>2229</td>
<td>1954</td>
<td>2101</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>2879</td>
<td>2641</td>
<td>2386</td>
<td>2223</td>
<td>2195</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>2960</td>
<td>2709</td>
<td>2489</td>
<td>2359</td>
<td>2238</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>3021</td>
<td>2761</td>
<td>2528</td>
<td>2400</td>
<td>2262</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>3181</td>
<td>2849</td>
<td>2602</td>
<td>2441</td>
<td>2269</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>3164</td>
<td>2919</td>
<td>2685</td>
<td>2523</td>
<td>2349</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>3196</td>
<td>2938</td>
<td>2692</td>
<td>2530</td>
<td>2381</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>variance</td>
<td>-258 -246 -162 -149 -242</td>
</tr>
<tr>
<td>variance</td>
<td>-8.1% -8.4% -6.0% -5.9% -10.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>212</td>
<td>135</td>
<td>97</td>
<td>99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>294</td>
<td>225</td>
<td>235</td>
<td>238</td>
<td></td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>322</td>
<td>334</td>
<td>291</td>
<td>309</td>
<td>304</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>401</td>
<td>376</td>
<td>359</td>
<td>347</td>
<td>342</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>430</td>
<td>398</td>
<td>375</td>
<td>369</td>
<td>350</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>455</td>
<td>445</td>
<td>387</td>
<td>383</td>
<td>362</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>465</td>
<td>448</td>
<td>397</td>
<td>395</td>
<td>365</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>467</td>
<td>449</td>
<td>403</td>
<td>398</td>
<td>367</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>485</td>
<td>450</td>
<td>404</td>
<td>400</td>
<td>369</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>475</td>
<td>452</td>
<td>408</td>
<td>401</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>476</td>
<td>455</td>
<td>408</td>
<td>403</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>variance</td>
<td>476 -21 -47 -5 -34</td>
</tr>
<tr>
<td>variance</td>
<td>-4.4% -10.3% -1.2% -8.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>798</td>
<td>896</td>
<td>1017</td>
<td>679</td>
<td>644</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>910</td>
<td>962</td>
<td>982</td>
<td>694</td>
<td>692</td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>994</td>
<td>945</td>
<td>978</td>
<td>771</td>
<td>701</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>1021</td>
<td>947</td>
<td>975</td>
<td>780</td>
<td>701</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>997</td>
<td>1042</td>
<td>949</td>
<td>962</td>
<td>794</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>1004</td>
<td>1041</td>
<td>954</td>
<td>960</td>
<td>808</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>1007</td>
<td>1054</td>
<td>958</td>
<td>958</td>
<td>818</td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>1008</td>
<td>1056</td>
<td>963</td>
<td>957</td>
<td>823</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>1008</td>
<td>1056</td>
<td>959</td>
<td>930</td>
<td>826</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>1011</td>
<td>1056</td>
<td>959</td>
<td>930</td>
<td>829</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>1011</td>
<td>1053</td>
<td>986</td>
<td>892</td>
<td>835</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>1019</td>
<td>1048</td>
<td>916</td>
<td>724</td>
<td>835</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>variance</td>
<td>29 -132 -192 -111 -96</td>
</tr>
<tr>
<td>variance</td>
<td>2.8% -12.6% -21.0% 15.3% -11.5%</td>
</tr>
</tbody>
</table>

### June 2018 to June 2019 comparison

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actives</td>
<td>2269</td>
<td>2139</td>
<td>-130</td>
</tr>
<tr>
<td>Retired</td>
<td>402</td>
<td>369</td>
<td>-33</td>
</tr>
<tr>
<td>Residents</td>
<td>108</td>
<td>105</td>
<td>-3</td>
</tr>
<tr>
<td>Students</td>
<td>829</td>
<td>739</td>
<td>-90</td>
</tr>
<tr>
<td>ALL</td>
<td>3608</td>
<td>3352</td>
<td>-256</td>
</tr>
</tbody>
</table>
MPHP COUNCIL REPORT
2nd Quarter 2019
April 1 thru June 30, 2019

