AMA Resolutions with Relevance to Members of the American Society of Echocardiography

The American Medical Association's (AMA) House of Delegate June meeting took place in Chicago with numerous resolutions being discussed. Multiple resolutions and reports are summarized below that have the potential to impact the members of the American Society of Echocardiography (ASE).

The American Board of Medical Specialties (ABMS) applied for and received official observation status. Multiple issues were addressed regarding the Maintenance of Certification (MOC) program. Several associations supporting physicians are actively assisting them to satisfy these new requirements. Support of the newly instigated ABMS requirements continues to occur regardless of the general consensus that these requirements are overwhelmingly onerous, expensive and obtrusive. One interesting aspect of the MOC program is that non-practicing physicians (those not seeing patients) may not be eligible for reaccreditation. This is due to the lack of an alternative pathway for some of the direct patient-related activities noted. The general assumption was voiced that a large number of lifetime-certified physicians will never take the exam since it is 10 years in the future.

Res. 003, *Social Media Guidance,* resolved that the AMA collaborates with other medical organizations and interested parties to develop guidance for physicians on social media that includes benefits, pitfalls and recommended safeguards. This was not changed or voted on, instead being simply reaffirmed with the existing policy.

Medical Service Report No. 3, titled *Medicare Update Formulas across Outpatient Sites of Service,* has a direct effect on ASE. The Council on Medical Service (CMS) prepared a thorough review and issued a report as a follow up to the resolutions passed at a previous meeting. The previous resolution, titled *Unfair Medicare Payment Practices,* had been presented by Florida. The question posed to the Council asked that the AMA seek legislation to fairly compensate procedures across all service sites, including offices, outpatient hospital departments, and ambulatory surgical centers, to include a single formula for reimbursement that recognizes the different average resource costs to provide each procedure and a single update formula for all sites. Medical Service Report No. 3 highlights the complexity of reimbursement formulas. It also demonstrates that the three major types of care delivery sites are highly variable in payment due to separate methodologies and varying updates which are applied to adjust for inflation costs, resource utilization, etc. One example of this is the gap between hospital outpatient departments and ambulatory surgical centers. This disparity has widened due to differences in these formulas over previous years. The Council also reviewed the existing AMA policy. They concluded that existing payment formulas have contributed to migration of outpatient care back to hospitals and hospital-owned facilities, that the update factors should be adjusted to more fairly represent changes in cost, and that inflationary adjustments should be consistent across all three sites. The Council voted to reaffirm AMA Policy H-400.957, which encourages CMS to expand the extended

amount of payment for procedures performed in physician offices to allow shifting of more procedures to less costly settings. Unfortunately, the second resolve then noted a second policy, D-330.997, which encourages CMS to define Medicare services consistently across settings and adopt payment methodology that will assist in "leveling the playing field" across all sites of services. Additional resolutions discussed the accurate determination of practice costs and fair reimbursement across office-based practices. ASE and another cardiology society jointly expressed concern regarding Resolve 2, particularly the "leveling the playing field" language. They also testified at the Reference Committee against Resolve No. 2. ASE offered testimony about the complexity of the situation, the inability to have a single simple formula, and the high variability of running labs that are ambulatory vs. all-encompassing inpatient laboratories. The Council actively listened to ASE but did not fully agree with the testimony presented. The Council chose to remove the "leveling the playing field" statement and noted doing so in their discussion. They also substituted the phrase "encourages CMS to adopt a single-facility payment schedule" with the phrase "site-neutral payment policy," which other groups had advocated for. During the House of Delegates meeting, ASE attempted to get this report referred for further discussion, expressing the sentiment that Policy H-330.925 is confusing and needs further refinement. Multiple groups attempted to amend or reconstitute other statements in that policy, but were unable to do so. Ultimately, the vote to refer for more studies also failed. This issue proved to be a very contentious matter, as primary care physicians were very vocal in expressing the belief that they have been unfairly reimbursed and expressed the sentiment that hospitals receive too much reimbursement for the same procedures, and that everything should be equalized across the board.

CMS 07 *Coverage of and Payment for Telemedicine* addressed coverage and payment for telemedicine services. The resolution was predominantly aimed at evaluation and management services, rather than the tele-imaging that many echo labs provide. A second resolution requested that the AMA study physician licensure issues with regard to telemedicine-type services, and advocated the evaluation of a potential national set of standards to facilitate the ability to do telemedicine more easily across state borders.

Resolutions regarding the Sunshine Act requested less stringent requirements on allowing industry to support the distribution of medical textbooks and reprints of peer-reviewed journal articles over and above the highly restrictive current Sunshine Act rules. They also recommended limiting expense reporting to values greater than $100 instead of $10.

There was considerable discussion regarding the release of Medicare claims data. Most of the discussion focused on a better explanation of the way data is released and what it means, given the wide variety of reimbursements.

There also continues to be discussion about ICD-10. The majority of the delegates do not want it adopted and would prefer that it simply go away. Additional resolutions were introduced to stop or

eliminate ICD-10, skip to ICD-11, and modify or simplify ICD-10. The AMA then took credit for the one-year delay in the ICD-10 that occurred in the "Doc Fix Bill" passed last year.

The incongruence between medical school graduate numbers and residency positions was discussed, as well as possibly designating physicians that cannot find a residency spot as "assistant physicians." This was recommended for adoption from the Reference Committee but voted down by the House of Delegates. There was a considerable sentiment against the concept of assistant physicians.

The duty hours issue was again revisited and re-reviewed.

Res. 520, *Modification to the USP Chapter 797 Guidelines as Currently Written,* would modify the current USP Chapter 797 Guidelines. This is the USP Guideline regarding immediate use and the one-hour rule of the USP. Considerable testimony was given, particularly from anesthesiologists, about the difficulty of maintaining this one-hour rule. Recently the Joint Commission interpreted certain practices involving admixtures used or available for longer than one hour as violating USP 797. Standards in question relate to recommended timeframes for administration of an immediate use product and also on limitations on the amount of time a container can be entered to compound substances. This doesn't appear to affect echo contrast agents as severely as radionuclear pharmacies, who no longer can mix up and compound radionuclear agents once a day and use in a multi-use fashion throughout an entire day. These limitations have the effect of markedly increasing costs to the point where money is lost on radiopharmaceutical compounded agents.

There was a considerable discussion about data transition costs when switching from one electronic medical record system to another and the lack of any standards regarding this. This is a similar problem to switching PACS systems and the onerous costs sometimes incurred for imaging data transmission. The standard discussion of the issues of cutting, pasting, and cloning, which perhaps could be construed to certain types of echo reports also, was brought to attention. Vigilance continues to be urged regarding the misuse of the copy and paste function of EHRs. There is concern that government audits will further increase the scrutiny of cutting and pasting, particularly if the data is found to be inaccurate, with repeated mistakes.

Another resolution supporting clinical data registry development was also discussed. The majority agreed that data registries are positive and that "costs should be minimized and benefits maximized." Specific plans regarding how data registries will be funded were not discussed.

A resolution about the Choosing Wisely Program, Res. 725, was amended. The revised resolution stated that the AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely Program. The title will be changed from endorsing the Choosing Wisely Program to supporting the concepts of the Choosing Wisely Program. The majority of the testimony in the session about this program was positive. Those testimonies that were less positive

related stories about adverse media responses to their society's endorsement of Choosing Wisely as being an endorsement of eliminating "irrelevant" procedures of the specialty.