



CALIFORNIA DELEGATION, 2007 AMA ANNUAL MEETING – HIGHLIGHTS
As of Wednesday, June 27, 2007

AMA People and Elections

Former CMA Council on Legislation Chair, **Rebecca J. Patchin, MD**, was successful in her bid for re-election to the AMA Board of Trustees. Sacramento pediatrician, and Delegate from the American Academy of Pediatrics, **Richard J. Pan, MD**, was successful in his bid for re-election to the AMA Council on Medical Education. Despite several ballots and a valiant effort, CMA Past-President **Robert E. Hertzka, MD**, was unsuccessful in his bid for election to the AMA Council on Medical Service. Loma Linda University medical student, **Laura Gephart**, was elected the AMA-Medical Student Section Governing Council Vice-Speaker.

The California Delegation and Pacific RIM Caucus recognized CMA legal counsel **Catherine I. Hanson**, and retiring Delegation members **Daniel B. Borenstein, MD**, and **Vincent Gualtieri, MD**. The California Delegation, Pacific RIM Caucus and the entire AMA House of Delegates paid special tribute to former CMA Past-President **Ronald P. Bangasser, MD**, by celebrating his life, and his contributions to patient care, organized medicine and philanthropy. Dr. Bangasser was named posthumous honorary chair of this year's AMA Foundation *Celebration of Giving*.

CALIFORNIA RESOLUTIONS

1. **Electronic Advance Health Care Directives:** Adopted a California resolution calling for the AMA to advocate for the implementation of secure electronic advance health care directives. (Res. 4)
2. **Public Disclosure of CMS Intermediary/Contractor Information:** Reaffirmed existing policy in lieu of a California resolution which called for the AMA to request that: (1) Centers for Medicare and Medicaid Services (CMS)/Medicare independent contractors be subject to federal freedom of information laws; (2) CMS mandate its intermediaries to publish Carrier Advisory Committee minutes in a timely fashion; and (3) CMS mandate its intermediaries to share CPT code-specific denial information with specialty societies. (Res. 108)
3. **Organizations Inaccurately Claiming to Represent Physicians:** Adopted a California resolution which asks the AMA to: (1) challenge any organization that falsely claims to represent physicians; and (2) formulate an appropriate response to inaccuracies that other organizations portray about the representation of physicians. (Res. 207)
4. **Physical and Nutrition Education:** Reaffirmed existing policy in lieu of a California resolution which called for the AMA to support: (1) efforts to expand the federal No Child Left Behind legislation to include funding directed toward physical education and provision of nutrition education in schools; (2) state and federal legislation that would ensure that only healthy foods and beverages can be marketed to children; and (3) state and federal legislation to require food nutrition information to appear in menus and on menu boards in chain restaurants. (Res. 208)
5. **Access to Emergency Contraception:** Adopted as amended a California resolution calling for the AMA to: (1) work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (2) urge that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel. (Res. 506)

6. **Adequate Prescription Medication Supply:** Adopted as amended a California resolution calling for the AMA to: (1) urge health plans to define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (2) urge health plans to allow prescription refills to provide the appropriate number of doses for the time period specified by the physician. (Res. 510)
7. **Reference Laboratory Regulatory Relief:** Defeated a California resolution which called for the AMA to: (1) support state or federal regulatory action or legislation to create an exception process to give a physician the authority to refer a specific test to a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory that does not hold a state license when, in his or her professional judgment, no state licensed laboratory is qualified to perform the test; and (2) seek to have a study performed to evaluate the quality and regulation of foreign laboratories performing genetic testing and tests for rare diseases and whether those laboratories should be exempted from federal CLIA certification when there are no other qualified laboratories available to physicians and patients in the United States. (Res. 512)
8. **Medicare Cost Effectiveness Analysis:** Adopted the recommendations of Council on Medical Service Report 8, with the remainder of the report filed, in lieu of a California resolution which asked the AMA to endorse appropriate cost effectiveness methodology in Medicare and health plan coverage policies. CMS Report 8, Strategies to Address Rising Health Care Costs, calls for the AMA to:
 - (1) recognize that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
 - (2) support the following broad strategies for addressing rising health care costs:
 - (a) Reduce the burden of preventable disease;
 - (b) Make health care delivery more efficient;
 - (c) Reduce non-clinical health system costs that do not contribute value to patient care; and
 - (d) Promote "value-based decision-making" at all levels;
 - (3) continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
 - (4) continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
 - (5) continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
 - (6) encourage the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
 - (7) encourage third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Consideration should be given to tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
 - (8) support ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (Res. 701)

9. **Definition of “Usual, Customary and Reasonable” (UCR):** Adopted a California resolution which asks the AMA as policy the following definitions: (1) “usual” fee to mean that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee); (2) a fee is “customary” when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and (3) a fee is “reasonable” when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans. (Res. 109)
10. **Collective Bargaining: Antitrust Immunity:** Referred for decision and report back at the I-07 meeting a California resolution which asks the AMA to advocate for changes in the law to allow joint negotiations by groups of physicians for payment of services by third party carriers without the threat of violating antitrust laws and actively campaign for passage by the United States Congress of legislation that accomplishes these changes. (Res. 209)
11. **Air Quality Standards and Human Health:** Referred for decision a California resolution which asks the AMA to support the more stringent 2006 air quality standards as recommended by the Clean Air Scientific Advisory Committee to the Environmental Protection Agency administrators. (Res. 416)
12. **Personal Medication Supply In Times of Disaster:** Referred a California resolution which asks the AMA to: (1) urge the US Department of Health and Human Services, pharmacy benefits managers and health plans to develop policies that would allow patients to stockpile up to a one-month supply of all appropriate medications for chronic medical conditions in the event of a flu pandemic or other local or national disaster; and (2) urge that health plans be responsible for paying for all stockpiled medications for chronic conditions in the event of a local or national emergency. (Res. 433)
13. **Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages With Special Appeal to Youths:** Adopted as amended a resolution sponsored by the Guam, California, Florida and Hawaii Delegations which asks the AMA to advocate for a ban on the marketing of products such as alcopops, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age. (Res. 435)

OTHER KEY ACTIONS:

1. **Elimination of Subsidies to Medicare Advantage Plans:** Adopted as a amended a resolution which calls for the AMA to: (1) seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services, and that any savings from the elimination of subsidies to private plans be used to address the Sustainable Growth Rate (SGR); (2) seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product; and (3) work with CMS to prohibit all products clauses from applying to Medicare Advantage plans and private fee-for-service plans. (Res. 229)
2. **Pay-for-Performance, Physician Economic Profiling, and Tiered and Narrowed Networks:** Adopted as amended Board of Trustees Report 18, with the remainder of the report filed. BOT Report 18 asks that: (1) the AMA to collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third-party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles and that the AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450-947; (2) the AMA to strongly oppose the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors; (3) the AMA pledge an unshakeable and uncompromising commitment to the

welfare of patients, health of the nation, and the primacy of the patient-physician relationship free from intrusion from third-parties; (4) because there are reports that pay-for-performance programs may pose more risks to patients than benefits, the AMA prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other quality initiatives; (5) the AMA continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries; (6) as a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, the AMA continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality cost-effectiveness, and appropriateness of care; and (7) the AMA advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payment or forfeiture of opportunity for additional compensation. (BOT Report 18)