680 Craig Road, Suite 308
St. Louis, MO 63141
800-958-7124
Physicians Health Program Statistics
2nd Q 2019 - April 1, 2019 to June 30, 2019

Current Geographic Distribution
(current participants 2019)

<table>
<thead>
<tr>
<th>Location</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saint Louis</td>
<td>40</td>
</tr>
<tr>
<td>Kansas City</td>
<td>16</td>
</tr>
<tr>
<td>Springfield</td>
<td>3</td>
</tr>
<tr>
<td>Columbia</td>
<td>17</td>
</tr>
<tr>
<td>Joplin</td>
<td>5</td>
</tr>
<tr>
<td>Poplar Bluff/CapeGirardeau</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
</tr>
</tbody>
</table>

2019 Participants

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>7</td>
</tr>
<tr>
<td>Cardiology</td>
<td>6</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Dermatologist</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>4</td>
</tr>
<tr>
<td>Family Practice</td>
<td>13</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>1</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>18</td>
</tr>
<tr>
<td>Medical Students</td>
<td>5</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>4</td>
</tr>
<tr>
<td>Neurosurgery/Neurology</td>
<td>2</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>6</td>
</tr>
<tr>
<td>Oncology</td>
<td>3</td>
</tr>
<tr>
<td>Optometry with MD</td>
<td>1</td>
</tr>
<tr>
<td>Otolaryngology/Otology</td>
<td>1</td>
</tr>
<tr>
<td>Pathology</td>
<td>0</td>
</tr>
<tr>
<td>Pediatrics/neonatal/oncol</td>
<td>4</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
</tr>
<tr>
<td>Proctology</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4</td>
</tr>
<tr>
<td>Pulmonary Critical Care</td>
<td>1</td>
</tr>
<tr>
<td>Radiology</td>
<td>5</td>
</tr>
<tr>
<td>Residents</td>
<td>5</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0</td>
</tr>
<tr>
<td>Surgery</td>
<td>7</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
</tr>
</tbody>
</table>

Specialties (current participants)

<table>
<thead>
<tr>
<th>TYPE OF CONTRACT</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery</td>
<td>78</td>
</tr>
<tr>
<td>Mental Health</td>
<td>18</td>
</tr>
<tr>
<td>Mental Health/Recovery</td>
<td>3</td>
</tr>
<tr>
<td>Referrals for this quarter</td>
<td>10</td>
</tr>
<tr>
<td>Total for year</td>
<td>36</td>
</tr>
<tr>
<td>Potential participants in treatment or in process of signing agreement with MPHP</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
</tr>
</tbody>
</table>
## Supplementary-Revenue Information

**2nd Quarter (April 1 to June 30, 2019)**

<table>
<thead>
<tr>
<th></th>
<th><strong>2019</strong> BUDGETED</th>
<th><strong>2019</strong> ACTUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>$315,000</td>
<td>$133,372</td>
</tr>
<tr>
<td>Participant Fees</td>
<td>$238,000</td>
<td>$109,022</td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
<td>$553,000</td>
<td>$242,394</td>
</tr>
</tbody>
</table>

Sponsored by the Missouri State Medical Association
Installation of Alliance officers took place on Saturday April 6 during the MSMA convention at the Westin Crown Center in Kansas City. President-Elect Diana Corzine and I were re-installed for a second term.

The Alliance executive board meeting was held in Columbia on Wed May 29 with almost full board attendance. Due to heavy storms, several members participated via conference call. This was a very effective form of communication during an ice storm at the February board meeting in Jefferson City and we will offer this option at future board meetings.

Our newly installed officers and committee chairs presented their plans for the year. We will continue many programs already in place in our state and explore some new initiatives. Future board meetings are scheduled for October 30, March 3 (White Coat Rally), and April 3.

