

**CALIFORNIA DELEGATION
2005 AMA INTERIM MEETING – HIGHLIGHTS
As of Tuesday, November 8, 2005**

AMA People and Elections

H. Hugh Vincent, MD, of Mill Valley was re-elected Chair of the California Delegation and **Richard Frankenstein, MD**, of Santa Ana was re-elected Vice-Chair.

Stanford medical student **Beau Briese** was elected Region I Delegate from the Medical Student Section.

CALIFORNIA RESOLUTIONS

1. **Mandatory Health Insurance:** Referred a California resolution which asks the AMA to work with the federal government to ensure that: (1) all Americans be required to have, at a minimum, catastrophic and preventive health care coverage; and (2) those with incomes between 200-400 percent of the federal poverty level, who are not eligible for Medicaid or SCHIP, be eligible for a refundable tax credit to support the purchase of health care coverage. (Res. 703)
2. **In-Office Use of Diagnostic and Therapeutic Modalities:** Reaffirmed existing policy in lieu of a California resolution asking the AMA to: (1) oppose any legislation that would restrict the right of physicians to appropriately utilize in-office diagnostic imaging services; (2) adopt policy that appropriately trained and licensed physicians shall be permitted to use diagnostic or therapeutic modalities in their own office settings for appropriate diagnosis and treatment which is an integral part of patient care; and (3) urge specialty societies which share common testing modalities to work together to develop uniform standards for the training and utilization of those modalities. (Res. 901)
3. **Equitable Surgical Reimbursement for Minimally Invasive Surgery:** Defeated a California resolution which called for the AMA to: (1) affirm that reimbursement for appropriate minimally invasive surgical procedures adequately recognize the time, skill and risk involved in effectively performing the procedure; and (2) adopt policy that improved surveys and other techniques to evaluate physician work be developed and implemented to improve the accuracy of decisions about reimbursement. (Res. 804)

OTHER KEY ACTIONS:

1. **AMA Use of Social Security Numbers:** Adopted as amended the recommendations of Board of Trustees Report 3, with the remainder of the report filed. BOT Report 3 addresses Resolution 625 (A-05) which called for the AMA to no longer require Social Security numbers on membership applications. BOT Report 3 reviews current AMA policies and procedures for handling sensitive data. The report recommends that the AMA: (1) change the Student Membership Application to eliminate the Social Security Number requirement, by implementing the appropriate system and process changes to enable this change. The new application and processes would be put in place for the 2007 membership year; (2) retain the complete SSN as collected through other processing methods including the receipt of the Association of American Medical Colleges (AAMC) file itself in order to maintain the quality and accuracy of the AMA Masterfile; (3) expand the use of the Medical Education number wherever possible in replacement of the use of SSN as a primary matching element; (4) continue to actively evaluate and implement additional measures to further secure the data elements contained within the AMA Masterfile; and (5) prepare a report for the 2006 Interim Meeting on the implementation of the changes to the student membership application and issues related to the security of confidential information. (BOT Report 3)

2. **HIPAA and Foreign Outsourcing:** Adopted as amended the recommendations of Board of Trustees Report 8, with the remainder of the report filed. The report recommends that the AMA: (1) encourage physicians to be careful that business associate agreements with overseas business associates adequately safeguard the privacy and security protections for patients set forth in Health Insurance Portability and Accountability Act and encourage physicians to perform adequate and appropriate due diligence prior to entering into relationships with overseas business associates; and (2) investigate ways to protect physicians from HIPAA violations when they have contracted for services in good faith and report back to the House of Delegates at the 2006 Annual Meeting. (BOT Report 8)
3. **Opting Out of Medicare:** Reaffirmed existing policy in lieu of a resolution which calls for the AMA to request that the Centers for Medicare and Medicaid Services review and revise the restrictions and provisions associated with non-participation in the Medicare program. (Res. 704)
4. **Health Savings Account for the Medicaid Population:** Referred a resolution which calls for the AMA to: (1) endorse the concept that the Medicaid population of each state should be allowed to participate in Health Savings Accounts; and (2) develop model legislation which could be used by the states to allow the Medicaid population to participate in Health Savings Accounts. (Res. 705)
5. **Medicare Reimbursement for Anesthesiologists:** Referred for decision a resolution which calls for the AMA to request that the Centers for Medicare and Medicaid Services reevaluate its reimbursement policies for anesthesia services and that the AMA advocate for the use of conversion factors that are comparable to those used for other physician specialties so that there is parity in the Medicare reimbursement paid to anesthesiologists. (Res. 718)
6. **Avian Influenza Preparedness for Guam and Other Border States and Territories:** Adopted a resolution which asks the AMA to: (1) lobby the Administration to ensure that the Centers for Disease Control and Prevention (CDC), other federal agencies and the World Health Organization (WHO) assist Guam with the necessary testing kits and other tools necessary for Guam to detect and contain Avian Influenza; and (2) assist other areas of the US to be considered as "border states or territories" for surveillance of this Avian Influenza from Asia, so that the CDC, other federal agencies and WHO may prioritize their resources to detect and contain this virus. (Res. 722)
7. **Medicaid Funding Cuts:** Adopted a resolution which asks the AMA to vigorously oppose components of the House version of the budget reconciliation which would impose mandated premiums and copayments for acute care services and pharmaceuticals on children at 133% of the federal poverty level or below. (Res. 724)
8. **Protecting Patients Rights:** Adopted a substitute resolutions which calls for the AMA to: (1) oppose Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet the AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five principles: (a) ensure quality of care; (b) foster the patient/physician relationship; (c) offer voluntary physician participation; (d) use accurate data and fair reporting; and (e) provide fair and equitable program incentives; (2) continue to advocate for the repeal of the flawed sustainable growth rate (SGR) formula without compromising the AMA's principles for pay-for-performance; (3) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines; and (4) provide a report back to the House of Delegates at its 2006 Annual Meeting. (Res. 902)

