AMA People and Elections

The California Delegation and Pacific RIM Caucus recognized outgoing Delegation Members: David Holley, M.D., Marvin Kaplan, M.D., and Gerald Murphy, M.D., for their dedication and leadership.

UC Davis medical student, and former CMA student trustee, Ryan Ribeira was elected Trustee from the AMA Medical Student Section to the AMA-HOD and will be seated at the conclusion of the 2013 AMA Annual Meeting.

UC Davis medical student Adam Dougherty and UC San Diego medical student Beth Griffiths were elected Medical Student Section Region 1 Delegate, and UC San Diego medical student Greg Goldgof and UCLA medical student Karthik Sarma were elected Medical Student Section Region I Alternate Delegates.

Patricia Austin, M.D., of Walnut Creek announced her candidacy for election to the AMA Council on Constitution and Bylaws in June 2013.

California Resolutions

1. Decoupling Social Security from Medicare: Adopted as amended a California resolution which asks the AMA to support abrogation of any connection between Medicare and Social Security benefits. (Res. 221)

2. Generic Medications and Pay for Delay Practices: Adopted a California resolution which asks the AMA to support federal legislation that makes tactics delaying conversion of medications to generic status, also known as “pay for delay,” illegal in the United States. (Res. 222)

3. Mandatory Physician Enrollment in Medicare: Adopted a California resolution which asks the AMA to: (1) support every physician’s ability to choose not to enroll in Medicare; and (2) seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. (Res. 223)

4. RAC Audits of E&M Codes: Adopted as amended a California resolution which asks the AMA to: (1) oppose Recovery Audit Contractor audits of E&M codes with the Centers for Medicare & Medicaid Services (CMS) and explain to CMS and Congress why these audits as currently conducted are deleterious to the provision of care to patients with complex health needs; (2) urge CMS and elected Washington officials to require physician reimbursement for time and expense of appeals if the AMA is unsuccessful in reversing the audits; and (3) urge CMS and elected Washington officials to provide statistical data regarding the audits, including the specialties most affected by these audits, and the percentage of denied claims for E&M codes which, when appealed, are reversed on appeal. (Res. 224)

5. Income Eligibility/Tax Deductibility of Student Loan Interest: Reaffirmed existing policy in lieu of a California resolution which asked the AMA to cause legislation to be introduced to allow 100% tax deductibility of student loan interest for physicians who choose a career in public
service, or who practice in a designated Health Professionals Shortage Area regardless of their income. (Res. 225)

The following AMA policy was reaffirmed in lieu of the California resolution:

**D-305.962 Tax Deductibility of Student Loan Payments** - Our AMA will draft legislation allowing 100% tax deductibility of student loan interest. (Res. 232, A-09)

1. **Penalties for Non-Adoption of Health Information Technology**: Reaffirmed existing policy in lieu of a California resolution which asked the AMA to oppose financial penalties by any payer for physicians who do not adopt health information technology, such as electronic medical records and electronic prescribing. (Res. 226)

The following AMA policies were reaffirmed in lieu of the California resolution:

**H-478.991 Federal EMR and Electronic Prescribing Incentive Program**

Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; and (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12)

**D-478.994 Health Information Technology**

Our AMA will:

(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);
(2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;
(3) support initiatives to ensure interoperability among all HIT systems; and
(4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services. (Res. 723, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed: Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Appended: Res. 220, A-12)

2. **Abuse of CPT Descriptors Related to “Surgery”**: Referred a resolution introduced by the American Academy of Ophthalmology and co-sponsored by California and other delegations which asks the AMA to urge the CPT Editorial Panel to retitle the section “Surgery” to read “Surgery and Procedures” and add the description of surgery in House policy H-475.983 to the section preamble. (Res. 601)

AMA Policy states:

**H-475.983 Definition of Surgery** - Our AMA adopts the following definition of “surgery” from American College of Surgeons Statement ST-11: Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or
disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212; A-07)

3. **ACGME Residency Program Entry Requirements:** Adopted a California resolution which asks the AMA to support entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association (AOA) accredited programs. (Res. 920)

4. **Shortage of Residency Training Positions:** Reaffirmed existing policy in lieu of a California resolution which asked the AMA to support efforts to urgently address the anticipated imbalance between the number of medical school graduates and available residency training positions. (Res. 921)

The following AMA policies were reaffirmed in lieu of the California resolution:

**D-305.958 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy**

Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. 2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. 3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. 4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. 5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians. 6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state’s health care workforce and health outcomes. (Sub. Res. 314, A-09; Appended: Res. 316, A-12)

**D-305.973 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs**

Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare
direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07)

5. **Designation of Electrodiagnosis / Other Services as Separate Category in Provider Networks:** Adopted as amended a California resolution which asks the AMA to: (1) oppose the re-designation of services traditionally provided by broader medical specialties as a separate specialty category for inclusion into a payor’s provider network unless compelling evidence shows it will improve patient care; and (2) support the ability for all appropriately trained neurologists and physiatrists to perform electrodiagnosis on patients within their provider network. (Res. 814)