The AMA Alliance Annual meeting was held at the Hyatt Centric Hotel on Magnificent Mile in Chicago June 8-11. Missouri provided the largest contingent of any state in the nation! This was announced by President Cami Pond. Missouri was represented by Marsha Conant, Diana Corzine, Sue Ann Greco, Donna Corrado, Kirk Doan, Mary Catherine Heimberger, Mary Shuman Gill Waltman, Jana Wolfe and Allene Wright. Mary Beth Ellison from Ohio was installed as the 2019-2020 AMA Alliance president. We attended many interesting workshops with excellent speakers, summarized in a report by President-Elect Diana Corzine in the current Show Me Alliance News.

Several MSMA Alliance members served on Annual Meeting Committees including Marsha (Presidential Aides), Gill (Elections), and Allene (Registration). Missouri members elected or appointed to the 2019-2020 AMA Alliance board included Sue Ann Greco (Secretary and Chair of Bylaws Committee, and Centennial Club Founder & Chair.), Jana Wolfe (Governance Committee and Communications & Social Media Chair on the Member Council, and on the Centennial Club Committee), Barbara Hover (Chair of the Physician Burnout/Wellness Committee and Physician Family Day, and as AMAA/PTA Opioid Initiative Liaison), Donna Corrado (appointed as AMA Alliance Ambassador to Missouri), and Mary Shuman (AHEI Council Advisor).
The SLMMS Alliance received the 2019 Health Awareness Promotion (HAP) Award for the opioid awareness program at Loyola Academy in St. Louis. Sue Ann Greco accepted the award on behalf of the Alliance. She gave a short presentation and acknowledged the main participants; Angela Zylka, Kelly O’Leary, Sandra Murdock and Dianne Joyce.

Barbara Hover is spearheading the AMA Alliance project to promote Family Physician Day to be held in each state on Saturday August 31, 2019. County Alliances are encouraged to organize local events for their local physician communities.

The Alliance Fall Conference will be held Oct 29-30 in Hannibal. Sandra Murdock is our Fall Conference Coordinator. An afternoon program will be followed by a Dutch treat dinner at the Hannibal Country Club. The board meeting will be held on Thursday morning.

I will be unable to attend the October MSMA Council meeting due to a conflict with an out-of-town commitment. President-Elect Diana Corzine will attend and give the Alliance report.

Respectfully yours,

Gill Waltman
2019-2020 MSMA Alliance President

e: gillian.waltman@gmail.com (314 941-4455)
Councilor Advisor Appointments – 2019

Commission on Medical Economics – David Kuhlmann, MD

Commission on Continuing Education – Peggy Barjenbruch, MD

Commission on Public Affairs – George Hubbell, MD

Physicians Health Committee – Lisa Thomas, MD
Physician Advocacy: The AMA Annual Meeting 2019

by the Missouri Delegation to the AMA and compiled by Charles Van Way, III, MD

The Annual Meeting of the AMA House of Delegates (HOD), is democracy at its disorderly finest. Delegates representing all states and most medical societies meet in Chicago to consider what the AMA should do, whether direct action, policy, advocacy, or education. The AMA HOD regularly considers a wide range of issues, but certain areas are emphasized each year. In 2019, the most important issues were:

- Expanding access to affordable health care coverage.
- Making augmented intelligence work for patients and physicians.
- Suicide among physicians and physicians-in-training.

The first session of the HOD was broken into by a group of demonstrators who called loudly for the AMA to support “Medicare for All.” Evidently, in the view of these activists, only their views are allowed to be heard. The group of about 50 demonstrators left after about a quarter of an hour, still chanting and waving signs.

As a matter of policy, the AMA has long been skeptical of expanding access to Medicare. Seema Verma, the Administrator of the Center for Medicare and Medicaid Services, spoke to the HOD at a later session. She opposed opening up Medicare to the general public, in large part because it would destroy the program for seniors. She expressed the commitment of CMS to simplify the paperwork burden, improve the transparency of EHR systems, and, as she put it, “level the playing field” for independent physician practices.

Universal access to health care is an important guiding principle for the AMA. The debate has always been, how should that be provided? Both the single-payer system and “Medicare for all” substitute government support for the existing system of employee-based insurance. About 180 million people, 60% of those under 65, would lose their coverage, which would be incredibly disruptive. The fee schedules under Medicare are already inadequate to support private practice physicians, and would become even lower under single-payer or “Medicare for all.” The AMA has consistently supported supports a pluralistic system which provides various options both to patients and physicians.