9. **Physician Pay-for-Performance Programs:** Adopted the recommendations of Council on Ethical and Judicial Affairs Report 3, with the remainder of the report filed. CEJA Report 3 offers guidance to physicians striving to practice ethically in the face of performance-based incentive arrangements, such as pay-for-performance (PFP) programs. To this end, physicians involved in the design or implementation of PFP programs should advocate for the incorporation of incentives and performance benchmarks that primarily benefit the patient and improve the quality of their health care. Moreover, physicians participating in PFP programs should honor their professional obligations by providing medical services on the basis of patients' medical needs and individual preference and by supporting access to medical care for all people. (CEJA Report 3)
10. **Banning Smoking in All Workplaces:** Adopted as amended a resolution asking the AMA to: (1) actively support national, state, and local legislation and actively pursue regulations banning smoking in all workplaces; and (2) work to ensure that federal legislation banning smoking in all workplaces does not prohibit or weaken existing more strict state or local regulations. (Res. 903)
11. **Pilot Program on Independent Experts and Testimony in Civil Cases:** Adopted as amended a resolution which calls for the AMA to: (1) applaud the expert witness pilot program established by the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association that addresses issues surrounding the admissibility of expert testimony in civil cases and the ability of a trial judge to call an independent expert; (2) monitor the progress of the expert witness pilot program established by the Chattanooga-Hamilton County Medical Society and the Chattanooga Bar Association and report to the House of Delegates; and (3) reaffirm existing policy H-265.994 which opposes unscientific or false testimony. (Res. 2)
12. **Emergency Preparedness:** Adopted as amended a substitute resolution which asks the AMA to: (1) call for each state and local public health jurisdiction to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the U.S. Public Health Service, the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies; (2) continually refine and more actively advocate its three courses, Core, Basic and Advanced Disaster Life Support, and other equivalent courses for training hospital medical and nursing staffs and public health physicians and nurses so they are better prepared to handle mass casualty situations; (3) work with and through the Federation of State Medical Boards, its member boards and state, district and territorial governments to implement a clearinghouse for volunteer physicians (MDs and DOs) that would validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; (4) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency; and (5) that the AMA Board of Trustees report back at the 2006 Annual Meeting with an update on AMA disaster relief activities. (Res. 803)
13. **Incentive Programs to Improve Access to Health Care Services in Underserved Areas:** Adopted as amended a resolution which calls for the AMA to: (1) conduct an analysis of the creative use of tax credits, student loan deferment and loan forgiveness programs, J-1 visa waivers, and practice subsidies as financial incentives to physicians for providing care in identified underserved areas; and (2) work with state medical societies and other appropriate entities to identify, catalogue, and evaluate the effectiveness of incentive programs, including the J-1 visa waiver program, designed to promote the location and retention of physicians in rural and urban underserved areas and, consequently, improve patient access to health care in these areas. (Res. 810)

