Physician Advocacy: The AMA Interim Meeting 2016

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

Your Missouri Delegation to the American Medical Association continues to have a strong voice in the AMA, because in our midst is President-Elect David Barbe, MD, of Mountain Grove. As usual, other members of the delegation have served in various ways. Dr. Van Way, your correspondent, served on the Committee on Rules and Bylaws, which performs several functions at the meeting itself.

The AMA has two meetings each year. This Interim meeting, held this year in November in Orlando, Florida, is intended to focus on the political and legislative arena. Advocacy is its purpose. The results of the election, a week before the meeting, stirred up the House of Delegates (HOD). Few expected the result.

Andrew Gurman, MD, President of the AMA, and James Madura, MD, Executive Vice President, both spoke. They expressed relief at the end of the awful election campaign, and optimism going forward. A public statement released by Dr. Gurman committed the AMA to working with the new administration, and to the “core principle” that “any new reform proposal should not cause individuals currently covered to become uninsured.” Disturbingly, there seemed little acknowledgement by the leadership that the Affordable Care Act has failed in many respects, and should be fixed.

A highlight of the meeting was the presentation of the AMA’s highest award, the Meritorious Service Award. This year, it was given to Bennet Omalu, MD, the discoverer of the new disease of chronic traumatic encephalopathy. CBI has changed our views of such disparate subjects as professional football and military casualties. Dr. Omalu was met with opposition from the National Football League, medical experts, sports figures, and even some universities. Dr. Omalu expressed his gratitude for the support of the AMA. His passionate acceptance speech was given a standing ovation.

The Reference Committee on Constitution and Bylaws considered several issues, including end-of-life care, ethical conflicts of employed physicians, and the definition of female genital mutilation. The Board of Trustees has recommended increasing specialty society representation, and further increasing the relative representation of the larger societies, such as the American College of Physicians and the American College of Surgeons. Shifting the HOD further towards specialty organization has risks, and is opposed by many. The HOD approved this recommendation, and it will be implemented. Stay tuned.

Reference Committee B considered many legislative and regulatory issues. Physician offices have been classified by the FDA as “compounding facilities,” and are now subject to a whole host of regulations. A resolution was passed to lobby the FDA to change this classification. The AMA is already working on the problem. Falsely adding physicians to the National Data Bank was highlighted. Documentation using the problem-oriented medical record is still not recognized as valid by CMS. Using SOAP may cause denial of payment. And then we have MACRA.
In 2014, the Medicare Access and CHIP Reauthorization Act, MACRA, eliminated the SGR formula. But it then created new ways for paying physicians: Merit-Based Incentive Payment Systems (MIPS) and Alternative Payment Models (APM). To make things more confusing, MACRA is now re-named QPP, Quality Payment Program. The final rules have just been released, and will take effect in January 2017. All that said, pushback from the AMA has softened the blow somewhat. Smaller practices may be able to exempt themselves from the requirements. Required reporting measures have been made simpler. There is more flexibility. Physicians will be able to participate to different degrees in the program next year, and will not, at least in the short term, be exposed to losing money. This is a work in progress. MACRA passed Congress with large bipartisan majorities. It is unlikely to go away, although ongoing modifications are very likely in the new political environment.

Unfortunately, many physicians simply don’t realize this is coming. Many have delegated this to practice managers. Others are involved in group, corporate, or employed practices. There was widespread concern that practices will be hurt by their failure to prepare for reporting. Much information is available on the AMA website, https://www.ama-assn.org/practice-management/understanding-medicare-payment-reform-macra, as well as from the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

One Missouri resolution was considered. This asked for a study of extension of the Family Medical Leave Act to businesses now exempt. The intent clearly was to advocate extension. The resolution was amended to “encourage” study. We may find out in another few months whether or not the AMA thinks this is a good idea.

Committee C considered medical education. Maintenance of Certification (MOC) was again a major concern. Besides several resolutions, there were several presentations about the problems with MOC. One of our colleagues from Oklahoma, Woody Jenkins, MD, presented the successful opposition of physicians to an attempt in the legislature to mandate MOC as a condition of licensing. A strong resolution committed the AMA to promote state legislation and hospital staff bylaws discouraging the use of MOC status in decisions about licensure, hospital privileges, and re-credentialing. Missouri medical students were instrumental in adopting policy encouraging mental health screening and treatment for medical students and residents.

Committee F considered finance and governance. A resolution was adopted calling for financial oversight and audit of the American Board of Internal Medicine, other medical boards, and the American Board of Medical Specialties. This reflects a profound distrust of the accrediting boards, in part driven by their expansion of MOC.

Committee J considered medical practice issues. There was particular interest in the plight of medical students and residents who are protected from deportation under Deferred Action for Child Arrivals. DACA, enacted by executive action in 2012, has resulted in a number of students entering medical education. There are 31 such individuals in medical schools, and perhaps as many more in residency programs. If DACA is abolished, as seems likely, these students will likely be unable to complete their educations. The HOD voted to advocate for their exemption from any changes in DACA.

Another resolution concerned communication
among physicians in the age of compartmentalized EHRs, strongly advocating improvements in interconnection and transparency. There were resolutions about ensuring equal access to high quality care, in such disparate settings as veterans, same sex couples, prisons, and breast reconstruction. A very popular resolution called for insurance plans to collect co-pays and deductibles from their plan enrollees, rather than requiring doctors to do it for them. Good luck with that.

Committee K studied issues of science and public health. Probably the most controversial was a resolution that the AMA cease to oppose the legalization of marijuana, as was done in a number of states in the last election. The question was referred to Council. It was said that a report from the National Academies of Science, Engineering, and Medicine will be released in the next few months. Expect further debate at the next Annual Meeting, in June 2017.

As usual, a number of resolutions were passed to make small improvements in the practice of medicine and public health. There were brisk discussions on such issues as opioid abuse, early childhood education, neuropathic pain as a new diagnosis, environmental exposures to lead and to polycyclic aromatic hydrocarbons, and youth incarceration in adult prisons. There was concern over the October 17 action by the DEA which mandates a 25% decrease in opioid production. This action is very likely to have unintended adverse effects. Graphic warning levels on tobacco packages were strongly supported, although these have not survived court challenges in the past.

The Physicians Foundation of the AMA supports physicians and health care in general. It has been particularly active in the area of costs. A recent book by the late Richard Cooper, MD, “Poverty and the Myths of Health Reform” is a must-read for any concerned with the continuing rise in health care costs. The Foundation’s biennial physician survey was completed in 2016. Almost two-thirds were pessimistic about the future of medicine. The major sources of dissatisfaction were paperwork and third party interference with the practice of medicine. The major source of satisfaction was their relationships with their patients. The direction of future AMA advocacy should be obvious.

Firearm-related injuries remain a health concern of the AMA. There were resolutions to further regulate firearms. Perhaps the best of these was a resolution to facilitate studies on firearm injuries and interpersonal trauma. Research in this area has not been funded by the Federal government, for a variety of reasons which include political pressure. Current and proposed legislation continues to be guided by untested assumptions. Debates about restrictions and other measures to reduce gun violence are singularly uninformed by data.

Surprisingly little attention was paid to graduate medical education. No one at this meeting appeared to be very concerned that we do not have enough training positions. We cannot accommodate even all U.S. graduates, much less international grads. There is a growing number of young physicians who can neither work nor pursue further training. The lack of training positions has become a barrier to increasing the physician workforce. A report on this issue is forthcoming, and we may expect more action on this issue at the Annual Meeting next year.