A number of other resolutions and reports about health care financing and access were considered by the HOD. Existing policy against the single-payer system was upheld, by a wide margin. There was support for universal access to essential public health services, such as vaccination. There was support for public health efforts to counter vector-borne diseases, which have increased in recent years. Better health care for people in jail and prisons was advocated. The HOD asked for a study of whether or not universal basic income proposals would increase access to care. There is an increasing sense that Affordable Care Act is not adequate, and should be reformed. What form this should take is being enthusiastically discussed. Possibilities include “public option,” more Federal subsidies for the insurance purchase, increased incentives for employer-based insurance, and still other proposals. The increased cost of drugs was discussed, with resolutions calling for limits on drug prices, increased transparency, and regulation of pharmacy benefit managers.

Health equity is emerging as an important concern. Many factors, usually lumped together as “determinants of care”, can lead to health disparities. These determinants include poverty, lack of education, adverse environments, previous trauma, as well as other factors. The AMA Foundation continues to support additional studies in this area. Promotion of health equity has become an additional goal of the AMA, and provides a standard by which interventions in the health system can be evaluated. For example, a resolution strongly supported universal

---

Charles W. Van Way, III, MD, FACS, FCCP, FCCM, MSMA member since 1989, Missouri/AMA Delegate, and Missouri Medicine Contributing Editor, is Emeritus Professor of Surgery, University of Missouri - Kansas City. Contact: cvanway@icx.net
access to essential public health services. Another called for elimination of non-medical exemptions to vaccination. Still another called for universal vaccination of immigrant children, whatever their legal status.

The HOD has adopted new policy on augmented intelligence (AI). AI, also called “artificial intelligence,” will become increasingly common in both healthcare and in health care education. An extensive report on the place of AI in medical education was put out by the Council on Medical Education.

In the area of medical practice, the HOD dealt with several important issues. “Prior Authorization” continues to burden physicians and their staff. The AMA is working to do away with it, or at least lessen its burden. Medicare Advantage programs have become increasingly “Medicare Disadvantage” programs, with limited networks, low reimbursement, and arbitrary administrative rules. The AMA has adopted an “Employed Physicians Bill of Rights,” continuing its commitment to ensure that all physicians can practice with as much autonomy and as few restrictions as possible. The AMA would like to see restrictions on the purchasing of practices by corporate entities. Especially in oncology, dermatology, and gynecology, this has often produced very unsatisfactory results for physicians. In some cases, the original purchaser has sold a bundle of practices on to a second entity less favorable to the physicians involved.

There was strong support to maintain physician compounding of medicines as a part of the practice of medicine. In a dozen or so states, boards of pharmacy have tried to regulate compounding by physicians, a matter of great concern to many different specialty groups.

Physician-assisted suicide is a major ethical issue. The AMA continues to oppose this, regarding it as a breach of medical ethics. There was a heated discussion concerning this, as some physicians feel it should be authorized, if not encouraged. There are those who wish to rename it “aid in dying,” a less harsh description. But the HOD voted to continue the AMA’s opposition to physician-assisted suicide, although leaving open the possibility that individual physicians in some states may disagree.

There was discussion of legalization of marijuana. A resolution called for the AMA to study the costs and benefits of legalization. The Surgeon General of the U.S., Jerome Adams, MD, stated that “there was no such thing as medical marijuana.” The AMA has opposed marijuana legalization, either medical or recreational. There was very little sympathy in the HOD for marijuana legalization, but there was also a general recognition that it has widespread public support. It is AMA policy that the restrictions should be relaxed enough to permit controlled research on marijuana and its derivatives. A particular resolution questioned what to do when a patient who takes medical marijuana is admitted to the hospital. Across the country, and in Missouri, several large health systems have opted out of issuing certificates to allow the purchase of marijuana.

Nicotine use in general and “vaping” in particular were the subject of several resolutions. The consensus was
that it should be possible to legally limit nicotine levels in products. The increased use of vaping by children and teenagers is concerning, and should be better controlled by regulations and by law enforcement.