6. **Evidence-Based Utilization of Services:** Adopted a California resolution which asks the AMA to: (1) support physician-led, evidence based, efforts to improve appropriate utilization of medical services; and (2) educate member physicians, hospitals, health care leaders and patients about the need for physician-led, evidence based, efforts to improve appropriate utilization of medical services. (Res. 815)

7. **Swipe Cards for Insurance Eligibility Determination and Payment:** Reaffirmed existing policy in lieu of the California resolution which asked the AMA to support requiring that health plans and insurers implement “swipe card” technology for the purposes of verifying insurance eligibility and enabling faster insurance payment for medical services at the point of delivery. (Res. 816)

The following AMA policy was reaffirmed in lieu of the California resolution:

**D-185.999 Information Included On Health Insurance Identification Cards**

Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing. (Sub. Res. 828, A-99; Modified: Sub. Res. 713, A-08; Reaffirmation A-09)

In addition, the Reference Committee reported that the AMA is active on this issue. As an official supporter of the Medical Group Management Association (MGMA) SwipeIT campaign, the AMA contributed to the content of the Workgroup on Electronic Data Interchange (WEDI) white paper regarding standardized ID cards.
Other Key Actions:

1. **Potential Combined HOD / NAC Meeting**: Adopted substitute recommendations contained in Board of Trustees Report 7 which is in response to AMA Policy G-600.125, AMA Meeting Schedule. BOT Report 7 asks that:

   1. The AMA organize and implement the pilot as specified in AMA Policy G-600.125.
   2. A study and report on the feasibility and logistics of reorganized future meeting dates and schedules be developed and presented to the House of Delegates.
   3. State and specialty societies be queried on the potential number of members who would attend a new, revised interim/NAC meeting.

   AMA Policy states:
   **G-600.125 AMA Meeting Schedule**
   1. Our AMA will convene as a pilot a combined interim policy making meeting and National Advocacy Conference.
   2. The combined meetings will be held at a location in the Washington, DC metropolitan area and at an appropriate time to avoid incurring contractual penalties.
   3. The pilot will take place within a reasonable time frame, and with adequate notice to members of the House of Delegates.
   4. Our AMA sections will be afforded the opportunity to meet immediately prior to and in close proximity to the meetings of the House of Delegates. (BOT Report 7)

2. **Eliminate ICD-10**: Adopted as amended a resolution that asks that: (1) in order to alleviate the increasing bureaucratic and financial burden on physicians, the AMA vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10; (2) the AMA to immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business; and (3) this communication be sent to all in Congress and displayed prominently on the AMA website. (Res. 209)

3. **Eliminating Legacy Admissions**: Defeated a resolution which asked the AMA oppose the use of legacy status in medical school admissions and support mechanisms to eliminate its inclusion from the application process, such as by encouraging the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and the Liaison Committee on Medical Education to encourage schools to remove any questions on secondary applications pertaining to legacy status. (Res. 902)

4. **Mandatory Immunization for Long-Term Care Workers**: Adopted a resolution that asks the AMA to: (1) support a mandatory annual influenza vaccination for every long term care health care worker who has direct patient contact unless a medical contraindication or religious objection exists; (2) recommend that medical directors and other practitioners encourage caregivers (both professional health care workers and family caregivers) to obtain these vaccinations; and (3) recommend vaccinations be made available and offered at no cost to staff working in long-term care settings. (Res. 916)

5. **Strengthening Medicare for Current and Future Generations**: Adopted as amended Council on Medical Service Report 5 which expands on longstanding AMA policy that supports providing Medicare beneficiaries with defined contributions and a choice of health care plans from which
to purchase coverage. The report also recommends a set of principles that should be included in a defined contribution system to ensure that Medicare remains a viable program that provides affordable and accessible health insurance coverage for the poorest and sickest beneficiaries.

The report recommends that:

1. That it be the policy of our American Medical Association that a Medicare defined contribution program should include the following:
   a. Enable beneficiaries to purchase coverage of their choice from among competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections.
   b. Preserve traditional Medicare as an option.
   c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare.
   d. Require that competing private health insurance plans meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare.
   e. Apply risk-adjustment methodologies to ensure that affordable private health insurance coverage options are available for sicker beneficiaries and those with higher projected health care costs.
   f. Set the amount of the baseline defined contribution at the value of the government’s contribution under traditional Medicare.
   g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. Lower income and sicker beneficiaries would receive larger defined contributions.
   h. Adjust baseline defined contribution amounts annually to ensure that health insurance coverage remains affordable for all beneficiaries. Annual adjustments should reflect changes in health care costs and the cost of obtaining health insurance.
   i. Include implementation time frames that ensure a phased-in approach.

2. That our AMA advocate that any efforts to strengthen the Medicare program ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans.


5. That our AMA continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (CMS Report 5)