14. **Policy Suggestions for Improving the National Resident Matching Program:** Referred a resolution which calls for the AMA to: (1) work with the National Resident Matching Program (NRMP) to keep transaction costs of the Match to reasonable levels, and that fees charged for each program a medical student applies to be capped at a reasonable level that takes into account medical students' budgeting constraints; (2) urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances such as: (a) Unforeseen family emergencies such as illness that would require the individual to care for a family member, (b) Unforeseen physical or mental health problems that would impede the individual's ability to participate in residency training, or (c) Required military or foreign service duty; (3) support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels; (4) study the use of collective bargaining with residency programs participating in the Accreditation Council for Graduate Medical Education to ensure fair and equitable terms of employment for resident physicians; (5) study the creation of a body that would establish and monitor criteria for fair and equitable terms of employment for resident physicians; (6) support the concept that programs should retain the ability to extend applicants positions outside the Match; and (7) support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional "Match Day" date in mid-March. (Res. 816)
15. **Strategic Lawsuits Against Public Participation (SLAPP):** Referred for decision a resolution which asks the AMA to: (1) develop an in-depth report on the prevalence of Strategic Lawsuits Against Public Participation (SLAPP) as it pertains to health care and report back to the House of Delegates, with recommendations, at the 2006 Annual Meeting; and (2) develop model anti-SLAPP legislation as it pertains to health care. (Res. 832)
16. **Inclusion of Residents in Medical Liability Reform:** Adopted a resolution which asks the AMA to: (1) officially support the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps; (2) advocate for the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation; and (3) work with state medical societies to advocate for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation. (Res. 907)
17. **Preventing Elimination of Medical Staffs and Independent Peer Review Through Hospital Economic Loyalty Policies:** Adopted a resolution which asks the AMA to vigorously seek enforcement of existing federal law and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards relating to medical staff responsibility for quality patient care, peer review and self-governance by taking the following actions: (1) Inform the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services Office of the Inspector General (DHHS-OIG) of hospital violations of the Medicare Conditions of Participation relating to medical staff responsibilities for professional performance and quality patient care and for medical staff participation in hospital operational and budget planning, through use of "loyalty" and "conflict" credentialing; (2) Inquire of U.S. Department of Justice whether hospitals' use of "loyalty" and "conflict" credentialing, in addition to potentially violating the anti-kickback law, may also violate federal antitrust laws when it involves using market power (a) to prevent physician participation in other institutions' performance improvement programs and (b) to create barriers to competitive medical services; and (3) Provide the JCAHO with sufficient documentation to compel it to enforce the JCAHO medical staff standards and to cite hospitals with conflict, loyalty and other policies that override the bylaws and usurp the legal responsibility of the organized medical staff. (Res. 909)

18. **Security of DEA Numbers and National Provider Identifier Information:** Adopted as amended a resolutions which calls for the AMA to: (1) work with the Drug Enforcement Administration (DEA) and Congress to assure that DEA numbers are not readily available to the public for commercial or other purposes not essential for prescribing verification; (2) continue efforts to work with the Centers for Medicare and Medicaid Services regarding the security, dissemination and integrity of the National Provider Identifier (NPI); (3) report back to the House of Delegates at the 2006 Annual Meeting, and annually thereafter for five years, on the outcome of these efforts to assure that DEA numbers and the NPI are only available and used for their intended purposes; and (4) undertake a widespread campaign to inform physicians that the use of DEA numbers for purposes of identification other than for prescription of controlled substances is inappropriate and that this campaign be positioned to inform the various entities which inappropriately request DEA numbers. (Res. 905)
19. **Status Report on Expanding Health Care Coverage to All Individuals, With An Emphasis on the Uninsured:** Adopted as a amended recommendations of Council on Medical Service Report 1, with the remainder of the report filed. The report recommends that the AMA: (1) continue to place a high priority on expanding health insurance coverage for all; (2) continue to pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; (3) continue to explore and support alternative means of ensuring health care coverage for all; and (4) that the AMA Board of Trustees consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region. (CMS Report 1)
20. **Health Insurance Coverage of Specialty Pharmaceuticals:** Adopted as a amended recommendations of Council on Medical Service Report 2, with the remainder of the report filed. The report recommends that the AMA: (1) reaffirm Policy H-125.991[5], which “encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third-party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies;” (2) support complete transparency of health care coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined; (3) adopt policy that employers and health insurers should eliminate the lifetime maximums of health insurance benefits; and (4) AMA continue to monitor health plan treatment of specialty pharmaceuticals to ensure patient access to needed pharmaceuticals, and report back to the House of Delegates at the 2006 Interim Meeting. (CMS Report 2)