The meeting of the Organization of State Medical Association Presidents (OSMAP) on the day prior to the HOD meeting was, as always, devoted to state issues. AMA President Barbara McAneny, MD, spoke of the current directions of the AMA, and in particular on the importance of health equity. Gary Price, MD, the president of the Physicians' Foundation, spoke of their work on defining determinants of health, and on their support of local initiatives in health. The opioid crisis was discussed. There has been progress. Deaths have stopped increasing, although still excessive. There has been a 33% drop in prescribing over last five years. There was a presentation on the successful joint effort of physicians in New York and New Jersey to oppose legalization of recreational use of marijuana – at least for this year. Physicians from California and Washington discussed their efforts to remove non-medical exemptions to vaccination.

Several people from Missouri served in leadership roles. David Barbe, MD, ended his term on the Board of Trustees, and will be moving on to a leadership role in the World Medical Association. Edmund Cabbabe, MD, serves on the Council for Long Range Planning and Development. Charles Van Way, III, MD, continues to serve on the Steering Committee of OSMAP.

Patrice Harris, MD, was inaugurated as the 174th president of the AMA. A child psychiatrist from Georgia, she is the first African-American woman to lead the AMA. She has promoted universal access to health care, better access to mental health services, and improvement of health care in underserved minorities. She has been a strong advocate of care for abused and neglected children throughout her career.

Susan Bailey, MD, was elected to be President-Elect. A physician from Texas, she has been the Speaker of the HOD for the past four years. She is a strong advocate of private practice. Her election marks the first time that the President, Past President, and President-Elect are all women.

All of the reports and resolutions adopted in the meeting are available on the AMA website. Highlights from the meeting are at https://www.ama-assn.org/one-block-delegates/annual-meeting/highlights-2019-ama-annual-meeting.

Young Physicians Section Report by Albert Hsu, MD & Laurin Council, MD

The Young Physician Section (YPS) of the AMA includes physicians < 40 years of age or within the first 8 years of practice. In Chicago, AMA-YPS adopted three resolutions to be forwarded to the HOD in November, on Basic Coursed in Nutrition; Ensuring Access to Safe and Quality Care for our Veterans; and Public Health Impacts and Unintended Consequences of Cannabis for Medicinal and Recreational Use. US Surgeon General Jerome Adams, MD, provided an inspirational lunchtime talk about his efforts to fight the opioid epidemic, reduce stigma, and ensure patient access to life-saving naloxone. He also mentioned the importance of showing the links between community health and economic prosperity.

In the HOD, several YPS-relevant topics included:

- Legislation for ‘Mature Minor’ Consent to Vaccinations
- Bullying in the Practice of Medicine
- Destigmatizing the Language of Addiction
- Peer Support Groups for Second Victims
- Dispelling Myths of Bystander Opioid Overdose

If you or someone you know is a young physician who may be interested in getting involved in the MSMA-YPS, please contact Stephen Foutes at stephen@msma.org or 800-869-6762.

Albert Hsu, MD, MSMA member since 2017 and Immediate Past Chair of the MSMA Young Physician Section, is a Reproductive Endocrinologist at the Missouri Center for Reproductive Medicine and Fertility in Columbia, Mo. Laurin Council, MD, MSMA member since 2019, is the American Society for Dermatologic Surgery representative to the AMA-YPS. She is an Assistant Professor of Dermatology at Washington University, St. Louis, Mo.

Contact: scooberhsu@gmail.com
RFS Report by Joanne Loethen, MD

The Resident and Fellow Section of the American Medical Association (AMA) convened at this year’s Annual Meeting in Chicago June 7-8. MSMA members Brette Harding, MD (ENT-MU), Jared Lambert, MD (EM-MU), Joanne Loethen, MD (MP-UMKC), and Nathan Nolan, MD (IM-MU), represented Missouri’s physicians-in-training as the section discussed issues pertinent to residents and fellows.

Issues ranged from supporting states who allow mature minors to consent for vaccinations, discouraging the use of non-FDA approved infant oximetry monitors, improving facilitation of physicians-in-training seeking mental health care through physician health programs, and advocating for reclassification of complex rehabilitation technology to improve access for patients.

Aside from policy actions, the RFS heard from Barbara McAneny, MD, AMA President, who spoke to the ongoing priorities of the AMA. Dr. McAneny shared how AMA is actively working to remove obstacles that interfere with patient care, lead the charge on public health crises, and advance the future of healthcare innovation.

The Surgeon General, Jerome Adams, MD, MPH, spoke to the RFS and encouraged early-career physicians to stay engaged in healthcare change, and then expanded on how the opioid crisis continues to cripple our nation.

John Andrews, MD, Vice President of GME Innovations at the AMA, spoke to the RFS about the new Reimagining Residency Initiative. Through this initiative, a total of $15 million has been awarded to eight GME programs investing in projects that promote systemic change in GME. This initiative compliments the Accelerating Change in Medical Education Consortium of 37 medical schools working to transform medical education across the continuum of medical training.

Missouri’s residents and fellows continue to have an active presence at both the state and national level through the support of the MSMA RFS. For more information on getting engaged with the MSMA as a resident, visit www.msma.org/resident-fellow-section. For complete details on the AMA Annual Meeting, visit www.ama-assn.org or follow AMA on Twitter, Facebook, or Instagram using the handle @americalassn.

Joanne Loethen, MD, MSMA member since 2016 and Vice Chair of the MSMA Resident and Fellow Section and MSMA RFS Vice Councillor, is at the University of Missouri, Kansas City in Internal Medicine and Pediatrics, Kansas City, Mo.
Contact: loethen@umkc.edu

MM
<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 12, 2019</td>
<td>MSMA Council Meeting</td>
<td>DoubleTree Hotel, Jefferson City</td>
</tr>
<tr>
<td>November 16, 2019</td>
<td>AMA Interim Meeting</td>
<td>Manchester Grand Hyatt, San Diego</td>
</tr>
<tr>
<td>January 11, 2020</td>
<td>MSMA Council Meeting</td>
<td>DoubleTree Hotel, Jefferson City</td>
</tr>
<tr>
<td>April 2, 2020 &amp; April 5, 2020</td>
<td>MSMA Council Meeting</td>
<td>Renaissance St. Louis Airport Hotel</td>
</tr>
<tr>
<td>April 3, 2020 &amp; April 5, 2020</td>
<td>MSMA Annual Meeting</td>
<td>Renaissance St. Louis Airport Hotel</td>
</tr>
<tr>
<td>July 11, 2020 &amp; July 12, 2020</td>
<td>MSMA Council Meeting</td>
<td>Margaritaville Lake Resort, Osage Beach</td>
</tr>
<tr>
<td>October 17, 2020 &amp; October 18, 2020</td>
<td>MSMA Council Meeting</td>
<td>DoubleTree Hotel, Jefferson City</td>
</tr>
<tr>
<td>April 8, 2021 &amp; April 11, 2021</td>
<td>MSMA Council Meeting</td>
<td>Westin Kansas City at Crown Center</td>
</tr>
<tr>
<td>April 9, 2021 &amp; April 11, 2021</td>
<td>MSMA Annual Meeting</td>
<td>Westin Kansas City at Crown Center</td>
</tr>
<tr>
<td>March 31, 2022 &amp; April 3, 2022</td>
<td>MSMA Council Meeting</td>
<td>Renaissance St. Louis Airport Hotel</td>
</tr>
<tr>
<td>April 1, 2022 &amp; April 3, 2022</td>
<td>MSMA Annual Meeting</td>
<td>Renaissance St. Louis Airport Hotel</td>
</tr>
</tbody>
</table>

Please reply promptly when you receive meeting notices, stating your hotel room preference and how many seats you will need for dinner. If your plans change and you cannot attend, please let us know so that we can cancel your room reservation and adjust our numbers for the meal to avoid unnecessary charges.

Ways to reply:

Email - cmartin@msma.org
Phone - 573/636-5151
Fax - 573/636-8552